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# Retention in Health: Improving HIV Retention within the SF Community Health Network

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## Abstract

Previous work on HIV retention improvement has focused on improving access to care for communities who are either at-risk of falling out of care or who have difficulty engaging in medical care for the first time due to socio-cultural barriers. The San Francisco Department of Public Health (SFDPH), with the support of Project PRIDE, a CDC three-year demonstration project geared towards supporting health departments in implementing public health strategies to reduce new HIV infections within the men who have sex with men (MSM) and transgender communities, is seeking to improve HIV patient retention throughout the San Francisco Community Health Network (CHN). The Retention in Health Pilot Project at Tom Waddell Urban Health Center was developed as a model for Project PRIDE, and as a response to the Health Center's current Clinical Quality Improvement (CQI) plan to improve HIV patient data capturing and reporting, and the HIV patient's experience. A pilot project within the CHN was developed using academic detailing methods as a means of demonstrating the usefulness of retention work both in patient health outcomes and clinic reporting on HIV measures of care required by the Ryan White HIV/AIDS Program. The Retention in Health program promotes monthly panel management to identify patients in need of a viral load draw, drop-in visits with nurse staff to increase accessibility to primary care, and care navigation to support in the reconnecting of out of care or lost-to follow-up patients. The program was implemented in April 2017 and is currently in progress in the health center through the support of clinic staff and a capacity building specialist from Asian and Pacific Islander Health Forum.

Retention in Health: Improving HIV Retention within the SF Community Health Network

## Motivation to Improve HIV Retention

Disengagement from HIV care leads to unfortunate consequences. Individuals from key affected populations are more likely to fall out of medical care due to socio/cultural barriers. The San Francisco Department of Public Health (SFDPH) identifies key populations as substance users, people of color, trans-identified individuals, people with mental health needs, the homeless, sex workers, children, people who were recently released from incarceration, and men who have sex with men (MSM). (SFDPH, 2016) Motivation to improve retention in HIV work comes from the public health risk of increased transmissions due to poor engagement in the healthcare system. HIV positive patients who are engaged in comprehensive care are less likely to transmit the virus to others, and play a major role in continuing the trend of decreased transmission rates. (Thompson, M.A. et al, 2012) In San Francisco, 28% of people living with HIV/AIDS (PLWHA) are not retained in medical care. (SFDPH, 2015) Retention in care and adherence to anti-retrovirals therapy(ART) is imperative since individuals who are not retained in medical care have been linked to 9 out of 10 new HIV transmissions. (Skarbinski J. et al, 2015) Academic research has investigated reasons why PLWHA have fallen out of care, where most of the research on retention has acknowledged barriers to care before someone has even been diagnosed with HIV.

There are many systemic factors that force hard to reach patients to disengage from the health care system. One factor that creates disengagement is stigmatization. Stigmatizing attitudes towards PLWHA who are also members of key affected communities causes the health

care system to not respond adequately to community's needs. The criminalization of sex work and drug use and the experience of members from these communities being unable to build trusting relationships with medical providers because of lack of cultural humility is just one example of this systemic issue. (WHO, 2013) PLWHA who experience homelessness face many challenges to their health. Homeless individuals are already three to six times more likely to become ill compared to housed individuals, and since those living with HIV/AIDS are immunocompromised poor hygiene, malnutrition, exposure to the elements, and crowded shelters increases chances of exposure to opportunistic infections. One study from the Alliance to End Homelessness reported that people who sleep in a shelter are twice as likely to have tuberculosis if they are HIV-positive (National Alliance to End Homelessness, 2006) People that experience homelessness tend to be high utilizers of emergency departments. Therefore, coordinated care networks need to be organized so that homeless PLWHA can receive the needed care (linkage to a primary care provider) when they present for health services. (University of California San Francisco Center for AIDS Prevention Studies, 2005)

Medical adherence is crucial. The clinical experiences of PLWHA who had delayed, declined, or discontinued ART and who also were generally poorly engaged in health care is extremely important to the understanding of not only poor clinical experiences, but also how the care continuum, while comprehensive, is not a one-size-fits-all approach to care-for-all. (Gwadz, M. et al, 2016) There is an opportunity for the improvement in retention in care from the side of the healthcare system towards communities who have been identified as being at-risk of falling out of care, to provide culturally responsive services, and to make use of new supportive interventions and strategies to reconnect patients that are out of care or lost-to-follow-up. For example, peer-based interventions and multi-disciplinary teams where medical providers and

social services work in tandem that provide non-judgmental comprehensive services have demonstrated success in retaining their hard to reach patients. (Govindasamy et al, 2014)

## Project Background

Studies have provided insight into the improvement work of the healthcare system in attempting to bridge the gaps to key communities and strengthen its process of providing low-barrier healthcare to individuals who are easily ignored. Data regarding the clinic experience is minimal, where some studies demonstrated poor uptake from the previously mentioned vulnerable communities. (WHO,2013) A study about retention in care for trans-identified women living with HIV found that members of the group typically faced stigma and ill treatment in the clinic setting. This ill treatment included refusal of care, verbal abuse, and sometimes violence. (Sevelius, J.M. et al, 2014) And yet, other studies have demonstrated improved uptake from at-risk community members when the healthcare system provided intensive interventions and unique pathways to sustained engagement. Improved access to harm reduction guided alternatives like Methadone and Buprenorphine improved retention in patients and gave guidance to medical providers to assess all patients for substance use disorder/dependence and to provide referrals to alternative treatment. (Thompson et al, 2012) Patients suffering from depression, who were regularly assessed by their medical providers, and provided referrals for counseling had improved retention in care and adherence to ART. (Thompson et al, 2012)

Other studies demonstrated engagement success when patients were able to engage in culturally responsive services. A small retrospective study that examined the impact of a bilingual/bicultural coordinated care team on HIV related health outcomes among Hispanic/Latino adults found that patients completed more primary care visits, had improved adherence to ART, and that over time had sustained viral load suppression. (Enriquez, 2008) A

34% increase in patient retention amongst HIV positive youth after tailored programs expanded social supportive services also demonstrated sustained success for their young patients. (Davila, 2012)

Access to medical and supportive care also plays a crucial role in patient engagement and health outcomes. Globally studies have demonstrated that MSMs from low to middle income countries not only have lower access to ART and therefore poorer adherence, but also face criminalization for their same sex behavior. (Arreola, S. et al, 2015) National studies on access to care for MSM have focused on the behavior of medical providers and the importance of their assessments being culturally responsive when it comes to questions regarding sexual identity and behavior. (Pathela P. et al, 2006) Improved interventions that focus on alternative pathways to care via supportive partners have shown great success in reconnecting patients. The use of treatment advocates or peer navigators, the use of strengths-based case management, and the use of care navigation are just some examples of innovative intervention methods aimed at reconnecting patients that were either lost-to-follow-up, or out-of-care. (Craw, J., et al, 2008); (Gardner L. et al, 2005); (Bradford J. et al, 2007)

## Project Scope of Work

The San Francisco Department of Public Health with the support of Project PRIDE, a CDC funded three-year demonstration project geared to support health departments in implementing public health strategies to reduce new HIV infections within the men who have sex with men (MSM) and transgender community, is seeking to improve HIV prevention and patient retention throughout San Francisco. Specific categories of services to be provided through the project include pre-exposure prophylaxis, otherwise known as PrEP, support demonstration projects that target MSM and Transgender persons at substantial risk of acquiring

HIV, and data-to-care demonstration projects that use surveillance data sources to identify MSM and Transgender persons not in HIV care. Health departments are expected to support implementation of data-to-care demonstration projects that expand or enhance linkage, retention, reengagement, and other HIV prevention activities in their local jurisdiction.

