Ending the HIV Epidemic (EHE) Regional Learning Collaborative

Alameda, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, and San Francisco Counties

Session 14:
Innovative Linkage to Care Approaches

Tuesday, November 16, 2021
10-11:30 a.m. PST

CHIPTS
Center for HIV Identification, Prevention and Treatment Services

Session Agenda

1) Presentations

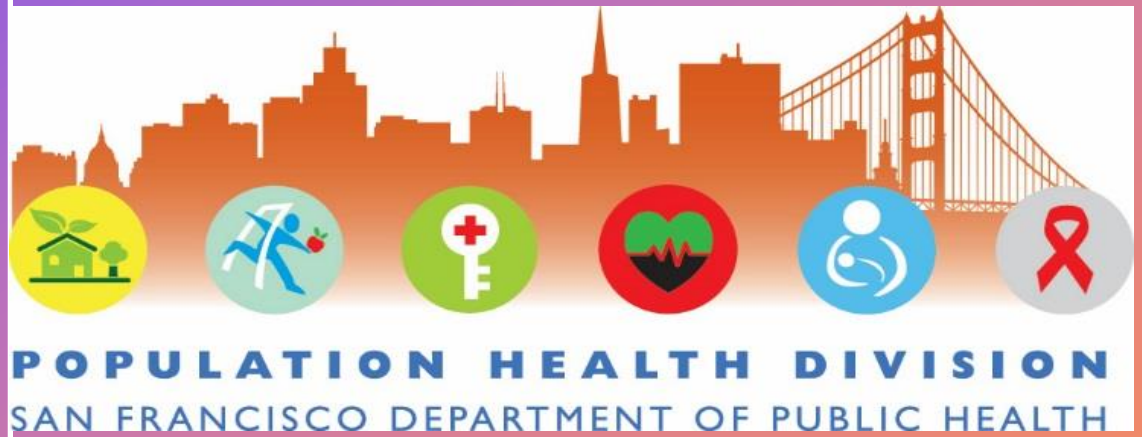
- San Francisco Department of Public Health [questions immediately to follow]
  - Erin Antunez, LINCS Coordinator
- DAP Health
  - Guillermo Ramos, Early Intervention Manager
  - April Cruz, Diagnostic Testing and Outreach Manager
- APLA Health
  - Tiana Monteilh, Program Manager, Care Coordination Services
  - Ruben Garcia, Project Coordinator, Options

