MORE: MOBILE OUTREACH RETENTION AND ENGAGEMENT INTERVENTION

CIE Center for Innovation and Engagement

Intervention at a Glance

This section provides an overview of Whitman-Walker Health's steps to implement the Mobile Outreach Retention and Engagement (MORE) intervention.

STEP 1	**Determine Participant Eligibility** MORE participants must be 18 or older, have a reactive HIV diagnosis with a detectable HIV viral load (<200 copies/mL), and/or have not attended an HIV care follow-up visit in the last six months.
STEP 2	**Develop Participant Referral System** WWH's Quality Improvement (QI) team conducts an EMR chart review twice per year to provide data on client retention in the MORE intervention. The MORE intervention also accepts ongoing internal referrals from clinical staff (e.g., Nurse Case Managers, Care Navigators, Medical Providers). Identified clients are connected to the Mobile Care Navigator (MCN). The MCN reviews each referred client's EMR chart to confirm eligibility and find contact information.

STEP 3

Conduct Baseline Participant Interview

The MCN conducts the baseline interview at the initial point of client contact. The baseline interview includes a brief "pitch" on the MORE intervention, a discussion about the client's willingness to participate and assessing the client's self-reported HIV medical care and supportive service needs. The MCN will schedule a follow-up meeting if they cannot complete an initial interview.

STEP 4

Participants Self-Select Level of Program Engagement

Participants self-select which three program levels (Low MORE, Medium MORE, Full MORE) meet their needs.

Low MORE participants receive:

- Medical visits at the health center
- Phlebotomy at the health center during standard hours
- Medical insurance sponsored transportation, tokens, or SmarTrip (metro-rail) cards

Medium MORE participants receive:

- Medical visits at the health center
- Phlebotomy at the health center during standard hours
- Medical insurance sponsored transportation, tokens, or SmarTrip (metro-rail) cards
- Care navigation support from Care Navigators (CN) at the health center

Full MORE participants receive:

- Mobile medical visits in-home or at a location of the client's choice with a Mobile Advanced Practice Practitioner (MAPP)
- Medical visits at the health center with flexible hours with a MAPP, or during regular hours with an internal primary care physician
- Mobile phlebotomy services at home, location of the patient's choice, or at Health Center during standard hours
- Medical insurance sponsored transportation, tokens, rideshare services (Uber/Lyft), or SmarTrip (metro-rail) cards
- Care navigation support from Mobile Care Navigators in their home, a location of patient's choice, or in the health center

STEP 5 	**Implement the Intervention** MORE participants are eligible for all benefits associated with the engagement level of their choosing and can access all services within WWH's two health centers. Mobile Advanced Practice Practitioners (MAPPs) and MCNs provide care and coordinate supportive services for clients (see Required Staffing and Considerations). MORE clients receive services for the duration of their engagement in the program and can cease participation at any time.
STEP 6 	**Conduct Rolling Enrollment – "Recapture Blitz"** WWH conducts periodic EMR reviews to assess if there are new or other patients who meet the eligibility criteria. "Recapture Blitz" is a data to care effort between DC Health and RWHAP providers to identify clients who are out of care and ensures that these individuals can participate in the intervention.
STEP 7 	**Evaluate Intervention Effectiveness** Evaluate the intervention by utilizing client EMRs to assess retention and viral load suppression rates.