A campaign that would focus on HIV retention was developed, using the methods of academic detailing, a 1 on 1 outreach education technique to increase uptake from primary care clinicians caring for people living with HIV. The goal would be that after outreaching to clinicians, providing up to date data on current HIV retention trends through casual conversation, and providing strategies to improve HIV retention in their health practice, that behavior change in favor of the public health priority would occur. Academic detailing is a practice that was developed from pharmaceutical detailing. Pharmaceutical companies use this technique to educate physicians about a vendor's products in hopes that the physician will prescribe the company’s products more often. The first clinic to be targeted within the Community Health Network was Tom Waddell Urban Health Center.

Named after Dr. Tom Waddell and established in 1988, Tom Waddell Urban Health Center provides comprehensive health care and social services to mostly poor, disadvantaged, and homeless persons, who are residing in the county of San Francisco. Tom Waddell is associated with the San Francisco Department of Public Health and located in the Tenderloin neighborhood. The Health Center specializes in multi-disciplinary services which allows the Health Center to respond to a wide range of medical, psychological, and social needs for its patients. The make-up of the Health Center is divided into two structures. The first is Clinical, where services include medical, nursing, social work, mental health, and outreach. The second focuses more on specific services aimed at bridging gaps for patients who experience barriers to

healthcare access under the traditional healthcare model; specialty services, such as HIV, Transgender Health, Mental Health, Substance Abuse, Women Services, Shelters and Substance Abuse Residential Centers. Tom Waddell's multi-disciplinary staff includes Doctors, Nurse Practitioners and Physician's Assistants, Nurses, Medical Assistants, Psychiatry, Social Workers, Case Mangers, Health Workers, Navigators, and Frontline staff.

**Retention in Health: Program Background**

The HIV positive patient's experience at Tom Waddell Urban Health is one that has been operating via panel management through the patient's clinicians. Panel management is a proactive approach to ensure that the 453 HIV-positive patients that are assigned to the Health Center are engaged and up to date on their basic care. HIV panel management in the clinic revolved around quarterly report generation and report action from medical providers that is called "scrubbing." Medical providers identified patients in need of medical attention and sent referrals to their medical staff to outreach patients for appointments to establish reconnection to the clinic. Patients in need of more intensive outreach are referred to the Linkage, Integration, Navigation, and Comprehensive Services program otherwise known throughout the HIV community as LINCS. LINCS is a program within the SFDPH that provides Care Navigation services that includes strengths-based case management, and health care system guidance for HIV positive patients that are out-of-care, or at-risk of falling out of care and who may be difficult to reach. The Retention in Health program is one that was envisioned as taking the clinics current quarterly panel management to a monthly clinic action that would identify patients in need of HIV lab work (viral load), and identify patients in need of LINCS navigation support before they were officially out of care.

**Retention in Health: Program Goals**

Retention in Health aims to improve Tom Waddell's current panel management program by identifying patients monthly who need a viral load draw and to improve the way the Health Center stays in contact with their patients. An HIV patient's viral load should be checked at baseline, before they start an ART regimen, with follow-up measurements being performed at regular intervals. While monitoring every 6 months is recommended for highly stable patients (those who are highly adherent with viral suppression over a long period of time), beginning the monitoring process at 4 months will increase the chances of Tom Waddell Urban Health improving its overall viral load suppression rate and patient retention.

Retention in Health also aims to demonstrate that patient engagement happens outside of the traditional care continuum. While patients may have difficulty seeing their medical provider, they engage with staff other than Medical Provider (Doctors, Nurse Practitioner and Physician's Assistant), like clinic Nurses, or Medical Evaluation Assistants (MEA). By identifying patients every month in need of a viral load via panel management Tom Waddell staff will be able to two things. The first is that monthly generated reports showing patients in need of viral load draw is showing patients who are at risk of falling out of care (especially those with viral loads greater than 200). The second, is that outreaching patients keeps clinic patient contact information up to date. Many patients at Tom Waddell cycle through phone numbers and mailing addresses and regular contact outside of when the patient drops-in for a visit increases chances of the clinic being able to stay in contact with the patient. Keeping information up to date will happen through encounters with patients through contacting patients through the clinic, for example asking patients if the contact information on file is preferred, and encounters with the LINCS program. LINCS Care Navigators can locate patients through various secure databases and once out of care patients have been found their information can updated in their medical record to

allow the clinic to communicate with the patient while they are being reconnected to primary care.

**Retention in Health: Roles, Activities, and Deliverables**

The Retention in Health program is a collaborative clinic effort that includes one MEA who acts as clinic representative in being the first contact to patients who are identified as needing a viral load draw. Once they make the first communication attempt, the MEA documents the interaction and tracks the patient's activity to ensure that they present to the clinic for their lab appointment. The MEA also documents all unsuccessful communication attempts and submits referrals directly to the embedded LINCS Care Navigator stationed in the clinic.

The Retention in Health program also includes a Program Coordinator (PC) who is responsible for the generation of monthly reports that are taken from i2i Tracks and are edited for the MEA. The PC also provides regular supervision that includes training around the importance of retention in HIV care, and best practices in clinic in/outreach. The HIV retention education piece of the program is one that focuses on the importance of established care for people living with HIV and their consistent engagement in medical care to ensure their uptake of medication and viral suppression. The PC is also responsible for all deliverables of the Retention in Health program that includes detailed workflows for MEA and PC that shows step-by-step process of retention program. The program workflows include guides for tracking contact attempts and include pre-written scripts that can be used when calling patients. Other deliverables include learning materials that focus on the importance of retention in HIV care.

The Retention in Health project measurements are aimed to demonstrate program success over time where consistent contact or outreach attempts should lead to an improvement in the total number of patients presenting to the clinic to have their HIV lab work done. The project's

outcome measure will be to determine the total number of patients who received a viral load draw every four months, where the numerator will be patients with a medical visit in the last year, and the nominator being patients that had a viral load draw every 4 months. Data from contact attempts, contact attempts with successful linkage to the clinic, and referrals to LINCS Navigation will be used to show the projects various processes.