2) Panel Discussion/Q&A

- Enter questions using 

- Share comments/resources using 

LINCS FOR EHE REGIONAL LEARNING COLLABORATIVE



Innovative LTC Approaches from San Francisco Department of Public Health

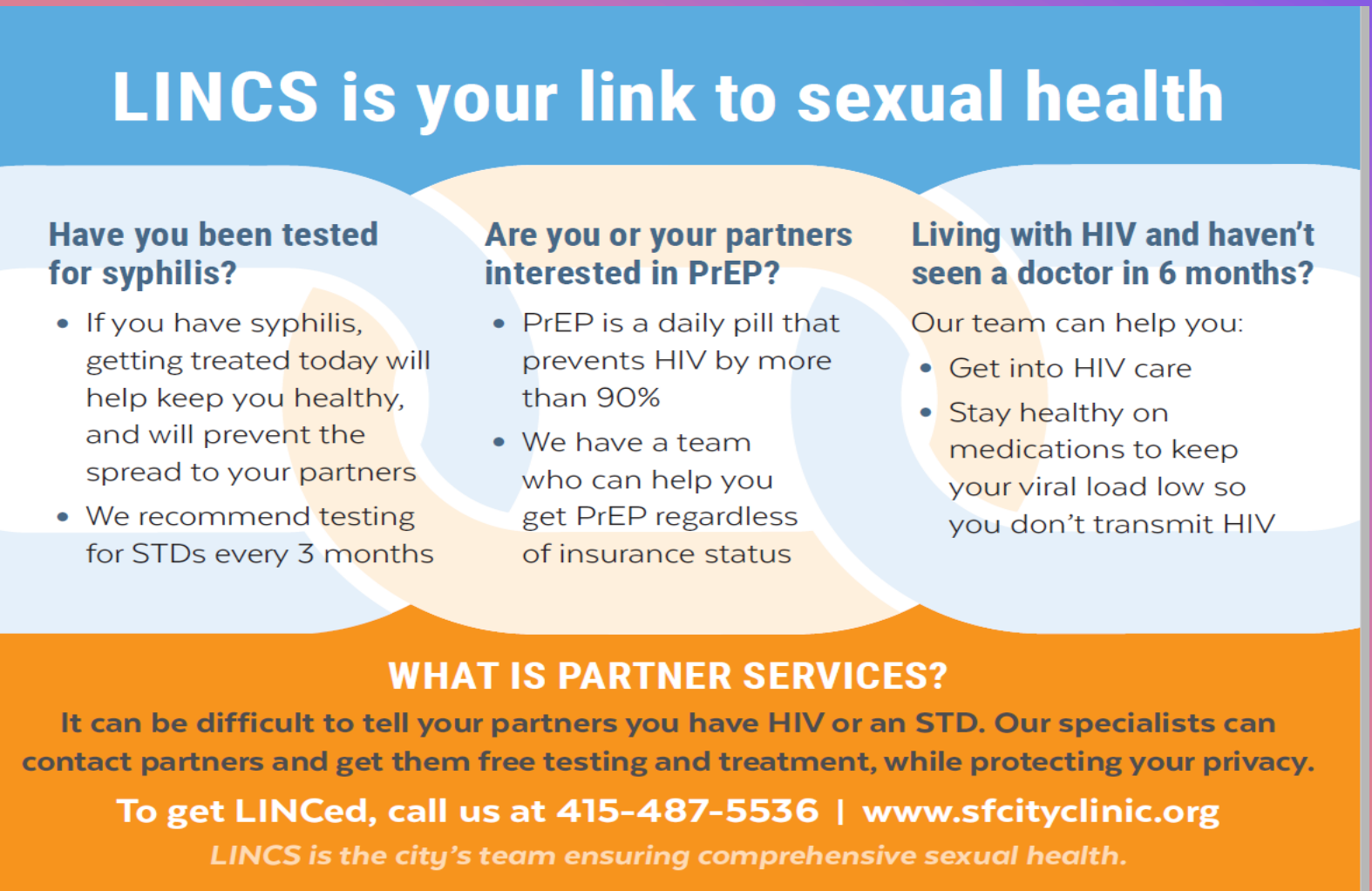
Erin Antunez, MS

LINCS Coordinator

SFDPH LINCS

- Who we are
- What we do
- How we work with people living with HIV and diagnosed with STIs?
- How we address challenges and barriers with LTC and navigation?

SFDPH LINCS



- Linkage, Integration, Navigation, Comprehensive Services
- Team of Disease Intervention Specialists working to prevent and reduce the incidence of HIV and STIs
- Unique health department role of partner services
- Integrated linkage to care and treatment for HIV+, syphilis, chlamydia, gonorrhea, other STIs
- Status neutral approach (Referral to PrEP and navigation for out of care HIV+)

11/16/2021

LTC APPROACHES

HELLO FROM LINCS DIS AND NAVIGATORS!

OUR GOALS:

- Provide comprehensive sexual health services and coaching
- Ensure treatment and LTC for HIV and STIs
- Ensure RAPID HIV start within 5 days of dx
- RAPID re-starts and 3+ months of Navigation for out of care HIV+ patients
- Address barriers to care
- Improve HIV VL suppression rates, especially where there are disparities

What does a DIS do?

Detective

Teacher

Therapist

Public Health Warrior

Customer service expert

What does a Navigator do?

Out of care HIV+ patients referred

Navigators work to locate patients

Located patients are offered Navigation services

Enrolled patients provided assistance to re-engage in care

LINCS Navigation Prioritization Flow

1. Dx <6 months ago + missed 1 appt
2. Hospitalized with detectable viral load

3. Detectable viral load, not seen in 4 months (prioritize VL>100,000)

4. CD4<200 and history of poor medication adherence

Our strategy: Use surveillance data to link people to STI/HIV treatment and services

1. Partner services (ie, contact tracing) is an evidence-based intervention that has been successful in identifying persons unaware of their HIV or STI status and reducing disease transmission. Field staff offer free confidential and anonymous HIV screening, risk reduction counseling and condoms for community members at high risk seeking public health services.

2. **Data to Care (DTC)** utilizes surveillance and clinical data to identify individuals diagnosed with HIV who need support in re-linking to care. HIV navigators provide short-term case management to help patient re-enter medical care and adhere to medications**.**

3. Support **clinicians and CBO partners to increase access to STI and HIV services**. This includes technical assistance and trainings on a variety of sexual-health and HIV topics to improve the quality of sexual health care delivery.

OUR SUCCESSES:

- GTZ- SF continues to see a decline in new HIV cases (131 vs 295 in 2015)
- High rate of LTC and RAPID (92% new dx persons in 2020 entered care within one month)
- High rate of VL suppression (77% of new dx persons between Jan-June 2020 achieved VL suppression within 6 months)

