2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

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Routinizing Data to Care within Ryan White HIV/AIDS Program Part A and Part B Jurisdictions

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Lessons Learned from Three Data-to-Care Projects in Massachusetts

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Utilizing HRSA and CDC Support to Build, Test, and Adapt Interventions

- **HRSA SPNS:** Systems Linkage and Access to Care for Populations at High Risk of HIV Infection: Strategic Peer-Enhanced Collaborative Treatment and Retention Model (SPECTRuM)

- **HRSA Bureau of Primary Health Care (BPHC) and CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP):** Partnerships for Care (P4C)

- **CDC NCHHSTP:** Cooperative Re-Engagement Controlled Trial (CoRECT)

SPECTRuM

- Developed communication system between MDPH and 8 clinical sites to facilitate re-engagement and retention in care, and achievement of HIV viral suppression
  - Created HIV laboratory database, communication protocols, and list of reporting providers
  - MDPH sent line list to clinical sites; clinical sites responded with follow-up list sent to MDPH
- Enhanced services for clients in need of care & treatment retention support
  - Developed standardized acuity assessment tool to identify clients and track progress in managing barriers to retention in care and treatment
  - Created peer/nurse service model to provide intensive, short-term, field-based services to small caseload of clients
- Results:
  - Compared to Controls, SPECTRuM clients achieved higher engagement, retention and HIV viral suppression
  - Participating facilities changed their practices to maintain methods for internal communication and activation of intervention for high-need patients

Partnerships for Care

- **Improve continuity of care for PLWH through collaboration between public health and primary care**
  - Data system enhancements to support identification of out-of-care
  - Public health work force training/development to deliver linkage and engagement assistance
  - Strengthen collaboration between public health and primary care
- **Developed data sharing strategies for MDPH and 6 CHCs**
  - Independent out-of-care lists: clinic (missed visits, medications); surveillance (lab results)
  - Monthly case reconciliation conference
- **Established routine HIV public health intervention**
  - Newly diagnosed HIV+ for partner services
  - Locate out-of-care individuals and assist re-engagement in care
- **Results:**
  - Use of surveillance and clinic data and adjudication process identified truly out-of-care compared to surveillance data only
  - Clinics can feasibly use data from health records to identify out-of-care individuals.
  - Public health-delivered intervention successfully re-engages out-of-care individuals.

CoRECT

- Study to evaluate effectiveness of public health intervention compared to clinic standard of care to re-engage and retain patients in HIV medical care
- Identification of out-of-care
  - Independent out-of-care lists: clinic (missed visits, medications); surveillance (lab results)
  - Monthly case reconciliation conference
- Out-of-care individuals of 9 clinical sites were randomized to receive either the facility's standard of care for out-of-care patients or a re-engagement intervention from MDPH field epidemiologists
- Examined costs associated with delivery of Health-Department intervention
- Results:
  - Enrollment of 600 patients is complete, and analysis underway
  - Clinic-surveillance data adjudication process is feasible and efficient

Lessons Learned: Program Design

- There are clinic and surveillance data efficiencies in identifying out-of-care individuals who would benefit from re-engagement assistance.
- Collaboration between public health and clinics is feasible and promotes improved engagement in care.
- Before initiating D2C, ensure that there is 'buy in' among key leaders (e.g. medical directors, program managers, etc.).
- Establish clear work flows – documented in process maps - and ensure that staff understand new systems and their own, and each other's, roles.
- Ensure that staff have adequate time to implement their roles by ensuring dedicated FTEs, especially for data management staff.
- Establish mechanism for updating reporting provider lists on routine basis.
- Develop mechanism to improve the quality of data completeness by incorporating information received during data reconciliation.
- Plan-Do-Study-Act (PDSA) cycles are efficient ways of exploring new ideas.

Lessons Learned: Staff

- Invest in regular, high quality clinical supervision.
- Ensure that staff have access to necessary client/patient data, confidential space, a dedicated telephone, policies and protocols allowing staff to engage in field-based services, and adequate field safety supports.
- Hire staff with demographic characteristics and linguistic capacities reflective of communities served.
- Provide regular opportunities for training and technical assistance, inclusive of peer-to-peer networking and problem-solving sessions.
- Ensure that staff have updated, comprehensive resource lists that include names and telephone numbers of program contacts.
- Build administrative support in implementation plan

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Questions?