Promoting Linkages to Care for Newly Diagnosed HIV + Persons in Racial and Ethnic Communities

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Ryan White Grantees Meeting

Disclosure

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Learning Objectives:

By the end of this session participants will be able to:

1. Discuss the engagement of clients in mental health care from jail to community.

2. Have knowledge of the primary mental health issues of HIV patients identified by the clinicians working with clients in jail and into the community.

3. Describe the various approaches of integrating case management, mental health and medical care.

Ben Taub General Hospital

Key Elements of the RUSH Program
(Routine Universal Screening for HIV)

- Routine HIV testing is Opt-Out
  - No additional consent is needed
  - Inform patients that they will be tested, unless they opt out
- Routine testing of patients aged 16-64
- Conventional blood test is utilized
- Only patients receiving a blood draw are screened
- Dedicated Service Linkage Workers to follow-up with positive patients and linkage to care
- Link to City of Houston DIS Workers

What Defines Service Linkage

- Patient is seen in the hospital or clinic setting
- Patients receive post-test counseling and has their needs assessed
- Appointments are made for eligibility, screening and doctor
- Patient's status is monitored to insure that appointments are kept

Barriers to Linkage to Care

- Denial of disease and stigma
- Breakdown in relationships
- Loss of family support and social support
- Substance abuse
- Depression and other mental illnesses
- Other responsibilities – work, children, etc
- Fear of family disclosure

Routine Universal Screening for HIV
(RUSH) Program

Ben Taub General Hospital

August 04, 2008 – July 15, 2010

- Total Tests 61,320
- New Positives 331
- Prevalence 0.54%
- Previous Positives 911
- Overall Prevalence 1.49%
- Total Positives 1242
- New +s linked to care 276 or 83%

Challenges

- Staff and provider buy-in
- Data Issues—collection, assimilation, and analysis
- Lack of cost effectiveness data
- Communications with the laboratory
- Economic conditions
- EC environment

Lessons Learned

- Training is continuous
- Keeping up with the changing times
- Culture Change of an existing department
- Building a network of colleagues that do the same thing
- Provider/patient relationships vary
- Promote your successes

Illinois Department of Public Health

Referring HIV positive ex-offenders to care services

IDOC Background

- Number of Inmates 2009 – 45,529
- Number of employees – 11,000
- Budget - $1.2b
- Total Correctional Facilities – 36
  - Includes 8 adult transitional centers – ATC
  - Largest facility – Stateville w/3,404 inmates
- Recidivism rate 2009 – 51.3%

IDOC Background

- Nationally recognized programs:
  - **Sheridan National Model Drug Prison and Reentry Program**
  - **National Model Meth Prison and Reentry Program**

HIV and Prison Population

- U.S. Department of Justice reports an estimated 2% of State prisoners nationwide are HIV+.
- IDPH AIDS surveillance and IDOC statistics reveal an estimated 6% of IDOC's population is HIV positive.
- IDOC reports an estimated 69% of inmates have not received an HIV test prior to release.
- AIDS Foundation of Chicago estimates that the prevalence of HIV/AIDS in correctional settings is 14 times greater than in the general population.

Referral process in Illinois

- Begins 6 months prior to release and at each facility.
  - Each facility holds a summit (health fair).
  - Each HIV positive offender completes a needs assessment
- At time of discharge:
  - Offenders information packet
    - www.HIVCareConnect.com
    - ADAP Application
  - Sign medical releases etc.

Referral process in Illinois Continued

- IDOC and offender complete Transitional Tracking Referral form (TTR)
- Referral made to Care Connect Regional Office or CORE Center in Chicago.
  - Spreadsheet tracking
  - Phone call or fax TTR form
- If offender reuses services, must sign denial form
- Offender given 1 month supply of medication with script for 2 additional weeks.