LINCS

People • Care • Prevention

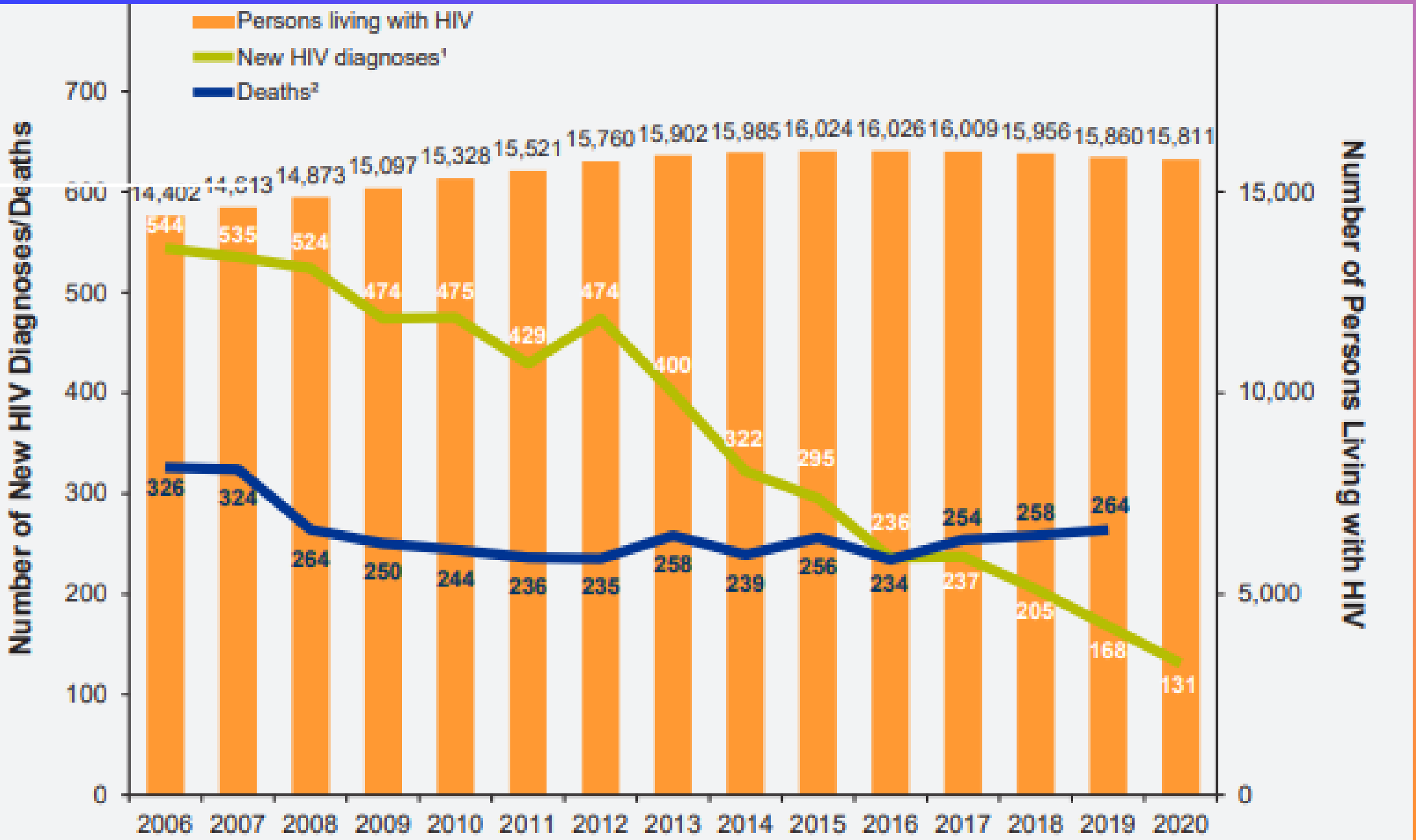
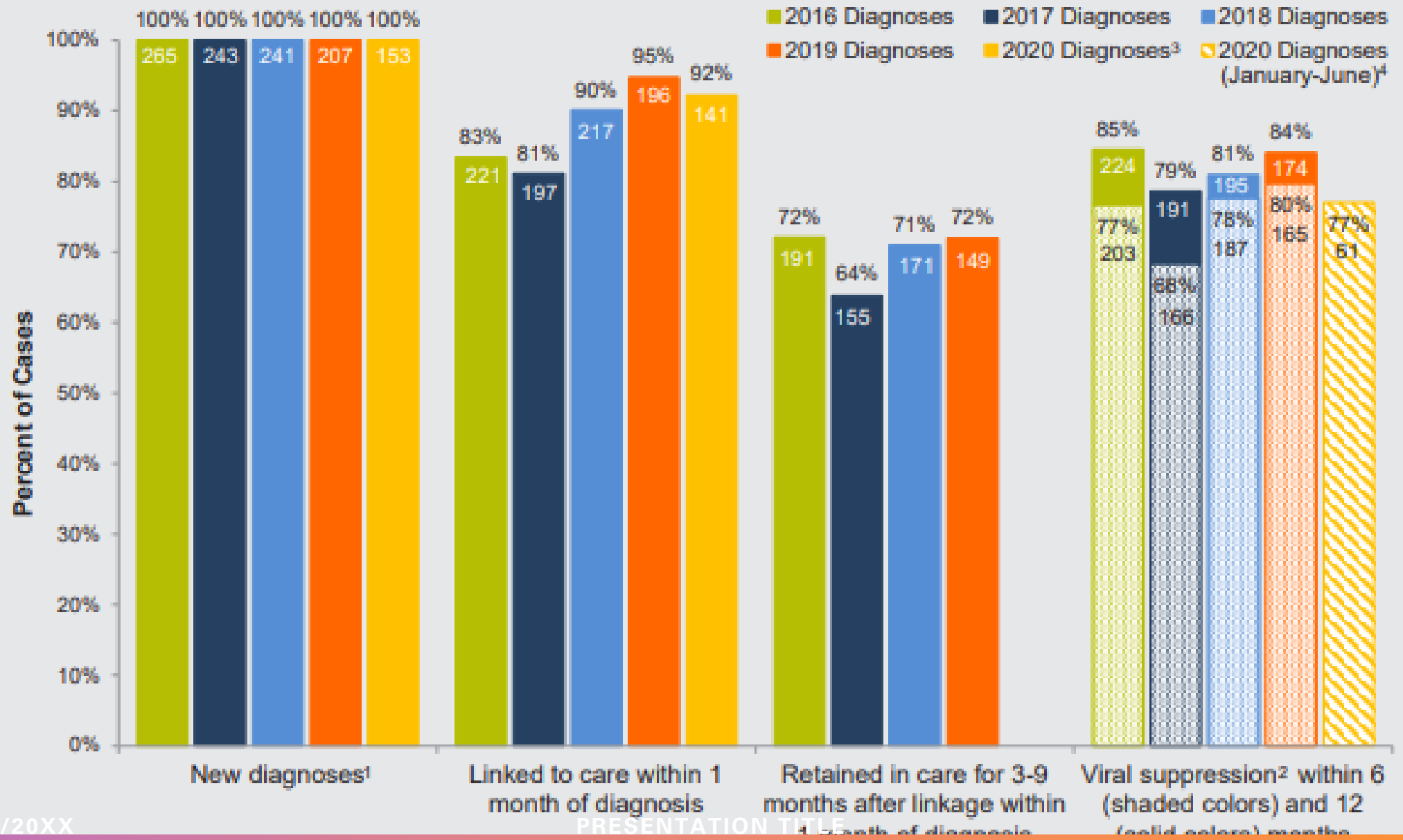