### Retention in Health: The Ecological Model

The Retention in Health program falls under two categories of the ecological model. The first is community. Retention in Health is a program that aims to provide an alternative pathway for HIV positive patients at Tom Waddell Urban Health, improving accessibility to care for patients who experience resistance to care. By acknowledging the availability of nurses in the clinic to provide care and to complete HIV lab work, patients who disengage due to long wait times for their primary care provider can get the needed medical attention without losing time. The Retention in Health program also touches on the Interpersonal elements of the model in that it promotes the building of stronger clinic support for patients through nurse interactions with the patients. Historically, the model of care promotes patient engagement through patient-provider interactions. By promoting patient-nurse, patient-provider relationships where patient-nurse is one that is easily accessible the patient so that they may be able to build their support system in the clinic-their Care Team.

## Project Impact

### Academic Detailing and Development of Retention Detailing

In developing an HIV retention plan that would be specific to the patient population of Tom Waddell Urban Health, and to get buy-in for the Retention in Health program, a three-day training on the practice of academic detailing was completed. Academic detailing, as defined by

the National Resource Center for Academic Detailing (NaRCAD), is “an innovative, 1-on-1 outreach education technique that helps clinicians provide evidence-based care to their patients. By using an accurate, up-to-date synthesis of the best clinical evidence in an engaging format, an academic detailers aim is to ignite clinician behavior change.” (NaRCAD, 2015) The tools learned through the training allow for when engaging with a clinician in their practice to: understand the clinician’s perspective, knowledge, and behavior towards the intended public health priority; modify the presentation and or conversation appropriately; and to keep the practitioner engaged throughout the encounter.

A key piece of the practice of academic detailing is the development of the intended program’s key messages, that which is going to be the bedrock of the detailing pitch. For detailing on retention, the key messages, or “asks” that would be brought to clinicians came down to: obtaining updated phone numbers, addresses, and insurance information at each visit; administering depression and substance use screen and providing mental health referrals if indicated at each visit, offering HIV care navigation to patients identified as having risks for falling out of care or patients who miss >2 appointments; and performing panel management every 6 months to identify if patients need a follow up appointment or referral HIV navigation. For each of the key messages, “benefits,” and “features” were categorized to organize the reasoning behind the asks of the academic detailer. In other words, benefits are facts or details that describe a product, if a product is a key message, and benefits are how features meet the needs of the clinician and their health practice, or as NaRCAD likes to call it, the “so what?” [1]

The features and benefits that were developed for retention detailing provided insight into the experiences of patients through the perspective of a Care Navigator. One feature touched on substance use amongst HIV patients, noting that patients who consume alcohol or drugs, who

can manage to take their medication and become virally suppressed, can provide great insight to medical providers on how best to provide culturally responsive care. This feature/benefit was one that was considered for Tom Waddell because of their large active substance user population.

**In+Care Campaign Data Validation**

With the restructuring of the Tom Waddell Clinical Quality Improvement Committee (CQIC), one of the tasks for the HIV CQIC was to validate HIV patient data from i2iTracks in order to submit to the In+Care Campaign. Started by the Ryan White HIV/AIDS Program for its grantees and their sub-providers across the country, this national retention campaign which is also sponsored by the Health Resources and Services Administration HIV/AIDS Bureau in coordination with the National Quality Center aims to use data to bring patients back to care and keep others from falling out of care. This national initiative is a no-cost, voluntary quality improvement effort focused on retention.

Tom Waddell has been participating in the program since December 2011. The health center had been using i2iTracks to pull data from their two electronic medical records systems, LCR and ECW. The data, while comprehensive, was wrong in that many patients captured through the built reports were either not Tom Waddell primary care patients (they were patients in their satellite clinics), or deceased. Data validation was needed to submit an accurate report on HIV patient retention. When HIV Data validation concluded, In+Care data submission included:

- Newly Enrolled in Medical Care, where newly enrolled was defined as the percentage of HIV patients (35%, N=14), regardless of age, who were newly enrolled with a medical provider with prescribing privileges who had a medical visit in each of the 4-month periods in the measurement year. (Table1)

- Medical Visit Frequency, where frequency was defined as the percentage of HIV patients (53%, N=249), regardless of age, who had at least one medical visit with a provider with prescribing privileges in every 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits. (Table 2)
- Gap Measure, where gap measure is defined as the percentage of HIV patients (19%, N= 273), regardless of age, who did not have a medical visit with a provider with prescribing privileges in the last 180 days of the measurement year. (Table 3)
- Viral Load Suppression, where viral suppression is defined as the percentage of HIV patients (76%, N=313), regardless of age, with a viral load less than 200 copies/mL at last viral load test during the measurement year. (Table 4)

**Clinic Focused Retention Pilot Project**

To prepare for the clinic specific project, I sought out assistance from Andreia Galindo, a Capacity Building Specialist with Asian and Pacific Islander Health Forum (APIHF). Together we drafted a scope of work that would allow me to combine the observations and assessments that I had made on the level of patient engagement, and tools that I had learned through USF's Health Programming course to develop a program that would not only benefit the patient experience, but would also improve the collaborative processes that are undertaken by Tom Waddell staff.

I began the process of structuring a retention project by meeting with members of the Tom Waddell staff that worked closely with LINCS patients, patients that were attempting to reconnect to primary care through the support of navigation. I asked MEAs, nurses, frontline staff that included reception and even security guards, and medical providers, what they found to be two of the biggest barriers to having patients consistently engaged. Of the 20 people that I

asked this question, the two responses that I seemed to be common amongst the group were long registration time and long wait time for the medical provider. Understanding that the registration process had already been streamlined for all patients in to ensure that all billing requirements were met, I began considering the provider/patient data and the possibility of their being an alternative to engagement in primary care.

I recognized that Tom Waddell's nurses were more accessible throughout the day for drop-in visits, and that while some had appointment slots, usually those appointments were to give lab results, or to follow-up on provider visits. After noticing that I had been asking a lot of questions around the HIV patient experience, I was informed that there were thousands of dollars in the form of vouchers (gift-cards for McDonalds, Burger King, and Safeway) that were designated for HIV patients that had not been used. I considered using these vouchers as incentives for the program. I ran data on viral load draws, looking for patients whose previous viral load had been drawn four months prior; the list generated 85 patients, where the oldest lab on record was in 2011. When I ran the patient list including last medical visit (using last blood pressure reading), the same person from 2011 had been in the clinic in 2017 for a drop-in nurse visit. Now going through a random selection of patients I noticed that many of them had either dropped in to the clinic with many missed appointments, had made some appointments with many drop-ins, or had not come in at all.

After reviewing the patient's medical records, I wondered if patient engagement could be measured through drop-in visits, or scheduled visits with the nurses. A method of in-reaching patients would be to call and inform that they were due for their labs and that for dropping in to the clinic to complete, they would be offered two vouchers as an incentive. If they made it and returned for their results, they would receive three vouchers for their time; patients with

abnormal labs would be "flipped," where the nurse appointment became a medical provider visit, and the patient would meet with their Doctor or Nurse Practitioner. If patients were not reached they would be referred to the LINCS Navigation program where a Care Navigator would be assigned to their case; Navigators would be able to locate the patient, provide reminders for the lab work, and possibly escort the patient to the clinic if requested.