HIV Care Connect Regions

Ongoing Support www.summitofhope.org

HIVCareConnect.com

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Amber Rossman

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August 25, 2010

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Routine Testing & Linkage to Care
two major initiatives combined

Linkage to Care:

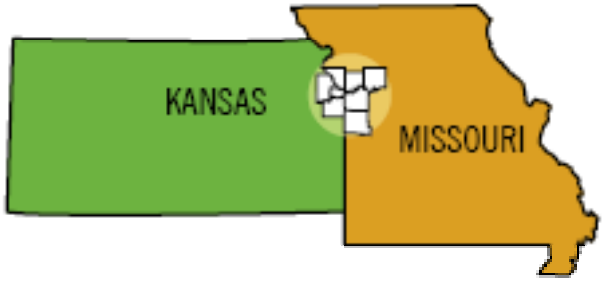
- Demonstration Project with ARTAS II, funded by Centers for Disease Control and Prevention
- 2005 – demonstration project studies begin
- 2008-2010 – funding continuation through City/State health department collaborations, subcontracted funding by HIV AIDS Bureau

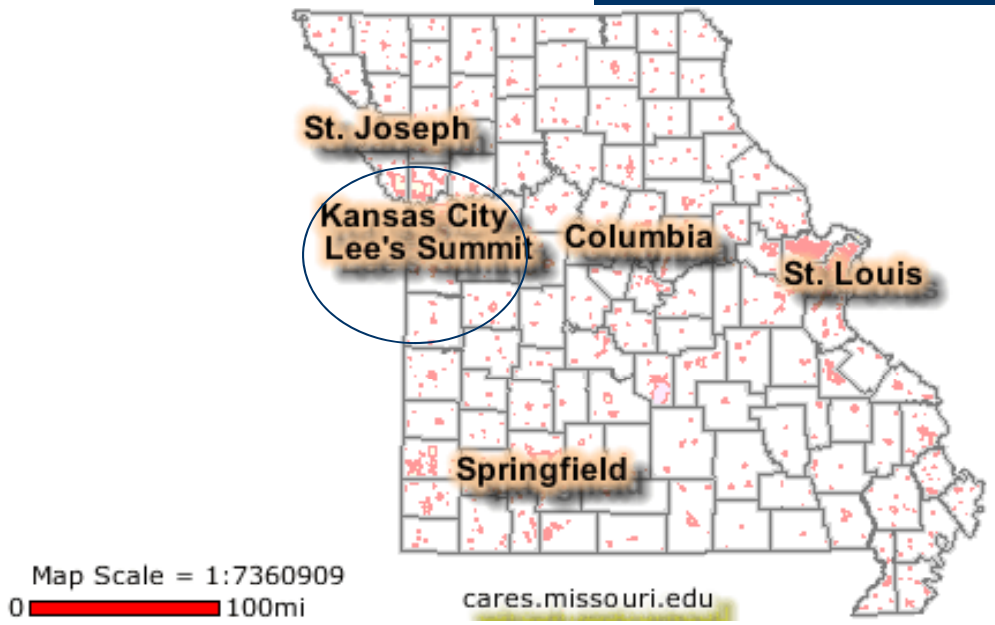
Routine Testing:

- Technical Assistance from HIV AIDS Bureau
- March 2007- First Site visit by TA providers
- Clinic developed implementation plan and continues through 2010

Project Area

Kansas City Free Health Clinic





Kansas City Project Area includes:

- 11 counties in MO
- 3 counties in KS

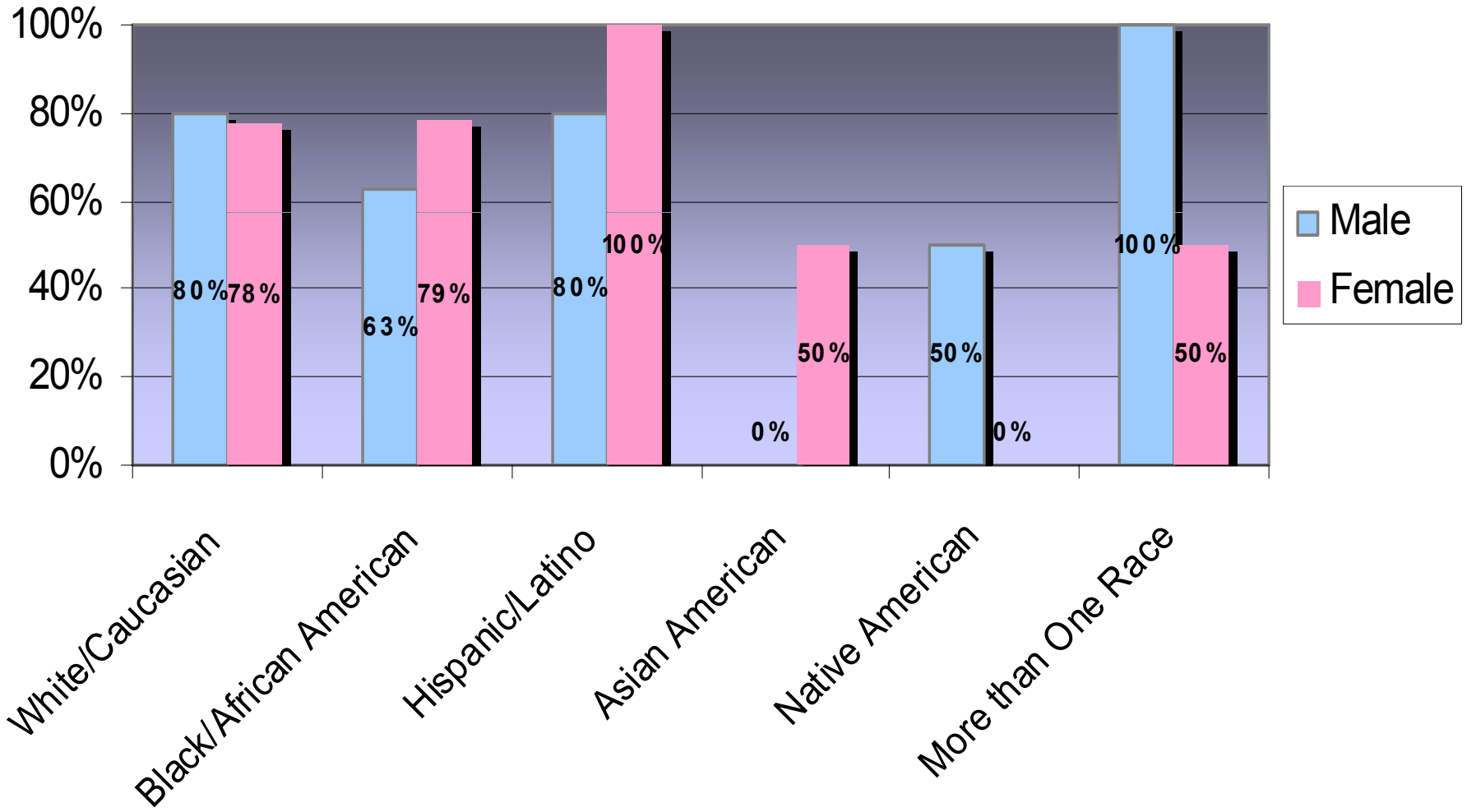
Most referrals from the following Health Depts:

- Kansas City Health Dept.
- Missouri Dept of Health and Senior Services
- Wyandotte Co. Health Dept.

Routine/Opt Out HIV Testing

- Free Health Clinic: Dental Clinic
- Free Health Clinic: General Medicine/STD Clinics
- Indigent Care Hospital: Emergency Department
- ***Future: Expanding to New Collaborations in Testing?***
  - Other outpatient public health clinics
  - Sexual and reproductive health care providers (i.e. *Planned Parenthood*)
  - Other Emergency Departments

Percent of Respondents Reporting Willingness to Take a Free, Rapid HIV Screening Test during a Dental Visit, by Ethnicity/Race and Gender



Testing in Dental: Results Reporting

- 73% (n=103) would be willing to be tested (p<0.001)
- *62% (n=100,) reported It Does Not Matter who provided HIV Screening test results to them (p=0.01)*
  - *Excluding "Doesn't Matter"*
    - *37% My Dentist*
    - *24% Personal Physician*
    - *3% Dental Assistant/Hygienist*
    - *11% Counselor*
    - *13% Letter*
    - *13% Other*

*In this pilot study, the majority of dental clinic patients responded favorably to the offer of a free, rapid oral HIV screening test.

***Participant demographics closely match the demographics of the dental clinic.*

Testing in Dental: Expected Conclusions… *Not Found!*

These conclusions were assumed by providers but NOT found in this pilot survey:

- Fear of Self-Awareness of HIV result? *NOPE*
- Fears or Issues of Consent/Confidentiality? *NOT HERE*
- Fear of being treated differently? *NO SIR*
- Fear of Dentist/Hygienist Knowing Results *OR* providing the results? – *NOT REALLY*
- Time constraints? – *NONE*
- Fear of HIV test accuracy? – *NOT SO MUCH*
- Dental pain is a barrier to testing? - *NADA*

Linkage to Care Case Management Program Purpose and Problem Overview

- 40-60% of newly diagnosed HIV+ not in care
- Late diagnosis is frequent
- Passive referrals less effective
- Missed opportunities for earlier care, interventions
- Complexity of patients lives = barriers to care

96% in the KC site study had no personal help with their HIV diagnosis and care.