Persons living with HIV
New HIV diagnoses¹
Deaths²
Number of New HIV Diagnoses/Deaths
Number of Persons Living with HIV
700
600
500
400
300
200
100
0
15,000
10,000
5,000
0
14,402
14,613
14,873
15,097
15,328
15,521
15,760
15,902
15,985
16,024
16,026
16,009
15,956
15,860
15,811
544
535
524
474
475
429
474
400
322
295
236
237
205
168
131
326
324
264
250
244
236
235
258
239
256
234
254
258
264
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020

Figure 3.1 Continuum of HIV care among persons newly diagnosed with HIV, 2016-2020, San Francisco



CHALLENGES, AND HOW WE ADDRESS:

- Recent staffing challenges (COVID, burnout)
- Increasing complexity of PLWH- beyond insurance
- Increase in People Experiencing Homelessness, Active substance use, Mental health
- Increase in cis and trans women, heterosexuals- some parallels with syphilis
- Address with partnerships: citywide network of SFDPH primary care clinics, PHAST team, CBO partners, GTZ (RAPID, Retention and Re-engagement, PEH committees), long term case management and ICM programs, social workers
- Get input from Staff and Patients and Prioritize
- Hire staff from community
- Address Wellness of Staff

Thank You!

LINCS staff and our patients
Rebecca Shaw
Meya Harris
Midori Hiyagon
Todd Watkins
Arcelia Gomez
Wanda Anderson
Josue Velasquez
Elia Arias
Vanessa Ruiz
Gloria Calero
Hugh Gregory
Cheryl Fields
Ki-Shawna Hampton

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Innovative Linkage to Care Approaches

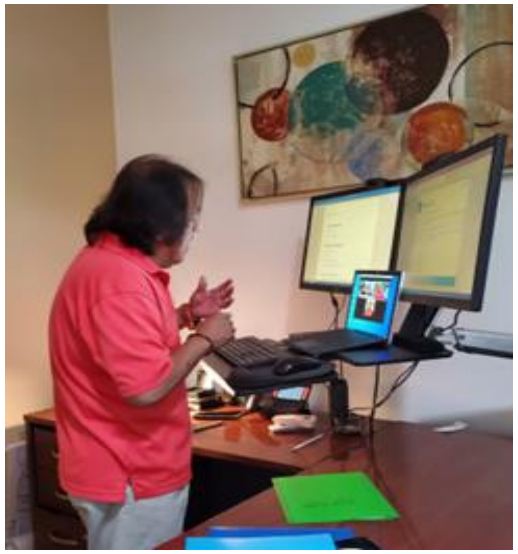
April Cruz- Senior Programs Manager
Guillermo Ramos- Early Intervention Manager

November 16, 2021

DAP Health

Access to Education

- **Schools** (Youth/High School)
  - Safe House of the Desert
  - Twin Palm Continuation
  - Yucca Valley H.S
  - Palm Desert H. S
  - Nellie Coffman Middle School
  - Moreno Valley H.S
  - Palm Desert Charter Middle School
  - La Quinta H. S



- Raymond Cree Middle School
- Torres Martinez Indian Reservation
- Temecula Valley H.S
- Youth Accountability Team (DHS H.S)
- Palm Springs H. S
- Insight DSUSD
- Health Academy Program (CV H.S)
- Olive Crest

