FY 2017 Houston EMA/HSDA Ryan White Part A Service Definition

Outreach Services – Primary Care Re-Engagement (DRAFT)	
HRSA Service Category Title: **RWGA Only**	Outreach Services
Local Service Category Title:	Outreach Services – Primary Care Re-Engagement
Budget Type: **RWGA Only**	Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	TBD
HRSA Service Category Definition: **RWGA Only**	*Outreach Services* include the provision of the following three activities: Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services, Provision of additional information and education on health care coverage options, Reengagement of people who know their status into Outpatient/Ambulatory Health Services
Local Service Category Definition:	Providing allowable Ryan White Program outreach and service linkage activities to newly-diagnosed and/or Lost-to-Care PLWHA who know their status but are not actively engaged in outpatient primary medical care with information, referrals and assistance with medical appointment setting, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPHES/RWGA policies. Outreach services must be conducted at times and in places where there is a high probability that individuals with HIV infection and/or exhibiting high-risk behavior, designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness, planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort, targeted to populations known, through local epidemiologic data or review of service utilization data or strategic planning processes, to be at disproportionate risk for HIV infection.
Target Population (age, gender, geographic, race, ethnicity, etc.):	Services will be available to eligible HIV-infected clients residing in the Houston EMA/HSDA with priority given to clients most in need. Services will target clients who cannot function in the community due to barriers which include, but are not limited to, mental illness and psychiatric disorders, drug addiction and substance abuse, extreme lack of knowledge regarding available services, inability to maintain financial independence, inability to complete necessary forms, inability to arrange and complete entitlement and medical appointments, homelessness, deteriorating medical condition, illiteracy, language/cultural barriers and/or the absence of speech, sight, hearing, or mobility.

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Services to be Provided:	Outreach service is field based. Outreach workers are expected to coordinate activities with newly-diagnosed or lost-to-care PLWHA, including locations outside of primary care clinic in order to develop rapport with individuals and ensuring intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS.
Service Unit Definition(s): **RWGA Only**	TBD
Financial Eligibility:	Refer to the RWPC's approved *FY 2017 Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients).
Agency Requirements:	Outreach Services must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care.
Staff Requirements:	Must meet all applicable Houston EMA/HSDA Part A/B Standards of Care.
Special Requirements: **RWGA Only**	Not Applicable.

FY 2018 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/08/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/01/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Assurance Committee**		Date: **05/18/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup**	Date: **04/25/17**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

PACIFIC AIDS EDUCATION & TRAINING CENTER

A strategic framework for improving linkage & retention in HIV care

June 2016 * Sophy S. Wong, MD

Why does linkage & retention in care matter?

- 40% of PLWHA in the US are linked and retained in care; California: 38%[1]
- Not being retained in care for 24 months after diagnosis (DHHS definition of 2 visits for each 6 month period at least 60 days apart) is associated with all-cause mortality: HR 2.36[2]
- Having >2 missed visits after diagnosis is associated with all-cause mortality: HR 3.20[2]
- For those retained in care, having >2 missed visits is associated with mortality: HR 3.61[2]
- PLWHA not diagnosed or retained in care are responsible for 92% of HIV transmissions[3]
- PLWHA not retained in care are responsible for 61% of HIV transmissions[3]
- If we get 90% of PLWHA diagnosed and 90% on ART, we could reduce HIV incidence by 50%[4]

3 steps & 3 levels for improving retention in care

★starred items indicate that they've been studied with at least moderate-to-high quality evidence

	Pick low-hanging fruit. 	**Level-up!** 	**Master it.** 
① **Track**	★ act on missed visits ★ track gaps in care >6 months ★ ask about adherence	★ track those not retained in care ★track missed refills	★ track >2 missed visits ● use public health surveillance data to monitor new diagnoses and those lost to care
② **Follow-up**	★do personal reminder calls immediately after a missed visit ● implement follow-up protocols for missed visits and gaps in care	★ implement multi-disciplinary team follow-up protocols including how the team reviews tracking data & delegates follow-up	● use data systematically to allocate resources ★ multi-disciplinary team meets regularly to analyze data and develop personalized action plans
③ **Connect**	● provide a reliable way to reach your team directly and quickly ★one-on-one adherence counseling ★ ask about health beliefs ★ provide once daily regimens, pill boxes, adherence reminders	★provide strengths-based intensive case management (ARTAS) ● build a coalition with testing and care sites ● involve patient input on programs and services	★train peers to provide strengths-based case management ● develop coordinated warm hand-off and retention protocols with the coalition with testing and care sites