After being given permission to expand on this theory of demonstrating patient engagement through nursing visits, an MEA by the name of Peter Donovan approached me and informed me of their interest in participating in the project. I developed workflows for us that would include monthly report generation, scripts for when calling patients to inform them of their pending lab work, ways of documenting and tracking all calls using Excel, and educational materials on the importance of HIV retention and ways to improve patient retention in a clinical setting. I met with Peter three times to go over the workflows, educational materials, and patient lists to get feedback around workflow distribution and management of tasks. (Figures, Pg. 31)

**Research and Program Implications**

As of March 2017, the Retention in Health Pilot Project development has been completed and is awaiting implementation through Tom Waddell Urban Health Center. Tom Waddell's CQIC has placed the pilot project on their QI Calendar for May, meaning that first contact attempts to patients will be made then. Current staffing transitions will allow for the project to have one dedicated Quality Improvement Coordinator to: validate further HIV patient data through i2iTracks; generate monthly reports for patient calls; conduct weekly check-ins with MEA Peter to go over contact attempts, making sure that they're logged and tracked correctly; meet with Capacity Building Specialist Andreia Galindo; meet with nursing staff and clinic

leadership to provide information on how best to dispense and track project incentives; and make appropriate referrals to the LINCS Navigation program.

Currently the contact attempts are scheduled to happen once every two weeks where the MEA will call patients to inform them of their need for HIV specific labs. Contact attempts will be documented and tracked over time by the Quality Improvement Coordinator. The outcome measurement for Retention in Health will be looking at patients who received a viral load every four months as a result of clinic contact. Other measurements will look at patients missing a viral load in the last four months that were successfully contacted; patients missing a viral load in the last four months that were contacted and came to see the nurse; patents that were not successfully contacted and were referred to LINCS that were reconnected to for nurse/viral load visit.

Further research on HIV retention at Tom Waddell Urban Health can include total number of hours needed to connect patients to have lab work completed. LINCS Navigation reported that the average number of hours that a Care Navigator spends with a Tom Waddell patient in reconnecting them back to care is 24 hours. Acknowledging the average amount of time needed to have someone reconnected to care, an average time needed to reconnect someone to have lab work done would be beneficial to understanding the overall need of additional Health Workers within the DPH system. Additional Health Workers can take on the needed HIV outreach and linkage work to the Community Health Network, providing a much-needed service to the City and County who has already done phenomenal work in bringing down HIV transmission rates.

## Conclusion

People living with HIV/AIDS who are not in care and who are engaging in risky behavior are more likely to transmit the virus than those who are engaged with their medical providers and who are on antiretroviral therapy. As a response to the fact that 28% of PLWHA have fallen out

of care, the San Francisco Department of Public Health, in collaboration with the CDC's Project Pride, developed a retention detailing campaign that would focus on physicians and health practices and that would promote health centers as an agent for getting clients back into care by conducting monthly panel management. Tom Waddell Urban Health Center was targeted as the first within the City's Community Health Network because of its diverse HIV patient population, where nearly a majority were either at-risk or already out of care (45%, N= 186).

Patients at Tom Waddell historically have struggled through continuum of care because of barriers that include stigma, racism, poverty, marginalization, homelessness, and conventionalism. The Retention in Health Pilot Project was developed to bring patients in need of a viral load draw back to the clinic through a robust reminder system that includes outreach and incentives for those that reconnected to the clinic for lab work and follow-up visits for results. Understanding that many patients felt that the provider experience at Tom Waddell was one that took up too much of their time, and patients dropped in or scheduled appointments with clinic nurses who have more availability than clinic medical providers.

The Retention in Health Pilot Project stands with other studies that have demonstrated improved uptake from at-risk community members when the healthcare system provides intensive interventions and unique pathways to sustained engagement. The interviews, assessments, and presentations completed at Tom Waddell not only provided insight to the experiences of patients, but also to that of staff and the need to increase capacity for the clinic's quality improvement plan. The work with Tom Waddell Urban Health Center provided insight on how to incorporate public health priorities into everyday practice. By focusing on five key messages to physicians' academic detailers, with the knowledge of the work done at Tom

Waddell, we will be able to increase uptake in monthly panel management from medical providers, and improve the health outcomes of their HIV patients.

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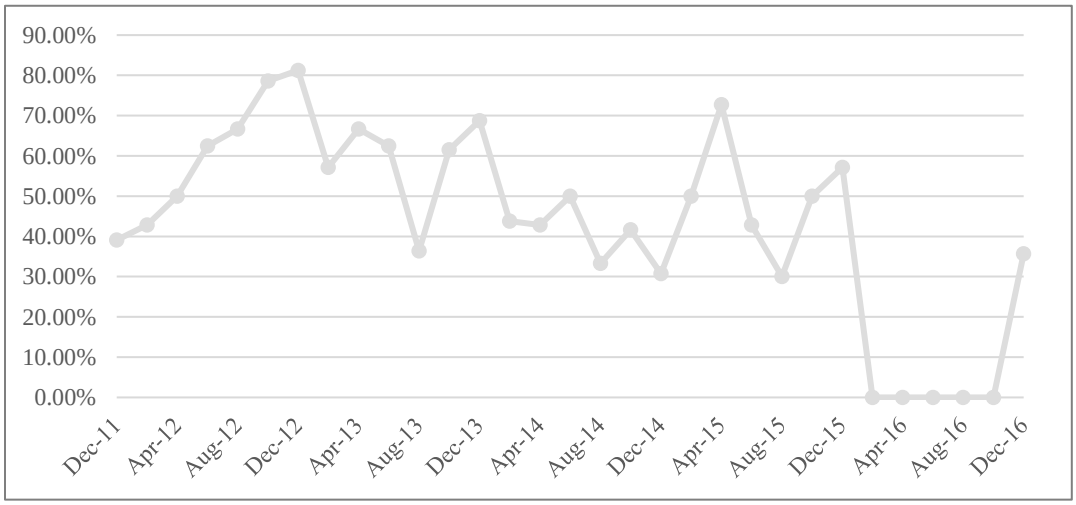
Tables