- **Presentations**
  - The ABC Club
  - The Alert Program
  - The Awareness Program
  - Betty Ford
  - Casa Cecilia
  - Casa Las Palmas
  - Hacienda Valdez
  - Hemet Valley Recovery
  - Metcalf Recovery
  - Michael's House (Co-Ed in-patient)
  - Phoenix Rising
  - The Ranch
  - Recovery Innovation
  - Re-entrée Initiative Program
  - House of Hope
  - Coachella Valley Sexual Assault
  - Indio Drug and Alcohol Program
  - CSUSB Palm Desert
  - College of the Desert (COD Health Department

DAP Health

➢ Recovery & Treatment Centers

- California Recovery Health, (Addiction Recovery)
- The Alert Program, Palm Springs (Out-Patient DUI Program.)
- The Awareness Program (Indio) (Palm Springs) (Out-patient DUI Program)
- James A. Venable Cabazon Community Center
- County Of Riverside Department of Mental Health Program Male/Female Groups / Female Groups / Male Groups only
- Martha's Village & Kitchen Homeless Shelter
- Coachella Valley Rescue Mission (Homeless Shelter)

- The ABC Club, Men and Women (In/Out-Patient Treatment Center)
- (Hazelden) Betty Ford Center (Co-Ed In Patient Treatment Center)
- Casa Cecilia (Female In-patient Treatment Center)
- Casa Las Palmas (Male in-patient Treatment Center)
- Hacienda Valdez (Woman Inpatient Treatment Center)
- Hemet Valley Recovery (Inpatient Co –Ed Treatment Center)
- Michaels House (Male Inpatient Residential Drug Treatment Program)
- Phoenix Rising Recovery (Co-Ed In-patient/Out-patient Residential Treatment Program)

Self Test Kits

Access to Testing & Treatment

Mobile Clinic: Status Neutral Approach

- STI Testing & Treatment
- Mobile PrEP
- Mobile Rapid Start
- Harm Reduction Program

Mobile Clinic

Previous Testing Van

Mobile Clinic

Mobile Clinic

DAP Health

- We realized it would be beneficial for the client to schedule a second appointment with the rapid stART clinician in the Orange Clinic within two weeks of initial RS appointment for a few reasons:
  - Labs are reviewed sooner and client is provided more HIV education by clinician.
  - Immediate health needs can be addressed sooner, for example, client can be prescribed antibiotics right to treat any infections.
  - Clinician can review medication adherence and side affects.
- Follow up appointment was scheduled within two weeks with Orange Clinic clinician which allowed for needs to be taken care of quicker. Upon completion of second appointment, client was scheduled with permanent HIV clinic at Blue/Green clinic(s).
- This change allows for the Orange Clinic clinician to provide permanent clinician with important information pertaining to patients care.
- Telemedince/telehealth visits
- Transportation assistance

DAP Health

Thank you!