References: 1. eHARS data, 2011-2013, 2. Mugavero, CID 2014, 3. Skarbinski, JAMA 2015, 4. Kelly, JAIDS 2015

A summary of evidence-based strategies for retention in care

The following is summarized from a 2015 literature review conducted by a working group with the East Bay Linkage & Retention network as well as the 2012 Thompson et. al. Annals of Internal Medicine article, *Guidelines for Improving Entry Into and Retention in Care and Antiretroviral Adherence for Persons With HIV: Evidence-Based Recommendations From an International Association of Physicians in AIDS Care Panel*.

Most highly recommended practices

[Level IA & IIA: strong recommendations with excellent or high quality evidence]

- Monitor entry into care and have a follow-up plan for no-shows
- Monitor retention in care, including no-show rates and gaps in care
- Obtain self-reported adherence: anything less than "excellent" is suspect
- Educate on specific adherence tools: pillboxes, medi-sets, phone alarms, daily triggers
- One-on-one ART education
- One-on-one adherence counseling
- Provide pillbox organizers for homeless patients

Moderately recommended practices

[Level I-IIIB : moderate recommendations with excellent, high or medium quality evidence]

- Strength-based case management, especially during the first 3 months in care
- Multidisciplinary education and counseling: engage other members of the care team; the patient may connect with particular team members
- Monitor pharmacy refill data and contact patients if refills are not picked up on time
- Use reminder devices for adherence
- Use once-daily ART regimens
- Case management for homeless patients
- Youth-focused support interventions

Unrated practices that have been studied and have shown efficacy in some settings

- **Assess client** for depression, substance use, housing, transportation, childcare, food insecurity, IPV and/or health beliefs that may interfere with engaging in care
- **Financial/travel/food incentives** for certain patients: the impact for financial incentives is greatest when used for smaller, non-hospital-based clinics and in patients with histories of not being virally suppressed [2015 HPTN 065 TLC+ study presented at CROI]

Warm Hand-off and Retention Protocols

client identified

- **When a client is identified to be**
  - newly diagnosed and not yet engaged in HIV primary care
  - transferring from one provider to another or recently moved to area
  - transferring from the jail, and/or
  - out of care
- For clients with a preliminary positive rapid test, proceed with linkage process on the same day and if possible, obtain and process a confirmatory test specimen.
- Obtain a release of information for the agencies you will be coordinating care with.

phone contact

- Referring worker discusses and decides on HIV care site with client, based on client preferences.
- Referring worker may consult the East Bay HIV Clinic List via Google document: *http://tinyurl.com/alcohiv* or *https://docs.google.com/document/d/1qooJV5cH12OH8jZoPMDsE6GxCK8lDZroqlj4EmRPMig/edit?usp=sharing*
- Referring worker calls the receiving worker and/or clinic to obtain intake appointment time. Ideally the phone number is one that can be answered immediately or responded to within an hour.
- If a message is left, the receiving worker is expected to respond to the message within 3 business days.
- Referring worker gets a current and reliable phone number and address for client (when possible) and shares the contact with receiving worker.

appointment coordination

- Referring worker, client, and receiving worker agree on an intake appointment date and time.
- Ideally this will be at a time where the client, referring worker, receiving worker, and provider can be present.
- Ideally the intake appointment will be within 2 weeks and at the latest within 1 month.
- Referring and receiving workers provide direct contact phone numbers (ideally cell numbers) to the client.

intake appointment

- If permitted/desired by client, referring worker accompanies or meets the client at the receiving care site.
- Referring worker ensures that the client and receiving agency has the information, records and release of information needed for continuity of care, and introduces her/him to the receiving worker.
- Optional: referring worker stays with client for the intake visit.
- If the client does not show up, the referring worker immediately tries to contact the client for follow-up.
- In a case when the referring worker is not able to attend the appointment or be involved in the linkage, the receiving worker notifies the referring worker, via phone or secure or encrypted email message, that the client successfully attended the intake appointment and saw the provider.
- Receiving worker asks about, identifies and addresses the client's immediate needs (health beliefs, insurance, resources for mental health, IPV and substance abuse, housing, transportation, food, benefits, etc.).