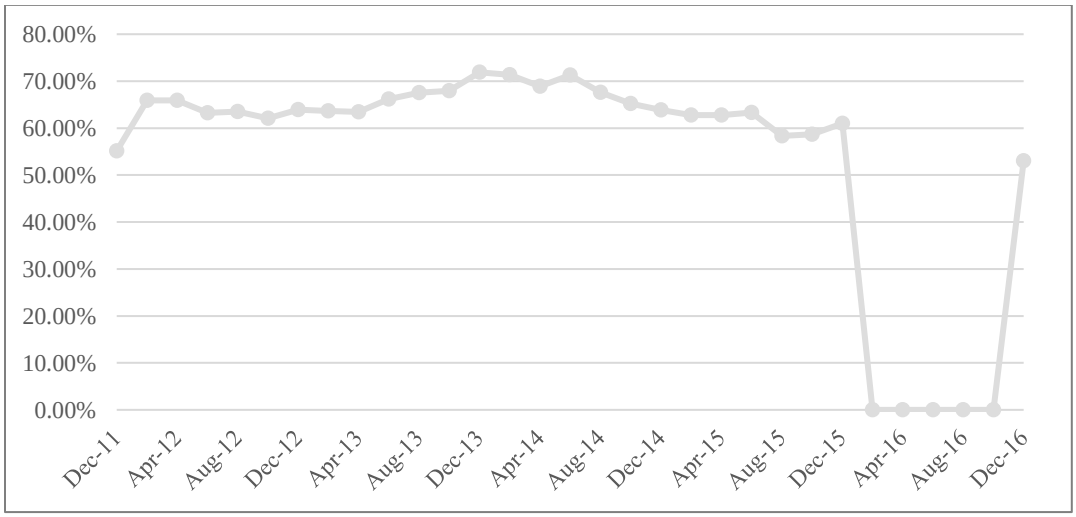
**In+ Care: Data (retrieved 1/9/2017)**

Table 1: *Newly Enrolled*



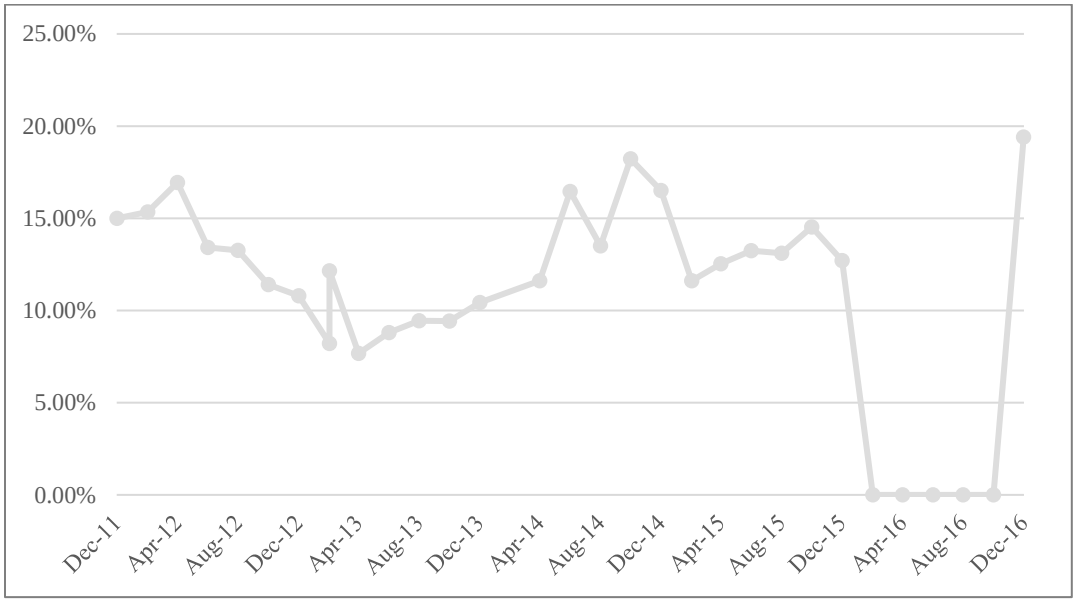

Newly Enrolled in Medical Care, where newly enrolled was defined as the percentage of HIV patients (35%, N=14), regardless of age, who were newly enrolled with a medical provider with prescribing privileges who had a medical visit in each of the 4-month periods in the measurement year.

Table 2: *Medical Visit Frequency*



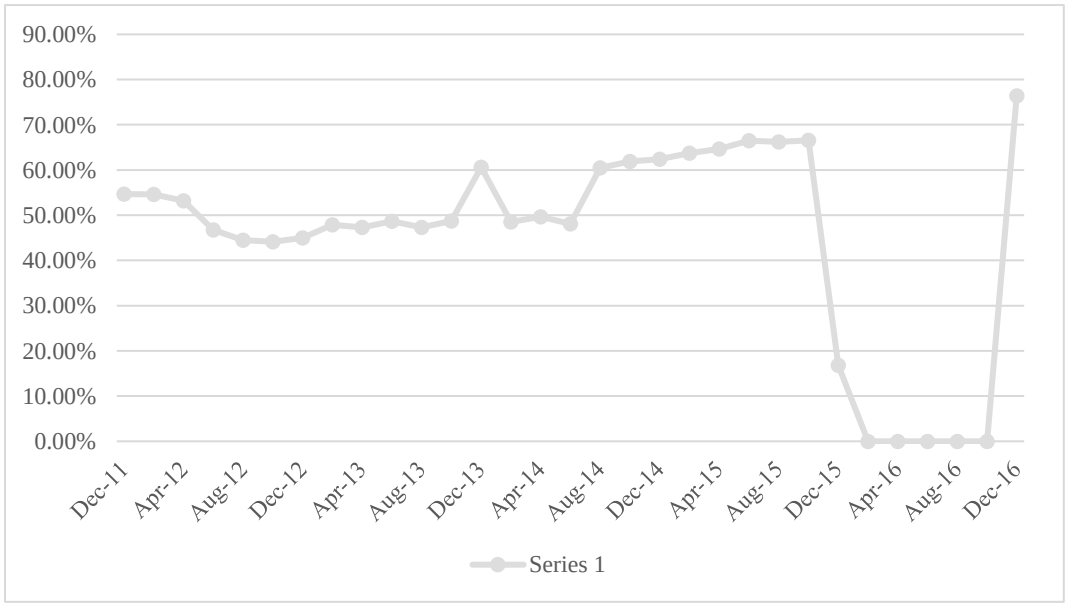

Medical Visit Frequency, where frequency was defined as the percentage of HIV patients (53%, N=249), regardless of age, who had at least one medical visit with a provider with prescribing privileges in every 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits.
uygv

Table 3: *Gap Measure*




Gap Measure, where gap measure is defined as the percentage of HIV patients (19%, N= 273), regardless of age, who did not have a medical visit with a provider with prescribing privileges in the last 180 days of the measurement year

Table 4: *Viral Load Suppression*




Viral Load Suppression, where viral suppression is defined as the percentage of HIV patients (76%, N=313), regardless of age, with a viral load less than 200 copies/mL at last viral load test during the measurement year.

