North Carolina Communicable Disease Conference

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Integrated Systems Approach to Improve Linkage / Retention and Viral Load Suppression
HIV/STD Integrated Core Team

**Coordinated and Focused Strategic Plan**

- Surveillance
- Prevention
- Early Detection
- Accelerated Interventions
- On-going Support and Monitoring
Core Functions of Team

- Surveillance and Data Mining
- Primary and Secondary Disease Prevention
- Early Detection/Intervention Strategies
- Evidence-based or Promising Practice Interventions
- Targeted and Ongoing Client Support
How Does Integrated Data Drive Integrated Service Delivery?

(Methods to improve link to services, community and patient HIV outcomes)
Un-mined data can connect the dots: communication is key.
Quantitative: Data Sources

• CARE WARE- data
• NCEDSS- data trends (state coordinated info has helped propel)
• GIS- location (down to census blocks)
• CLINIC- data
• Outreach – data
• TB data (foreign born trends)
• Hepatitis data
• Partners data: (Adoptions, Foster Care, Schools, Hospitals, CBO’s, Gang suppression) data insert chart
Qualitative Data:

• Case Studies and Client Interviews
  • Focused team interventions and interview of staff and clients

• Assimilation of case study findings into surveillance- data insert chart of the after action
Evidence Based Strategies and Promising Practices that are Client Specific

- Literature Review searches to explore and validate methods (FDT, EPT, Acuity Ranking)
- CDC models
- Tailored use of key findings- on adherence, transition, age appropriate education, family centered care, adoption, MSM, etc.)
“Systems Approach” to target and link to care

• How to connect the dots? (clients, data, service links)
• Who needs the linkage to services? (the #’s tell us)
• What will work best? (ask the experts and the clients)
• How to accomplish better links to service? (coordinated systems approach)
How does Data Team help?
Data Supports Link to Care

The data entry team generates reports of Clients “soon-to-be-lost-to-care.”

• Providers in Clinic are each involved in the work to contact their own patients on the list and,
• Patients that cannot be located/contacted by providers are referred to Bridge Counselors for follow up.
COORDINATED STRATEGIES

HIV/ STD/ CD

COORDINATED STRATEGIES
Community Links and Clinical Partnerships

- Alliance of AIDS Services-Carolina
- Under One Roof
- Community Dental-Warrick & Associates
- CommWellHealth, Inc
- Duke University Pediatric (RW-D) HIV Case Management (for pregnant women and infant care)
- Raleigh Infectious Diseases Associates
- Sohi Eye Care OD, PA
- WakeMed Health and Hospitals
- University of North Carolina School of Medicine
- Wake Health Services, Inc.-Horizon
HIV Outreach Strategies
Out of the Brick Building Approach

• Targeted Community-based programs and interventions

• Education multiple venues

• Social media outlets

• Non Traditional Testing sites (NTS)

• Partnerships: Strong Community Collaboration

• Bridge Counseling is a model for linkage to care for newly diagnoses HIV+ clients.
  – Connect clients to treatment adherence, support services, mental health, substance abuse, prevention for positive cases, food, housing, emergency and financial assistance and long term care AIDS case management.
  – Follow up with clients: Did Not Keep Appointments (DNKAs) or clients who have not shown up for their appointments.
  – Re-engage with clients: Lost to Primary Care (after 9 months missed appointments)
Bridge Counseling
Why is this important?

Of those with HIV, 80 percent know their status; of those who know, only 70 percent are linked to care; and of those who are linked to care, only 60 percent are retained in care.” (Emory Center for AIDS Research, March 2012)

Recommendations:

• Systematic monitoring of successful entry into HIV care.
• Systematic monitoring of retention in HIV care.
• Brief, strengths-based case management (bridge counseling) for individuals with a new HIV diagnosis.
• Intensive outreach for individuals not engaged (lost to care) in medical care.
• Use of peer or paraprofessional patient navigators may be considered.

Annals of Internal Medicine: Guidelines for Improving Entry Into and Retention in Care and Antiretroviral Adherence for Persons with HIV: Evidence-based Recommendations March 5, 2012.
Communicable Disease Section Strategies

• Epi- Surveillance
• Cross trained staff
• Co-morbidity enhanced awareness and testing
  – TB
  – Hep C
  – Other STI’s
• Collaboration in multiple research studies
• Direct interface with hospital
• Disease Intervention Specialist (highly integrated)
• Field Delivered Therapy
DATA MONITORING AND CLIENT OUTCOMES

Why does it matter?
## Client Retention Rates

<table>
<thead>
<tr>
<th>Year</th>
<th>Retention %</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>94.7</td>
<td>(n=187)</td>
</tr>
<tr>
<td>2005</td>
<td>88.7</td>
<td>(n=397)</td>
</tr>
<tr>
<td>2006</td>
<td>87.5</td>
<td>(n=559)</td>
</tr>
<tr>
<td>2007</td>
<td>93.1</td>
<td>(n=659)</td>
</tr>
<tr>
<td>2008</td>
<td>77.3</td>
<td>(n=837)</td>
</tr>
<tr>
<td>2009</td>
<td>84.9</td>
<td>(n=870)</td>
</tr>
<tr>
<td>2010</td>
<td>87</td>
<td>(n=918)</td>
</tr>
<tr>
<td>2011</td>
<td>92.4</td>
<td>(n=934)</td>
</tr>
<tr>
<td>2012</td>
<td>94.5</td>
<td>(n=1008)</td>
</tr>
</tbody>
</table>
Importance of Linkage to Care and Viral Load

% non-Detectable VL (all patients)

- 2008: 55.8%
- 2009: 63.2%
- 2010: 70.3%
- 2011: 73.4%
- 2012: 75.1%

Data Source: WCHS CAREWare
Importance of Linkage to Care and Viral Load 2012 breakdown:

% non-Detectable VL (all patients)

- Male: 76.8%
- Aged 13-24: 59.1%
- Race/Ethnicity: 74.8%
- MSM: 75%
- Perinatal: 50%
- NOT on ADAP: 73.8%

Data Source: WCHS CAREWare
What’s Next for Wake County HIV?

• **Further define our 25% non-suppressed VL** (what do they look like?)

• **“Systems Approach” to identify behavioral benchmarks** for loss to care clients

• **Tailor our response** to those clients

• **Refine allocation of Case Management/ Bridge Counselor** based upon benchmarks

• **Acuity ranking** of HIV clients for Case Management assignments
Benchmarks for Acuity Ranking?

• Level 1 Well Controlled
• Level 2
• Level 3
• Level 4
• Level 5 Acute Hospitalization Crisis
Core Team Linkage to Care Successes

- **Crucial component**: Consistent and standardized source data
- Data Drives Integration
- Developing a Common Integrated Plan (still a work in process)
- Better alignment of expertise
- Cross-trained staffing
- Adding additional focused strategies to integrate and link services
- Constant assessment of metrics and methods to focus and improve service links
Questions for our group
Thank you.....................
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