- 62% would depend solely on an HIV professional
- 34% perceived they would have no help

Linkage to Care Activities

Newly Diagnosed HIV+ Person

90 Day, Intensive Intervention:

- Health Literacy, Disease & Treatment 101
- Identify patient strengths that facilitate care
- Identify barriers to care
- Set goals for HIV tx
- Negotiate complicated care system
- Attend appointments; debrief with patient; identify long term payer source
- "Graduated Disengagement" & "Active Handoff"

BARRIERS TO CARE

Personal Barrier:

Addictions

Behavioral Health

Lifestyle/Culture

Health literacy

Poverty

System Barrier:

Complicated systems
Availability
Costs

LINKAGE:

Access to Medical Care

ENGAGEMENT:

Long term engagement in medical care

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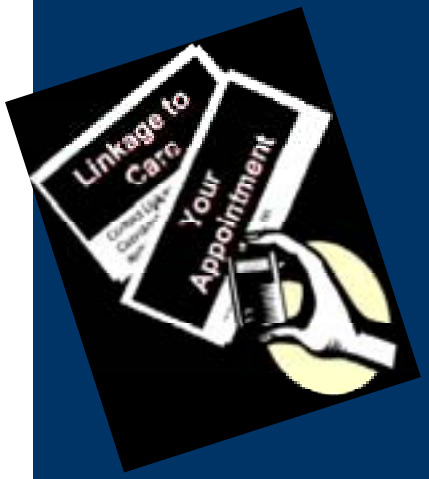

HIV Diagnosis

Page Linkage to Care – *20m response*

Initial Response – meet with patient and diagnosing provider

Intervention - Enrollment or Referrals

Linkage to Care - 90 Day, intensive intervention of LTC
Case Management (continuation w/ referral to CM services)

87% COMPLETE:

Graduate to long term HIV Case Management Services, continue engagement in care

8% COMPLETE:

Graduate to self-sufficiency, continued HIV care with own resources

5% NOT COMPLETE:

Lost to Care, Unable to Contact, Disengaged from Program; cont'd attempts re-engagement

84% of graduates still in care after 12 months.

Referring Sites

- Hospitals
- Health Depts (KC, Jx, Jo, Wy, MO)
- Publicly Funded Testing Sites
- Free Clinic (KCFHC)
- Med Offices/Other
- Self Referral

free health clinic KC
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Lessons Learned in Linkage to Care

Results from ARTAS-II indicated that 79% of all participants visited an HIV clinician at least once within the first six months (Craw, et al., 2008)

- *Linkage to Care programs – state health department grantees or CBOs with existing strong testing, care and case management programs*
- *Sources of referrals of HIV-infected persons to the Linkage to Care program*
- *Marketing the benefits of the Linkage to Care program*
- *Partnerships with HIV primary medical care providers*

Lessons Learned in Linkage to Care

- *Transportation for the linkage coordinator: the advantage of being mobile*
- *Disengagement process: transitioning clients from ARTAS linkage case management to long-term case management*
- *The "active hand-off": a model for facilitating the transition to long-term case management*
- *Distinguishing ARTAS linkage case management from long-term case management*
- *Supervision of the linkage coordinators*

Lytt Gardner, Ph.D., Jason Craw, M.P.H. Lessons Learned from Implementing a Linkage to HIV Care Program using the ARTAS Model.

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Linkages to Care for HIV + Persons Leaving NYC Jails

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Ryan White All Grantee Meeting