**Capstone Project Competencies**

| Competency: | Method of Achievement: |
|---|---|
| Analyze quantitative and qualitative data using biostatistics, informatics, computer-based programming and software, as appropriate | The retention in health project pulls data from i2i Tracks which captures patient data from their electronic medical record (EMR). The project analyzes the patient data to identify patients that are out of care and in need of clinic outreach. Measurements of program success are completed through tracked data over time, measuring program success through successful outreach attempts, patient engagement, and viral suppression. |
| Interpret results of data analysis for public health research, policy or practice Public Health & Health Care Systems | Reviewing of patient data drives clinic outreach and measurement of retention program success. Over time retention clinic data will demonstrate level of patient engagement in HIV care and level on intervention needed for clinic to maintain standard level of panel management. |
| Discuss the means by which structural bias, social inequities and racism undermine health and create challenges to achieving health equity at organizational, community and societal levels Planning & Management to Promote Health | The Retention in Health program aims to successfully bridge gaps to care for HIV positive patients of vulnerable communities. By restructuring the HIV care continuum for Tom Waddell Urban Health, the clinic will be able to demonstrate patient engagement that is favorable to the lived experiences of patients that for example are active substance users, or marginally housed. Patients who hold higher acuity, where the standard model of clinic practice creates barriers to care, will be able to engage in a more accessible fashion. The project aims to dismantle the standard model of care that creates unfavorable images of difficult to reach patients in order to promote equity in care for patients in need of robust outreach and linkage. |
| Assess population needs, assets and capacities that affect communities' health | Interviewed HIV positive patients who were out of care on their interactions with their medical homes. Asked questions that focused on engagement in medical care, perceived barriers to |

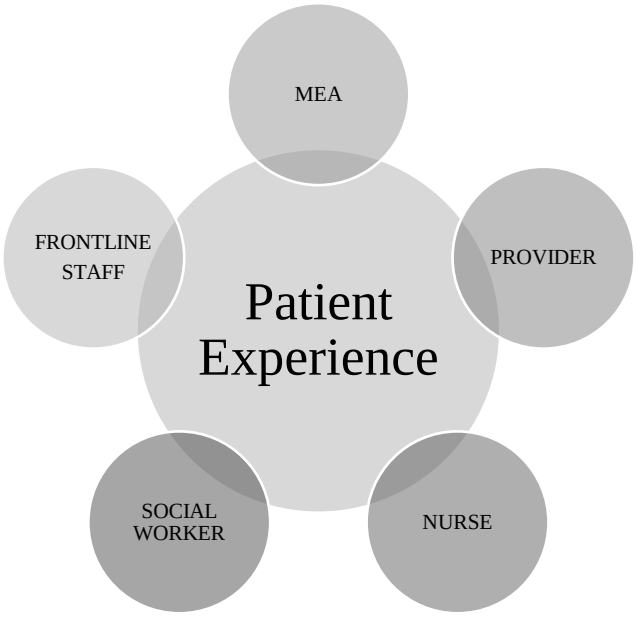
| | |
|---|---|
| | medical care, perceived barriers to engagement in social/supportive services, and needed improvements in the medical systems they were trying to connect, or reconnect to. Conducted clinic observations around cycle times (patient appointment experience from when they registered to when they were checked out), and patient clinic navigation experience. |
| Apply awareness of cultural values and practices to the design or implementation of public health policies or programs | Developed a retention program that acknowledged and considered the lived experiences of patients outside of the traditional care model. Tom Waddell Urban Health is an appointment driven clinic where majority of patients who were out of care/difficult to reach tended to drop-in vs arrive on time. By considering barriers to care, the retention program highlights on the accessibility of nurses over medical providers and highlights the level of consistent care they are able to provide to the patients. |
| Design a population-based policy, program, project or intervention | Developed HIV retention in care program to promote in-clinic panel management with the outcome of: Improved tracking of patient contact information, improved engagement in medical care, and increased chances for viral suppression and therefore less virus transmission. |
| Apply principles of leadership, governance and management, which include creating a vision, empowering others, fostering collaboration and guiding decision making | Provided bi-weekly HIV, and HIV retention education to medical assistants and clinic volunteers. Coordinated meetings with clinic nurses and medical assistants to discuss importance of potential retention project in the clinic. |
| Communicate audience-appropriate public health content, both in writing and through oral presentation | Developed HIV Retention 101 that described why retention in HIV care was so important, and provided strategies on how to improve clinic practice to promote retention in care. Also, I presented retention 101 and educational materials through PowerPoint. |

| | |
|---|---|
| Describe the importance of cultural competence in communicating public health content | Described patient population and importance of cultural humility in clinic practice as a means of improving retention for HIV patients. Also, created educational materials which highlight communication methods for patients that are difficult to reach. |

Figures

**HIV Care Coordination Diagram**

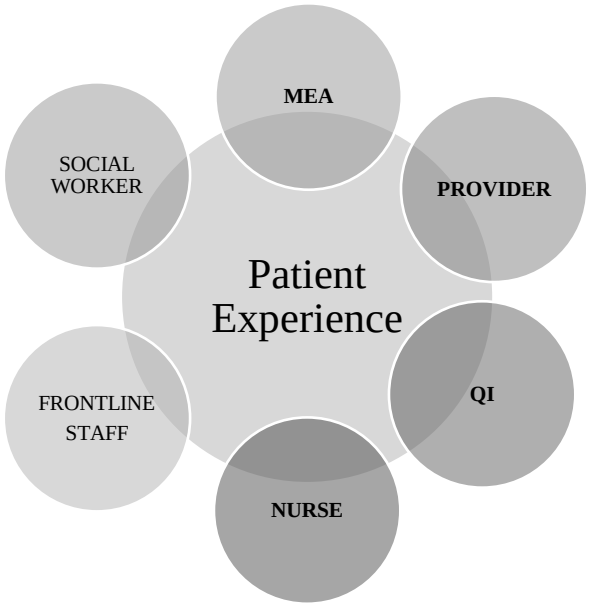
Figure 1: Basic Coordination




The HIV positive patient's experience at TWUHC is one that is operating via panel management through the patient's clinicians. Patient needs are met when either the patient is seen outside of the clinic, drops-in to the clinic, or has a scheduled appointment.

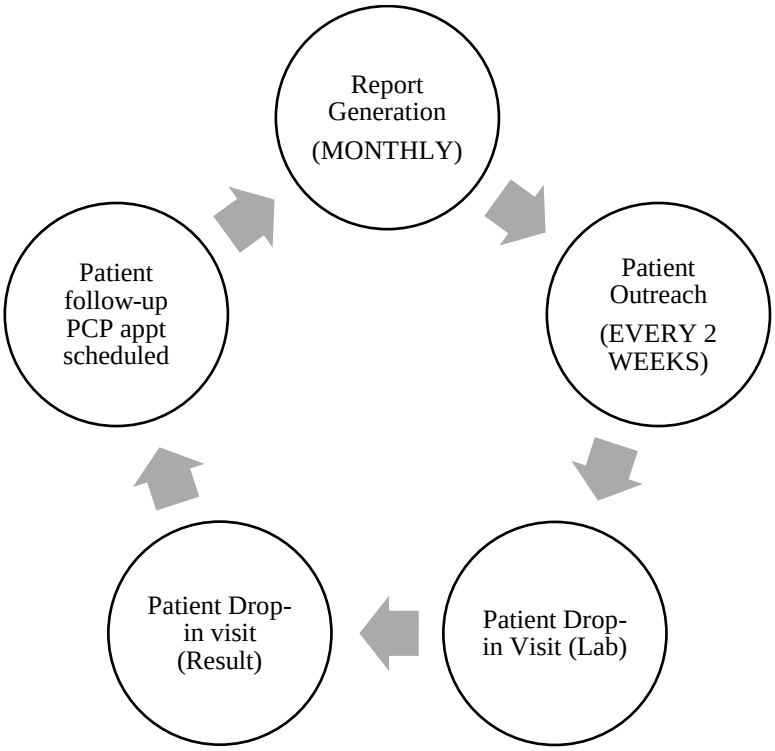
*Not all of TWUHC's patients fall into these categories. Many patients require a different identifying measure.

