HIV Testing and Linkage

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Georgia’s HIV Testing Program

- Health Districts
- Community Based Organizations
- Community Clinics
- Jails
- Colleges/Universities
- Health Fairs
- Clubs/Bars
- Emergency Rooms
- Outreach Events
HIV Testing Program

- TOT for district identified CTL Trainers
- Provide a Social Network Strategy training for funded non-clinical test sites to increase targeted HIV testing
- Up-to-date with CTL data in Evaluation Web
HIV Testing Program

- Assessment of CTL data in Evaluation Web
  - Frequent errors with data collection
  - Numerous sites are not in compliance with deadline submissions of CTL forms
  - Missing or incomplete data recorded for positive results
    - Behavioral risk profile
    - Linkages to care and other services
What’s next for CTL

• Improve the way we capture Counseling and Testing data

• Focus on Data Quality:
  – Reduce data collection errors
  – Improve timely submission of CTL forms
  – Track linkages as documented on CTL forms for positives

• Inform opportunities for training, improved data fidelity and better communication with agencies
What’s next for CTL

- Re-structure Agency and Site associated testing as captured in Evaluation Web
- Better capture where testing is taking place and what testing events look like amongst DPH funded agencies and across sites throughout Georgia/MSA
MATLC & HIV CTL

• Development of partnerships that align with the goal of promoting routine HIV testing in healthcare/clinical settings as well as testing in non-clinical settings

• Implement a test event management and planning with testing data from Evaluation Web and other data sources
MATLC and HIV CTL

- Collaborating with Surveillance
- Better identify target populations and improve programmatic activities
- Identify areas of high prevalence, new diagnosis and positive HIV ratio
- Use of surveillance data to monitor linkages to and retention in care for newly diagnosed and previously positives
Surveillance Metrics

• Laboratory reports and dates can be used as proxies for medical visits.
  – CD4
  – Viral load

• Engagement in care
  – A medical visit within 3 months of HIV diagnosis
  – Cases known in surveillance w/ at least one lab (CD4/viral load)

• Retention in care
  – 2 or more medical visits 3 or more months apart
  – Cases known in surveillance w/ 2 or more labs (CD4/viral load) that are 3 months apart within 12 month period, excluding first lab drawn after diagnosis
Surveillance Metrics

- Re-engagement in care
  - Cases known in surveillance with at least two labs
  - Out of care: No labs in 12 months
  - Number of cases without a CD4 or viral load within 12 months or less from the diagnosis date

- Linkage to care, PS, and prevention services is currently captured on an aggregate level for testing events with a positive result

- Linkage and retention in care can be better assessed in eHARS
  - 3 months, 6 months, and 12 months
Linkage to Care Survey

Purpose - To see what linkage looks like throughout Georgia

Agencies Represented

- CBO/ASO: 8
- Health Districts: 11
- Ryan White Clinic: 2
- Health Dept/RW: 1
- RW/ASO: 1
- Other (STD Prog): 1
Linkage to Care Survey

Who is responsible for referrals and linkages?

- Case Manager: 14
- Linkage Coordinator: 9
- Public Health Nurse: 3
- No data: 1

Does your agency distinguish between referrals & linkages?

- Yes: 59.3%
- No: 44.4%
## Linkage to Care Survey

<table>
<thead>
<tr>
<th>Linkage to Care Data</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your agency have forms to document linkage activities?</td>
<td>81.5%</td>
<td>18.5%</td>
</tr>
<tr>
<td></td>
<td>(22)</td>
<td>(5)</td>
</tr>
<tr>
<td>Is summary data collected at your site to reflect linkage activities (aggregate data)?</td>
<td>81.5%</td>
<td>18.5%</td>
</tr>
<tr>
<td></td>
<td>(22)</td>
<td>(5)</td>
</tr>
<tr>
<td>Does your agency have written policies and procedures around linkage to care?</td>
<td>71%</td>
<td>29%</td>
</tr>
<tr>
<td></td>
<td>(17)</td>
<td>(7)</td>
</tr>
<tr>
<td>Does your agency have a quality assurance program to monitor linkages to care?</td>
<td>69.6%</td>
<td>30.4%</td>
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<tr>
<td></td>
<td>(16)</td>
<td>(7)</td>
</tr>
</tbody>
</table>
Linkage to Care Survey

Distinguishing between a Linkage and Referral

**Linkage**

- “Calling and setting up appointment for patient and do follow-up to see if patient attended first appointment”
- “When a client is successful connected with an agency or individual services needed, and is followed up from the Coordinator”
- “When a client sees a medical provider within 3-6 months of their diagnosis along with follow-up”

**Referral**

- “Act of providing list of resources to client or specific care provider”
- “Telling the patient of the services available and providing phone numbers and addresses”
- “Process that connects our consumers to services, resources, and opportunities”
Linkage to Care Survey
Defining a Successful Linkage

• “If a newly positive individual comes in for the appointment and (is) retained in care going forward”

• “Someone who schedules and keep their clinical appointments. Why they miss initial appointment, staff follow up with them. If they miss their medical intake after seeing case management, staff follow-up. “

• “Once a client has attended his or her first appointment.”