APLA Health Innovative Linkage To Care Strategies

Tiana Monteilh, Program Manager
Ruben Garcia, Project Coordinator

Innovative Linkage to Care Approaches
November 16, 2021

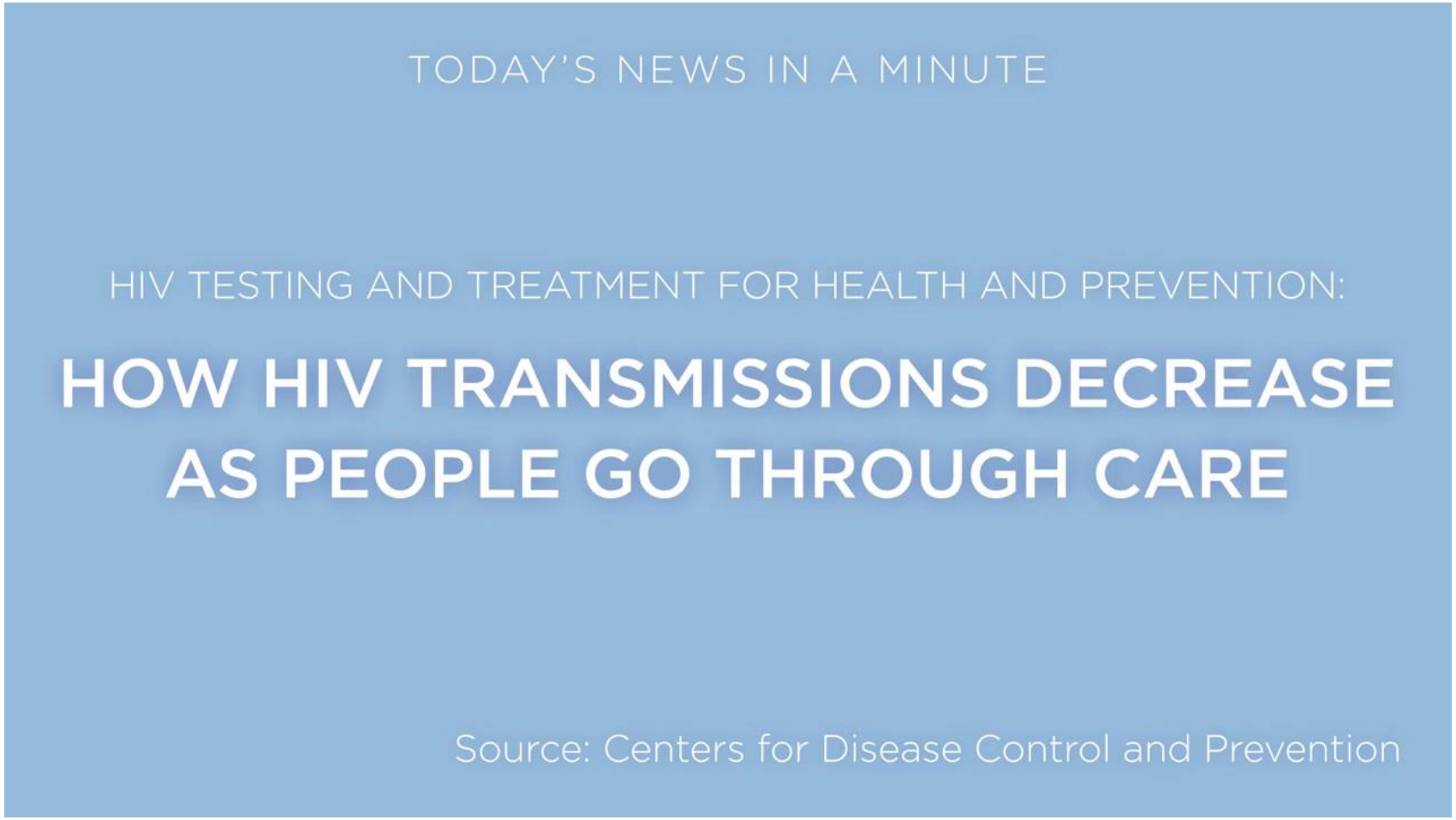
Learning Objectives

1. Describe APLA Health's Options Linkage Program.
2. Assess strategies to successfully increase linkage to care targeting MSM.
3. Identify lessons learned in from the Options program.

APLA Health

What Guides your Work?

APLA Health


TODAY'S NEWS IN A MINUTE
HIV TESTING AND TREATMENT FOR HEALTH AND PREVENTION:
HOW HIV TRANSMISSIONS DECREASE AS PEOPLE GO THROUGH CARE
Source: Centers for Disease Control and Prevention

APLA Health

APLA Health
Options Program

- Non-Clinical Case Management Setting
- Targeted population HIV+ MSM
- Addresses traditional/non-traditional risk behaviors
- Integrated into all APLA Health program
- Encourages PLWH to share biomedical risk reduction strategies with their sero-discordant partners.

* Guided by the Los Angeles County Division of HIV/STD Programs and contract guidelines