Figure 2: Intensive Care Coordination



By incorporating QI into care coordination, patients who are either at-risk of falling out of care, or who are already out-of-care can be identified and in-reached by the clinic through the work of staff or through the support of a Care Navigator (LINCS Navigator)

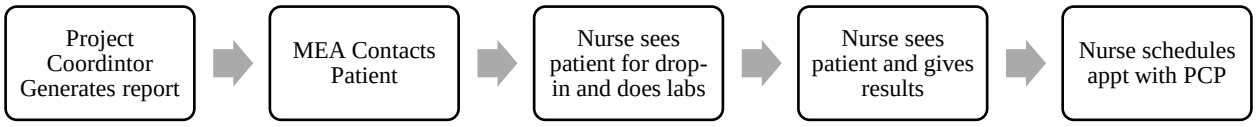
**RH: Improvement in 5 steps**




**Patient retention to increase in 5 steps**

1. Monthly report identifying patients in need of viral load is drawn
2. Patient are outreached and informed of lab recommendation
3. Patient drops-in to TWUHC to meet with nurse and have viral load drawn within 2 weeks.
4. Patient returns to clinic for lab result within 2 weeks of VL draw.
5. Patient leaves TWUHC with follow-up appointment with PCP scheduled.

**RH: Mode of Engagement**




**RH: Viral Load Monitoring**

A patient's HIV viral load should be checked at baseline, before they start an ART regimen. Follow-up measurement on the viral load should be performed at regular intervals. While monitoring every 6 months is recommended for highly stable patients (those who are highly adherent with viral suppression over a long period of time), beginning the monitoring process at 4 months will increase the chances of Tom Waddell Urban Health improving its overall viral load suppression rate and patient retention. By identifying patients every month in

need of a viral load via panel management Tom Waddell staff will be able to two things. The first is that monthly generated reports showing patients in need of viral load draw is showing patients who are at risk of falling out of care (especially those with viral loads greater than 200). The second, is that outreaching patients keeps clinic patient contact information up to date. Many patients at Tom Waddell cycle through phone numbers and mailing addresses and regular contact outside of when the patient drops-in for a visit increases chances of the clinic being able to stay in contact with the patient.

**RH: Standard Workflow**

- **Workflow 1: Report Generation**
    - Reports will be generated monthly by the project coordinator Miguel Ibarra.
    - Reports generated will demonstrate patients from Tom Waddell Urban Health who have not had a viral load drawn in four months.
    - Reports will have the patient name, date of birth, referring provider, last VL drawn date, and last VL value.
    - Once report is generated and formatted for outreach, the report will be delivered to the MEA during monthly check-in (to happen first Friday of the month)

- **Workflow 2: Report Action #1 (MEA)**
    - MEA will call all patients on list. During call MEA will inform patients of:
        - MEA will confirm calls to patient is okay. MEA will note in eCW
        - Patients will be informed of new guidelines at Tom Waddell, where patients will be given two vouchers for dropping in to see the nurse for viral load.
        - Patients will be informed that this is a NEW program and that viral loads will be drawn every four months
        - Patients will be informed of all relevant information regarding drop-in appointments for nurses (drop-in times, lab times, voucher limits, for example)
        - MEA can use scripts for calls:
            - **Script One:** “Hello, this is Peter, one of the medical assistants calling from Tom Waddell. I’m calling you today because we would like you to come in and have your labs drawn. We would like you to drop-in to the clinic within the next two weeks to meet with one of our nurses. We understand that coming to the clinic is a

lot, therefore if you would like I can schedule you an appointment with a nurse, which will mean a shorter wait time, or you can drop-in. I would also like to let you know that for dropping in for these labs, we will be providing you with two $____ vouchers as a thank you for your time."

- **Script Two:** "Hello, this is Peter, one of the medical assistants calling from Tom Waddell and I wanted to let you know that we need you to come to the clinic for labs. If you could come in to the clinic within the next two weeks to drop-in and see one of our nurses that would be wonderful. As a thank you for dropping in to the clinic, we will be giving you two $____ vouchers as a thank you. You will also be given three $_____ vouchers when you come in for your results.
    - If patients ask about vouchers: "The vouchers were provided to the clinic as part of a program to help patients come in to have their viral loads checked regularly."

- MEA will documents all contact attempts (phone calls) at initial contact.
    - All successful contacts will be documented as "Y" in contact log.
        - A successful contact means that the MEA spoke to the patient and the patient agreed to drop-in for nurse visit.
    - All unsuccessful contacts will be documented as "N" in contact log.
        - An unsuccessful could be one of the following:
            - Left Message (LM)
                - Messages that are left for the patient should say:
                    - "Hello, this is Peter calling from Tom Waddell. We called you today because we would like you to drop-in and see one of our nurses to have labs drawn within the next two weeks. Dropping in to the clinic for these labs will make you eligible to receive two $____ vouchers. If you receive this message and need more information, please contact Miguel Ibarra at 415-574-9431.
            - Disconnected Number (DN)
            - Wrong Number (WN)
            - Missing Number (MN)
        - Patients who are not reachable will be referred to LINCS navigation.

                - Patients who are left messages will be contacted again in two weeks. Second attempt will be documented under “Second Call” in MEA call patient log.
        - MEA will track successful contacts and will document nurse visits as “Y” for successful drop-in, or “N” for unsuccessful drop-in
            - A successful drop-in means that the patient came to TWUHC for nursing appointment within two weeks after initial contact.
            - An unsuccessful drop-in means that the patient either the patient did not come for drop-in after initial contact.
                - Patients will be contacted again.
- **Workflow 3: Report Action #3 (Project Coordinator)**
            - Collect MEA contact log after initial contacts are completed.
                - Project coordinator will conduct QA on contact log to check that all contact attempts are documented correctly.
                - Contact attempts that are documented as “N” shall be reviewed and LINCS referrals will be generated. Referrals to LINCS shall be marked as “R” in call patient log.
                    - Contact attempts that are marked as “N” and “LM” will be highlighted for two-week contact attempt.