• “Confirmation of the clients attendance at their first Ryan White appointment”
Linkage to Care Survey

Barriers, Challenges, and Successes

**Barriers/Challenges**
- Database needed which all programs can be linked to
- Transportation
- Lack of private providers in the districts for clients who are not eligible for Ryan White
- Getting correct information at onset of reactive test results
- Clients returning for confirmatory test results

**Successes**
- Retention specialist contacts patients who are late receiving services
- Case Managers follow-up on referrals to patients leaving the service area
- Linking those who have fallen out of care back into medical care
- Patients wanting to tell their story and help others facing this epidemic
Linkage to Care Survey

We have the results- now what?

• TLC Network meeting in October 2013

• Focus groups to further vet linkage to care questions, concerns, challenges and other feedback
The Georgia TLC Network
Goals of the Georgia Test, Link, and Care Network:

1. Identify and promptly link to care persons who are living with HIV and not receiving care
2. To improve patient retention in HIV primary care

1. **Test**
   - Targeted HIV testing

2. **Link**
   - Linkage Case Managers (ALCM)
   - Network Providers
   - Linkage to care tools

3. **Treat**
   - Access to treatment
   - Increase retention in care
   - AIM to achieve viral suppression

**Support for Linkage and Retention:**
- Linkage Case Managers trained on ARTAS
- Create a wrap around approach to linkage services
- Create client empowerment videos
- Create strong inter-agency collaboration to facilitate communication and data sharing
- Reinforce and replicate linkage and retention best practices as identified using the “Plan Do Study Act”
What ARTAS?

- Anti-retroviral Treatment Access Study
- Individual, Multi-session, Time-limited intervention
- Link newly diagnosed clients to HIV
- Strengths-based Case Management
TLC Network

- HIV Prevention
  - Four Public Health Districts
    - Clayton, Fulton, Cobb-Douglas, and DeKalb
  - Seven ALCMs

- Ryan White (MAI)
  - Five Public Health Districts
    - Clayton, Fulton, Coastal, Albany, Augusta
  - Six ALCMs
Each TLC Network:

- ALCM
- 2 CBOs
- HIV Care Provider
2012 Programmatic Activities

• Funded Spring 2012
• Seamless ARTAS initiative between HIV Care and HIV Prevention (created the GIA annex)
• Staff trained as TOT
• Contract monitors and other health district staff trained
• Feasibility to use CareWare or Access to store ARTAS data
• Peer networking with other states
Current Programmatic Activities

• HIV Prevention – five ALCMs hired
• HIV Care – six ALCMs hired
• ALCMs all trained
• Data tools specifically for Georgia
• Clayton and DeKalb network meetings
• Funded agencies to implement testing
• Linkage to Care survey statewide
• Casting call to create L2C videos (Care, Eligibility, and Patient)
IHI Collaborative Meeting

- October 2013
  - Host a Metro-wide meeting with those in the 4 TLC Networks
  - Use the IHI Collaborative Model to help those in the TLC Network address their challenges associated with HIV linkage and retention in care
    - Results from the statewide linkage survey will guide the topic(s) of the IHI Collaborative Model exercise
IHI Collaborative Meeting
Test-Link-Care Network
GA Department of Public Health

Select Topic (develop mission)

Expert Meeting

Develop Framework & Changes

Planning Group

Participants (Health Districts)

Prework

LS 1 → LS 2 → LS 3

AP1 → AP2 → AP3*

October Meeting

Quarterly Meetings

Dissemination
Holding the gains
Publications
Congress
Etc.

*AP3 - continue reporting data as needed to document success

Supports
Email (listserv)
Phone Conferences
Visits
Assessments
Monthly Team Reports

LS - Learning Session

AP - Action Period

We Protect Lives.
IHI Collaborative Meeting
Model for Improvement

What are we trying to accomplish?

How will we know that a change is Improvement?

What changes can we make that will result in improvement?

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Other Linkage Activities
Other Linkage Activities

• ARTAS Linkage to Care Meeting- August 6, 2013
  – DeKalb Board of Health

• Modifying ARTAS Linkage Forms for “General Linkage”
Contact Information

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