3-month follow-up

- Referring worker contacts the receiving worker to confirm if the client continues to actively receive HIV medical care with labs, medication refills and/or provider visits.
- If active HIV medical care can be confirmed in 3 months , the referring worker closes the client's linkage case.
- If a client has not followed up in 3 months and neither the receiving nor referring worker is able to contact or locate the client, please work with Kelly Stempel at the Alameda County Department of Public Health: Kelly.Stemple@acgov.org or 510-268-7649

+For additional help if clients are lost to follow-up, and/or identifying whether clients are in jail, newly diagnosed or previously diagnosed, for new diagnoses you may contact Kelly Stempel at the Department of Public Health Kelly.Stemple@acgov.org or 510-268-7649 for people who have been in care but are now lost to follow-up, contact Georgia Schreiber: Georgia.Schreiber@acgov.org or 510-268-7650. For problems related to organizations involved in this warm hand-off process, please contact Dr. Nicholas Moss, Director of the HIV STD Section at Nicholas.Moss@acgov.org or 510-268-7635.

This document was last updated February 26, 2016.

Retention Protocol

Assessment questions to include at client interviews (initial and annual):

Research shows that discussing the following topics with clients helps retain them in care.

Health beliefs: to discuss with care team
What do think about having HIV? Taking HIV medications? Coming to clinic appointments?

Depression – (PHQ2): for provider counseling and behavioral health referrals. During the last month…
1. Have you often been bothered by feeling down, depressed, or hopeless?
2. Have you often been bothered by little interest or pleasure in doing things?

Substance use screening – (CAGE questionnaire): for substance abuse counseling
1. Have you ever felt you ought to cut down on your drinking or drug use?
2. Have people annoyed you by criticizing your drinking or drug use?
3. Have you felt bad or guilty about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

Food insecurity: for food resource referrals. During the last month…
1. How often did you eat less than you felt you needed to because there wasn't enough money for food?
2. How often were you worried that you might run out of food before you got more money?
3. How often couldn't you afford to eat balanced meals?

Intimate partner violence (IPV): for counseling and referrals
1. Have you ever been emotionally or physically abused by your partner or someone important to you?
2. Are you afraid of a past or current partner?
3. Has anyone forced you to have sexual activities?

Intensive support in the first 3-6 months of care:

1. Develop a system for making ~3 contacts (phone, text, in-person) with a new client in the first 3 months to ensure they are getting the services they need and have your direct contact number.
2. Provide personal outreach reminders for at least the first 3 medical visits and/or in-person counseling follow-up during those visits.
3. For harder-to-reach clients, consider accompanying the client to the first 3 medical visits.

When a patient misses a visit: follow-up at the time of the missed visit

1. The MA or case manager attempts to contact the patient on the same day via phone and/or emergency contacts (family, partner, etc.). If patient is reached, our staff checks to see how the patient is doing and reschedules the appointment time accordingly.
2. If there are urgent issues, the patient is rescheduled on the same day and at least within a week.
3. If there are no urgent issues, the patient is rescheduled within the next month.
4. If unable to reach the patient the same day, the HIV case manager or linkage coordinator is alerted and will attempt to reach the patient over the next month via phone, text message, and email.
5. An update about patient contact is given to the provider each week.
6. If the patient cannot be reached by phone, text message or email within a month, send a certified letter to the patient's address.
7. If the patient still has not responded and/or her/his status has not been verified (e.g. successfully transferred care to another provider) within 3 months, for Alameda County clinics, the MA or case manager will contact Georgia Schreiber, Linkage Coordinator at the Alameda County Department of Public Health, to investigate the patient's care status: Georgia.Schreiber@acgov.org, 510-268-7650. For patients in other counties, please contact your HIV public health case investigators.
8. Documentation of patient outreach is completed in the chart.

When patients have not been seen in the last 3-6 months (out of care)

1. At least once per month a member of the HIV team prints a list of the patients who have not been seen at the clinic in the last 3 months and/or 6 months.
2. The patient's travel and incarceration status is reviewed by the clinician. For example, the patient is known to be traveling or abroad, and has a follow-up plan upon return.
3. The HIV case manager is alerted and will attempt to reach the patient over the next month via phone, text message, and email.
4. Attempts to contact the patient will be recorded in the NextGen telephone template.
5. An update about patient contact is given to the provider each week.
6. If the patient cannot be reached by phone, text message or email within a month, we will send a certified letter to the patient's address.
7. If the patient still has not responded and/or her/his status has not been verified (e.g. successfully transferred care to another provider) within 1 month, the HIV Coordinator will contact Georgia Schreiber, Linkage Coordinator at the Alameda County Department of Public Health, to investigate the patient's care status: Georgia.Schreiber@acgov.org, 510-268-7650.