**RH: Program Measurements**

Outcome

- Patients who received a viral load every four months
    - D: Patients with a medical visit in the last year
    - N: Patients who had a viral load draw every four months

Process

- Patients missing a viral load in the last four months that were contacted and came to see the nurse.
    - D: Patients that were successfully contacted
    - N: Patients that made it for the nurse/viral load visit
- Patients missing a viral load in the last four months that were successfully contacted
    - D: Patients missing a viral load in the last four months
    - N: Patients that were successfully contacted
- Patents that were not successfully contacted and were referred to LINCS that were reconnected to for nurse/viral load visit.
    - D: Patients missing a viral load in the last four months and were referred to LINCS

N: Patients that made it for nurse/viral load visit

**RH: Educational Materials**

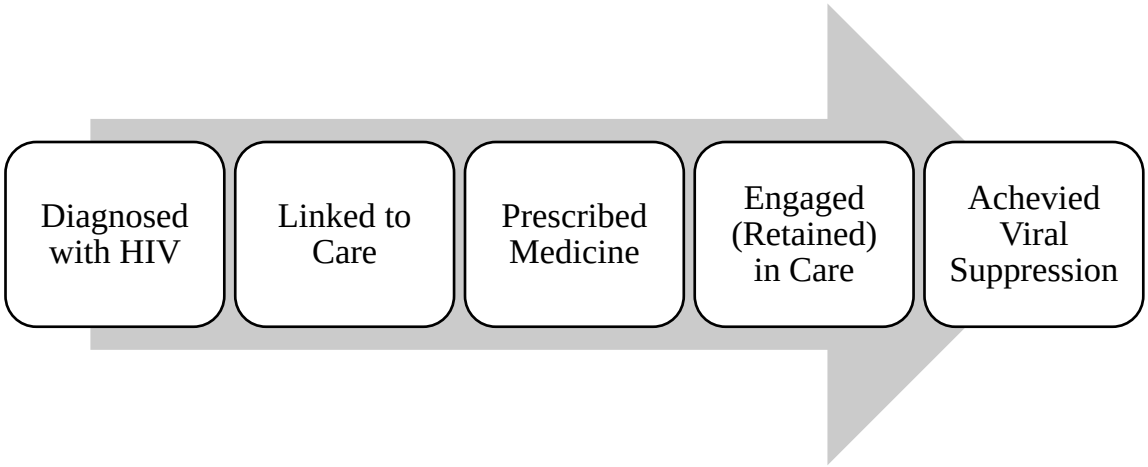
**Why is HIV Retention So Important?**

- **Health Outcomes:** Patients that are retained in care are more likely to experience improved health outcomes.

- **Social Support:** Patients who fall out of care, or who are hard to reach often face barriers in other areas of their lives. Reconnecting with patients in medical care is a good way to link them to social workers in the clinic who can provide support and resources to assist in stabilization so that patients can put all their attention on their health.

- **HIV Transmission:** Patients who are not engaged in medical care have been directly linked to new infections. Getting patients linked to medical care and retained in care where they are on medication and on the road to viral suppression will decrease the number of new HIV transmissions.

- **HIV Care Continuum:** A series of steps that a person living with HIV takes in order to achieve viral suppression and increase their chances of living a long and healthy life.




***How to Improve HIV Retention***

Clinic Environment

A warm and welcoming environment is the strongest way to ensure that patients stay engaged in care. Everyone in the clinic, including the receptionist who greets the patients, the medical assistant who takes vital signs, the clinician that provides medical care, the social worker or case manager that helps the patient navigate the clinic system, basically anyone that has an interaction with the patient from the moment they enter to the clinic to when they leave plays a vital role in

the patient's HIV journey. A welcoming and inviting environment is important so that patients feel welcomed, supported, and cared for.

Patient Communication

Patients who are not engaged in care can sometimes be frustrating. They may show up out of the blue with urgent needs, they may even drop-in to the clinic demanding to be seen. It is important that when communicating with a patient who is inconsistent with their clinic attendance to provide immediate support and education that focuses on their health and wellness. Here are some sample messages:

- "While I know it can be hard for you to make it to the clinic for appointments, or to even drop-in regularly, I want you to know that there is really strong evidence that suggests that patients who engage with the clinic regularly actually have improved health outcomes later in life. When you miss appointments, or don't check in, we can't work together to keep you healthy."

- "You deserve the best care and support from this clinic, but when you miss appointments or do not show up for your lab work, it is really hard to monitor your progress and adjust your treatment should there be any problems."

- "You have an important role in your health and well-being. When you do not show up to your appointment it is really difficult for us to partners in your health journey."

- "When you come in to the clinic regularly, it is actually easier for our staff to provide you the best service possible. Whether that be medical or social services. When you come, you make us work for you."

- "Coming in regularly to the clinic, and engaging with your support team not only keeps you healthy and safe, it also keeps others you may encounter healthy and safe."

Patient Connection: A Strengths-based Approach

Focusing on a patient's strengths, their skills and ability to take care of themselves, is a great way to connect with patients. Focusing on patient's strengths improves relationships with providers, social workers, and other clinic staff. Focusing on patient's strengths teaches the patient to advocate for themselves, thereby decreasing the possibility of the patient developing resistance to the care you want to provide. When a patient is aware of their strengths they are better able to develop goals, and set plans for themselves on how to best to achieve them. When trying to find appropriate ways to spotlight a patient's strengths make use of:

- Past successes in their life

    - How have you solved this problem in the past?
- Avoid things that they may have done wrong, or that they did not complete
    - "Okay, you made a mistake, but I think you're being too hard on yourself."
- Affirmations that promote their personal effort in their health and wellness
    - "You know, by actually coming to your appointment, you're playing a major role in creating a healthier life for yourself."

Educating Patients on their HIV

Patients not understanding their HIV can be one reason why they chose not to engage in medical care. It is important that when patients present to the clinic that you take time to walk them through their HIV and to shed light on any concerns or confusion that the patient has. Patients can avoid the clinic because they do not want to be reminded of their diagnosis, and it is important that when you are with the patient to make them feel at ease.

I hate coming to the clinic because it reminds me that I have HIV, and it makes me depressed."

What you can say

"I just want to first say thank you for coming in today. HIV being a chronic illness takes a lot out of you, yes, but by coming to your appointments and by being an active participant in your health you're actually setting yourself up to live a long and healthy life."

There is always a Next Time!

When patients leave the clinic, they have to know they can always come back if they have a need. Make sure that patients know that the clinic wants to hear about problems or concerns related to their health. Patients need to know that if they develop any new symptoms or if there is suddenly an issue with taking their medication they need to come to the clinic.

Appointments! Appointments! Appointments!

If your patient responds better to appointments, make them one and get their updated contact information so that they can be reminded. If your patient is prone to drop-ins then walking away with update clinic information is a good way for them to know when they can come in for care.