NYC Health

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RIKERS ISLAND, NY

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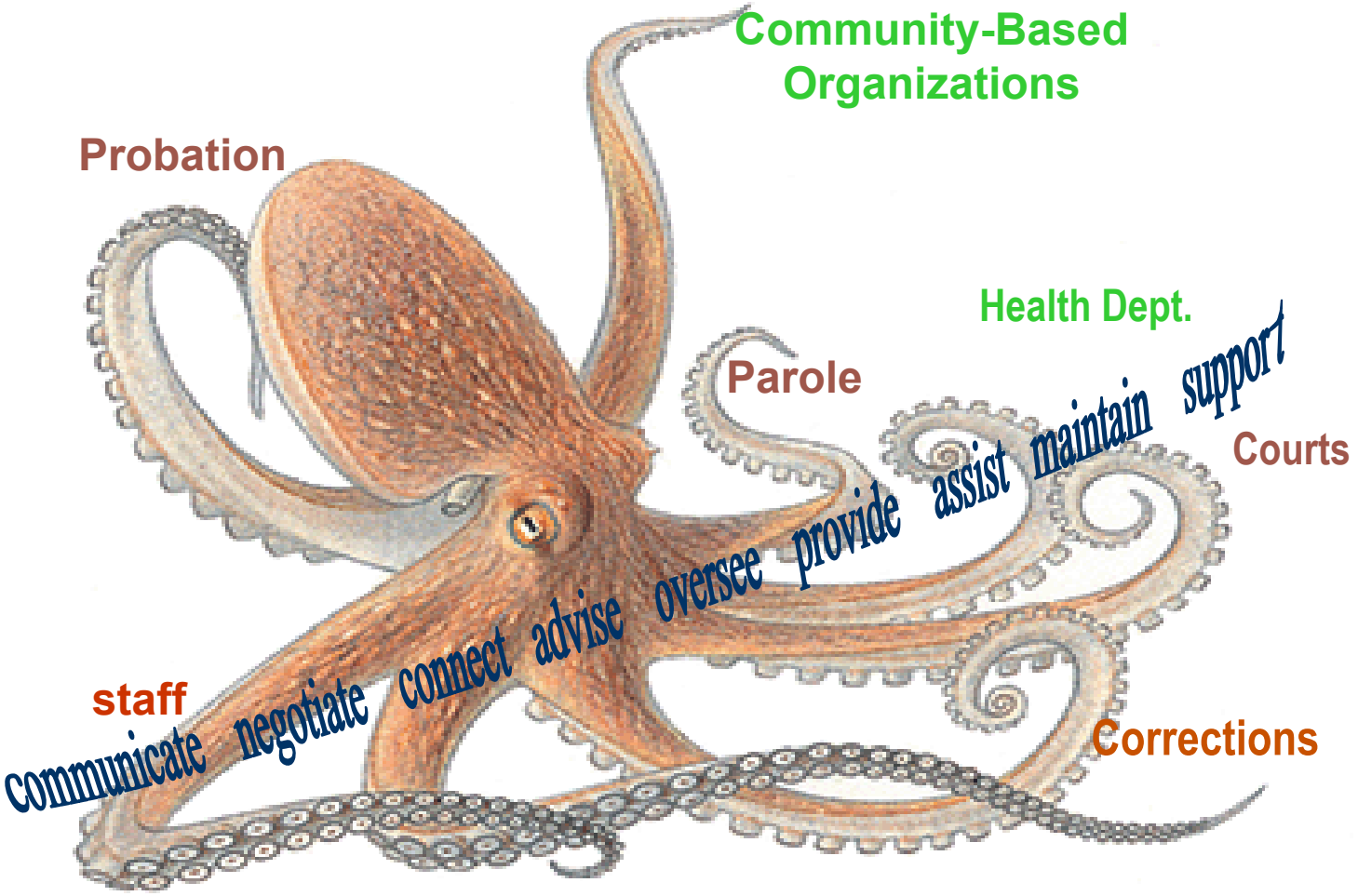
NYC Jail Health

- High risk of HIV infection (2006 blinded serosurvey)
  - 4.7% (4.1% - 5.3%) in males
  - 9.7% (8.3% - 11.1%) in females
- Over 70% released to the community return to the areas of greatest health disparities
- Women are twice is sick as male counterparts



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Discharge Planning

- Engage client
- Conduct assessment
- Screen for Benefits
- Arrange discharge medications
- Coordinate post-release plan
- Facilitate continuity of care
  - Aftercare letters / transfer medical information
  - Make appointments / walk-in arrangements
  - Arrange transportation / accompaniment

Post-release Plan

- Housing
- Treatment (Substance Abuse / Mental Health)
- Primary Care
- Specialty Care
- Social Services
- Transitional Case Management

Supported Transitions

- Case conferencing prerelease
- Court advocacy and Alternatives to Incarceration (ATI)
- Community case manager
- Accompaniment / transport
- Patient Navigator / Care Coordinator

What a Team!

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