The Missing Link in Test & Treat:

Best practices in HIV linkage & retention

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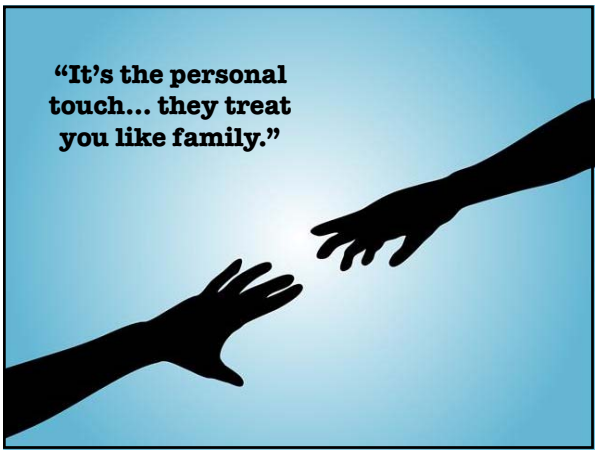


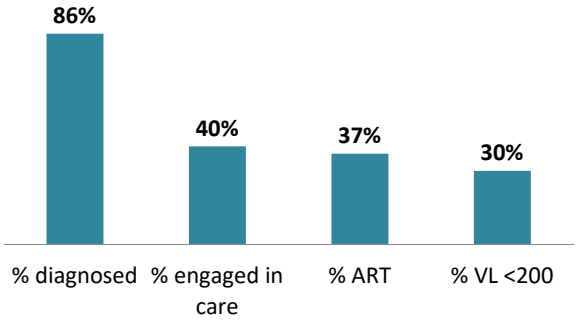
Objectives:

why linkage matters + **how** to link = ↑link & retain

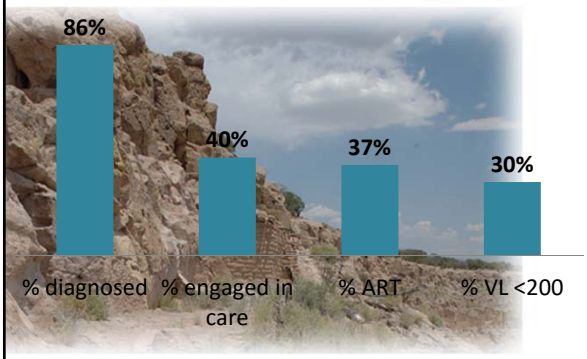
- ↓ New HIV infections
- ↑ Access to care: test & treat!
- ↓ HIV health disparities

Why does linkage & retention matter?

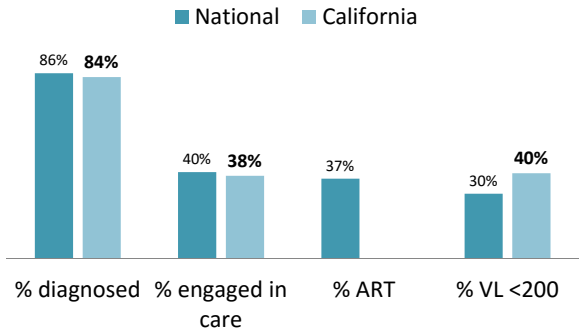
US HIV care continuum



US HIV care cliff?



California HIV care continuum



How much is baseline CD4<50 associated with dying?

Is lack of retention associated with dying?

How much are >2 missed visits after diagnosis associated with dying? Hazard ratio of…

A. 1.4
B. 2.0
C. 2.6
D. 3.2

Are >2 missed visits associated with dying?

Among people retained in care, are >2 missed visits associated with dying?

PLWHA not in care are responsible for what % of HIV transmissions?

If we get 90% of PLWHA on HIV meds, can we make a difference?

<u>How</u> do we improve linkage & retention?

3 steps to improving retention:

1. **Track patients**
2. **Follow-up**
3. **Connect**

3 steps & 3 levels:

	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

Start with low-hanging fruit

1. Track: missed visits, gaps in care, adherence
2. Follow-up: personal calls, protocols
3. Connect: direct contact, adherence counseling, ask about their lives and beliefs

Do you track retention in care at least monthly?