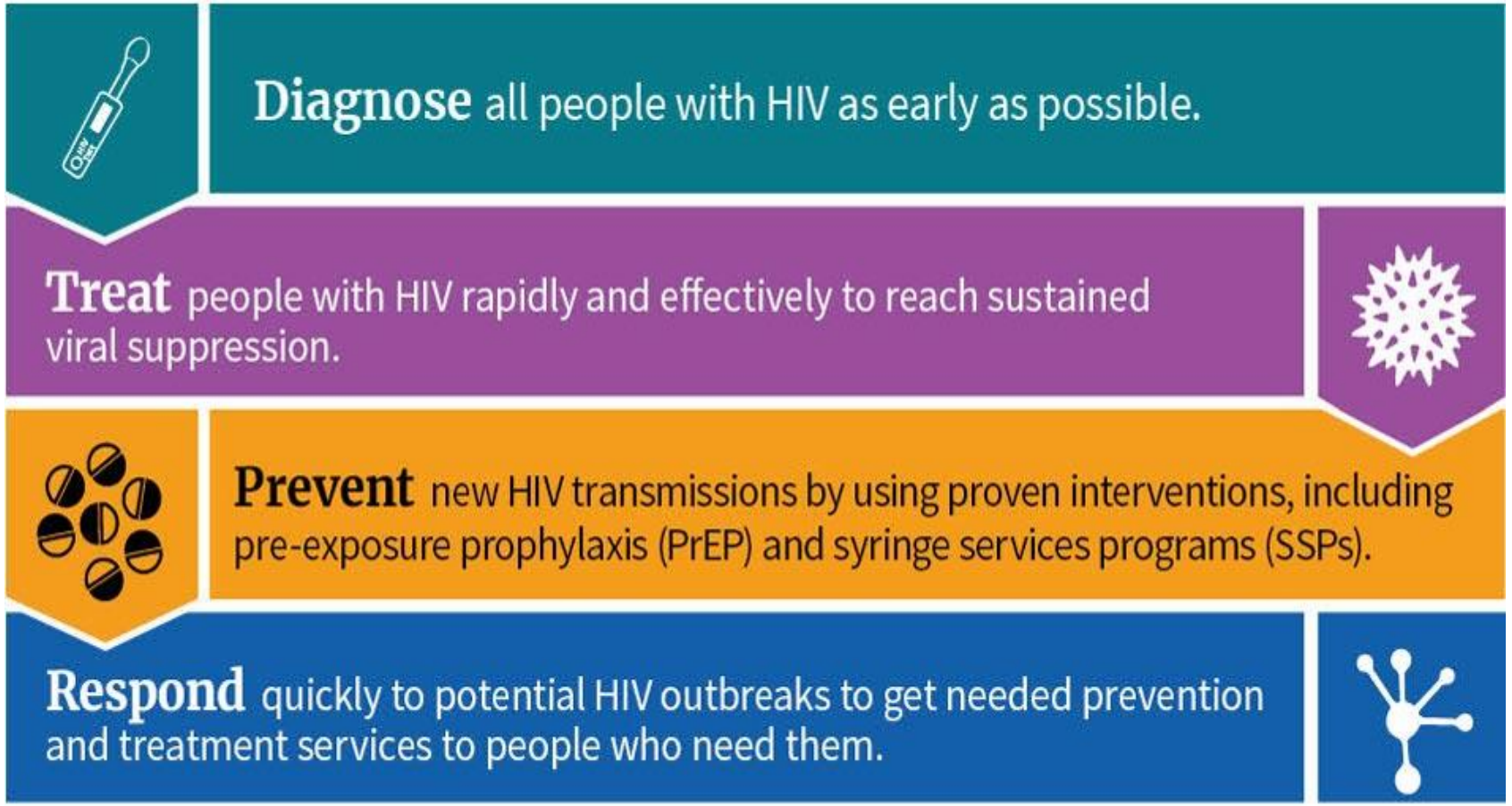
APLA Health

APLA Health
Options Program

- Information-Motivation-Behavioral Skills (IMB) model based
- Motivational Interviewing techniques
- Builds on provider-patient relationship
- Incorporates brief individualized discussions
- Follow-up