When to mark patients "inactive"

1. Patient is confirmed to have transferred care to another HIV provider (including while incarcerated).
   a. Patient verbally confirms and is able to name the new HIV provider and date of the next visit.
   b. Provider (including jail or prison) confirms transfer of care, verbally or in written form.
   c. Nursing home residence with HIV consultation confirmed with patient, nursing home staff, or HIV consultant
   d. The Public Health Department confirms that the patient has moved out of the region and/or has transferred care to another HIV provider.
2. Patient is confirmed to be deceased by public health or a death registry report.

Strategies for clients with difficulty engaging in care

1. Assess client for depression, substance use, housing, transportation, childcare, food insecurity, IPV and/or health beliefs that may interfere with engaging in care
2. Engage other members of the care team; the patient may connect with particular team members
3. Personalized case management services: youth-focused support, personality matches, etc.
4. Use motivational and strengths-based counseling techniques
5. Provide one-on-one ART and adherence education and counseling
6. Provide pillbox organizers or ask pharmacies to dispense medications in medi-sets
7. Share other adherence tools: cell phone reminders, triggers during their usual daily routine
8. Monitor pharmacy refill data and contact client has not picked them up
9. Consider using financial/travel/food incentives for certain patients

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News

Men, Black People and Injection Drug Users Have Higher Risk of Discontinuous HIV Care

By Mark Mascolini

March 29, 2017

In a 17,000-person U.S./Canadian analysis, men, blacks, and drug injectors had a higher risk of discontinuous HIV care even after statistical adjustment for access to care, the competing risk of death and other risk factors. NA-ACCORD investigators suggest these groups need "improved outreach to prevent disruption of HIV care."

Previous research links inconsistent retention in HIV care to poor outcomes, including shorter survival. Because prior work found worse HIV care retention among men, blacks and drug injectors, the National HIV/AIDS Strategy aims to diminish these disparities. But previous research in this field remains limited because the studies sometimes lacked information on antiretroviral use or were performed in the context of clinical trials, at single centers or in resource-limited settings.

To get a better understanding of factors affecting discontinuity in HIV care, NA-ACCORD investigators analyzed data from this multicohort U.S./Canadian collaboration. The analysis involved adults who had one or more primary care visits and began antiretroviral therapy (ART) between January 2000 and December 2010. To focus on people likely to have equivalent access to care, the investigators also limited the study to individuals who had one or more CD4 counts after ART began and before death or the first discontinuity in care. They defined discontinuity as failure to keep two or more HIV care visits separated by at least 90 days in a calendar year. To assess risk factors for discontinuity, the NA-ACCORD team used regression analysis that considered the competing risk of death and other variables.

Related: The Impact of HIV Health Literacy on Viral Suppression

The analysis involved 17,171 adults with a median age of 47.1 years, 16% of them women, 44% black and 19% with drug injection as their HIV acquisition risk. During a median follow-up of 3.97 years, 49% of cohort members experienced discontinuity in care, 9% died before experiencing discontinuity and 42% had no discontinuity in care. After 10 years of follow-up, the adjusted cumulative incidence of discontinuity was 67%, while incidence of death before discontinuity was 9%.

In an analysis adjusted for demographics, baseline CD4 count and CD4 nadir after ART initiation, two factors were independently associated with a lower hazard of discontinuity in care: older age (hazard ratio [HR] 0.61 per 10 years older, 95% confidence interval [CI] 0.59 to 0.62) and female sex (HR 0.84, 95% CI 0.79 to 0.89). Two variables were independently associated with a higher hazard of discontinuity: black versus nonblack race (HR 1.17, 95% CI 1.12 to 1.23) and drug injecting versus other HIV risks (HR 1.33, 95% CI 1.25 to 1.41).

After adjusting for drug injecting status, black race was not associated with discontinuity among women. Risk of death did not differ significantly between women and men, blacks and non-blacks or drug injectors and other HIV risk groups. Additional analysis determined that reentry to care after first discontinuity did not differ by sex, race or drug injecting status.