1. Yes
2. No

Case: Miguel is newly diagnosed

He came for disclosure and initial labs but…

He didn't show up for his ART initiation visit.

Participating with Poll Everywhere

Pollev.com/aetc

Or text "AETC" to 37607:

What will help Miguel come in?

You need to get to know your patient…

Level-up!

1. Track: not retained, missed refills
2. Follow-up: team protocols
3. Connect: strengths-based intensive case management, involve a coalition and patients

Case: Joe was doing well…

Started meds, virally suppressed.

Then his partner died…

Joe started unraveling…

Missed visits

Missed refills

Didn't come in for 8 months

What might help Joe…

Peer support groups

intensive outreach

"Without him I could not imagine myself sitting here talking to you…"

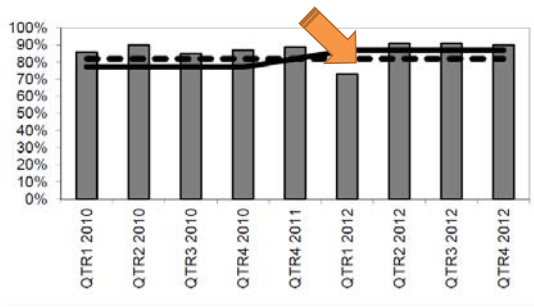
What my patients tell me helps them stay in care:

"You listen"
"You get me"
"You make time to understand"
"I can call you, you call back"
"You really know about my life"
"You don't judge me"

Master it.

1. Track: >2 missed visits, surveillance data
2. Follow-up: targeted interventions, teams
3. Connect: trained peers, coordinated coalition protocols and strategies

HIV ACCESS retention trends: 2010-2012



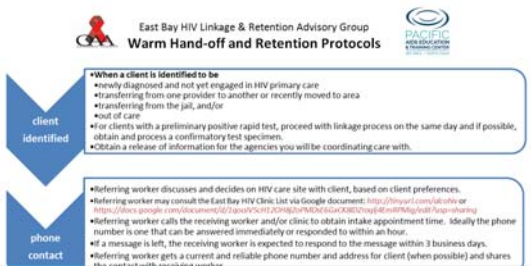
Who in the US is least likely to be retained or VL suppressed?

2012 RSR data

Who in the US is less likely to be virally suppressed?

2012 RSR data

Linkage & retention protocol



Alameda County Linkage-to-care 2012

70%

before warm hand-off protocol

Alameda County Linkage-to-care 2013

73%

1st year after warm hand-off protocol

Alameda County HIV ACCESS 2014

83%

After FOCUS project launch

Alameda County
HIV ACCESS
2015

94%

After linkage system strengthening

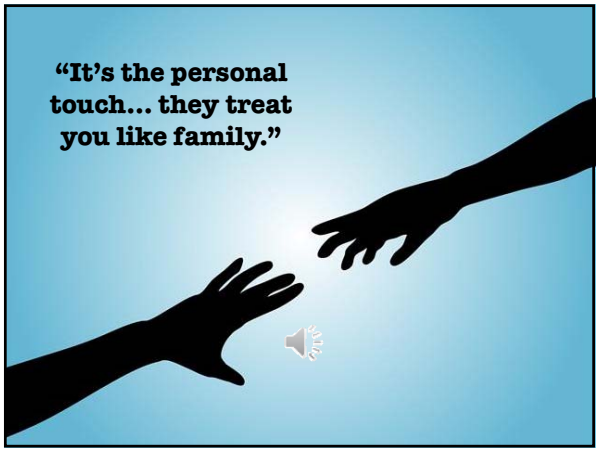
How much are >2 missed visits after dx associated with dying?

A. 1.4
B. 2.0
C. 2.6
D. 3.2

What retention level are you at?

1. Looking at fruit
2. Low-hanging fruit
3. Leveling-up
4. Mastering it

What will you do?



Thank you!

PACIFIC AIDS EDUCATION & TRAINING CENTER

Questions?

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