APLA Health

Ending the HIV Epidemic



APLA Health

Intervention Strategies

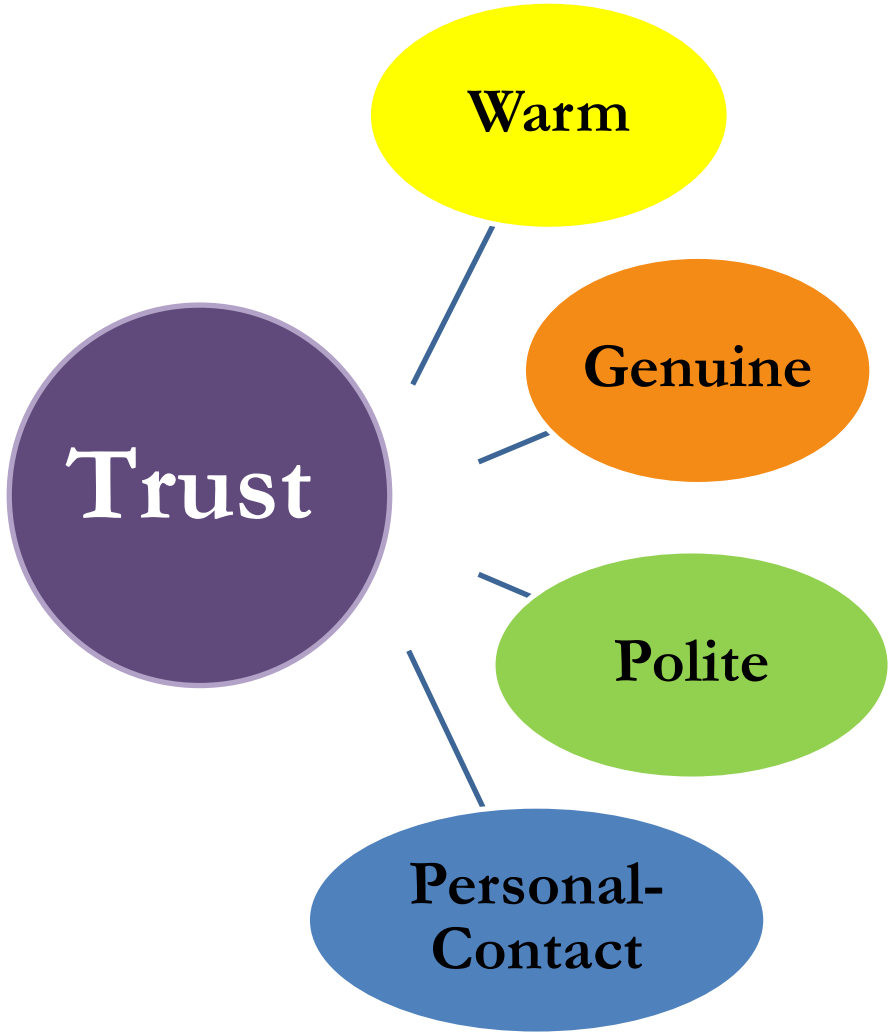
Client Centered Approach

Building Strong Community Networks

Follow-up

APLA Health

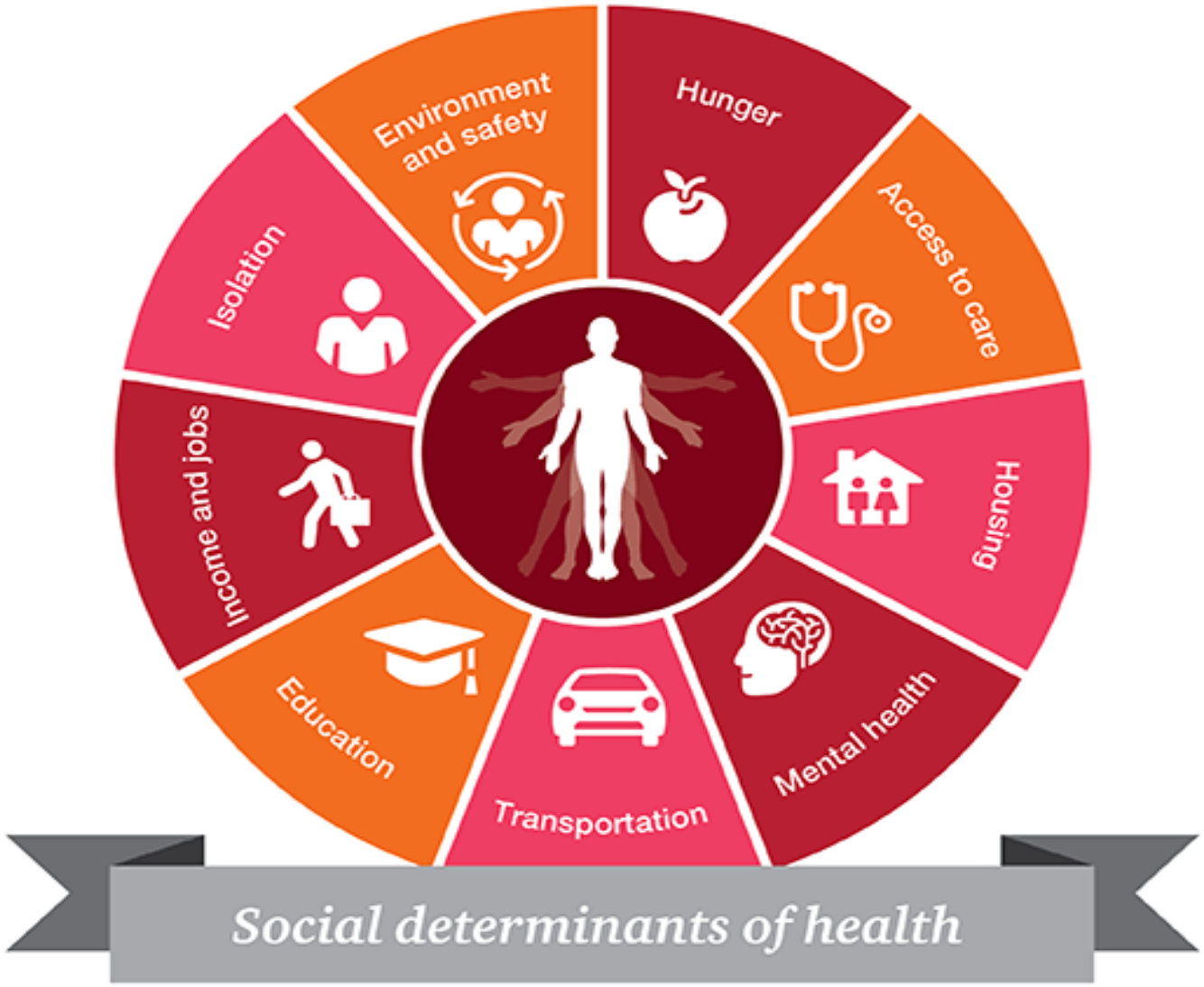
Client Centered Approach



- Flexibility and accessibility
- Allow the client to set the tone of the session while staying faithful to intervention
- Making time and creating a safe space

APLA Health

Building Community Networks



Expanding Linkage Networks

Oral health, behavioral health

Food & Nutrition

COVID Testing & Vaccines

Benefits Counseling

Housing Support Services

MCC Teams
- Tx Adherence
- Transportation

Follow Up

Check-in with clients

1 week before

1 day before

After appointment follow-up

APLA Health

Follow Up

Financial Incentive

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Lessons Learned

- Ambivalence
- Go beyond their diagnosis
- Building trust with both clients *and* providers
- Scheduling flexibility
- Staffing
- Realistic expectations

APLA Health

Options Program

- Options is a feasible and practical intervention that it is effective in the adoption of health promoting behaviors targeting PLWH over the course of a 30, 60, 90-day follow-up.
- Establishing connections and relationships with a network of programs and agencies is critical.

APLA Health


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Health