The researchers believe their results can be generalized to the U.S. and Canadian HIV populations because the NA-ACCORD group is demographically representative of the national U.S. and Canadian HIV populations. "Beyond clinic-level interventions aimed at improving overall clinical retention," the researchers advise, "individual-level interventions such as enhanced medical case management, peer navigation, transportation subsidies, and mental health evaluation and treatment should be offered with greater vigilance and consistency to the identified vulnerable groups[.]"

Mark Mascolini writes about HIV infection.

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Press Release

For immediate release: Monday, February 23, 2015
Contact: National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (http://www.cdc.gov/nchhstp/)
(404) 639-8895
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9 in 10 new U.S. HIV infections come from people not receiving HIV care

New CDC analysis reinforces importance of HIV testing and treatment for health and prevention

More than 90 percent of new HIV infections in the United States could be averted by diagnosing people living with HIV and ensuring they receive prompt, ongoing care and treatment. This finding was published today in *JAMA Internal Medicine* by researchers at the Centers for Disease Control and Prevention.

Using statistical modeling, the authors developed the first U.S. estimates of the number of HIV transmissions from people engaged at five consecutive stages of care (including those who are unaware of their infection, those who are retained in care and those who have their virus under control through treatment). The research also shows that the further people progress in HIV care, the less likely they are to transmit their virus.

“By quantifying where HIV transmissions occur at each stage of care, we can identify when and for whom prevention and treatment efforts will have the most impact,” said Jonathan Mermin, MD, MPH, director of CDC’s National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. “We could prevent the vast majority of new infections tomorrow by improving the health of people living with HIV today.”

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Jonathan Mermin, MD, MPH, director, CDC’s National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

The analysis showed that 30 percent of new HIV infections were transmitted from people who did not know that they were infected with the virus, highlighting the importance of getting tested. People who had been diagnosed were less likely to transmit their infection, in part because people who know they have HIV are more likely to take steps to protect their partners from infection.

“Positive or negative, an HIV test opens the door to prevention. For someone who is positive, it can be the gateway to care and the signal to take steps to protect partners from infection.

For someone who tests negative, it can be a direct link to important prevention services to help them stay HIV-free," said Eugene McCray, MD, director of CDC's Division of HIV/AIDS Prevention. "At CDC, we're working hard to make testing as simple and accessible as possible."

Today's analysis suggests that simply being in care can help people living with HIV avoid transmission of their virus. According to the model, people who were engaged in ongoing HIV care, but not prescribed antiretroviral treatment, were half as likely (51.8 percent) as those who were diagnosed but not in care to transmit their virus. Being prescribed HIV treatment further lowered the risk that a person would pass the virus to others.

People who were successfully keeping the virus under control through treatment were 94 percent less likely than those who did not know they were infected to transmit their virus. However, previous national estimates have indicated that just 30 percent of people with HIV have reached this critical step in care.

The study authors stress that effective HIV care offers multiple mechanisms to prevent transmission. For example, in addition to antiretroviral therapy, HIV care should include risk reduction counseling on how to protect their partners, screening and treatment for other sexually transmitted infections, and treatment for mental health and substance use disorders.

To estimate HIV transmission at each stage of care in 2009, the new analysis used statistical modeling based on three national HIV data sources: CDC's Medical Monitoring Project, National HIV Surveillance System, and National HIV Behavioral Surveillance System.

This is the latest in a growing body of evidence that prevention of new infections depends on reaching people who are HIV-positive with testing, care, and treatment. CDC has responded by more extensively focusing its prevention strategy on people living with HIV, while continuing to ensure HIV-negative people have tools and information about all available prevention options, including daily pre-exposure prophylaxis (/nchhstp/newsroom/docs/PrEP-FactSheet-508.pdf) .

CDC efforts also include innovative partnerships to make HIV testing simple, accessible, and routine; programs to help health departments and community partners identify and reach out to infected individuals who have fallen out of care; and public awareness campaigns to urge testing and encourage people with HIV to seek ongoing care.

For more on the new analysis and CDC's HIV prevention efforts, visit www.cdc.gov/nchhstp/newsroom (/nchhstp/newsroom) .

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Page last reviewed: February 23, 2015
Page last updated: February 23, 2015
Content source: National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention

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