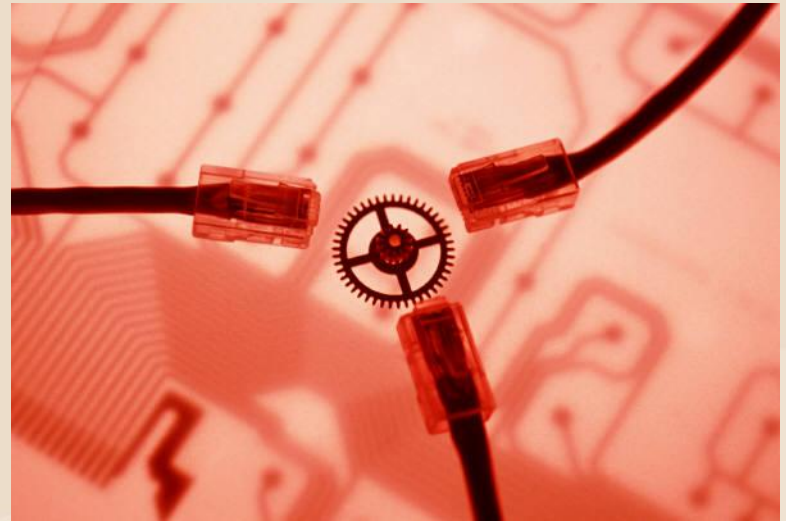




# North Carolina Communicable Disease Conference

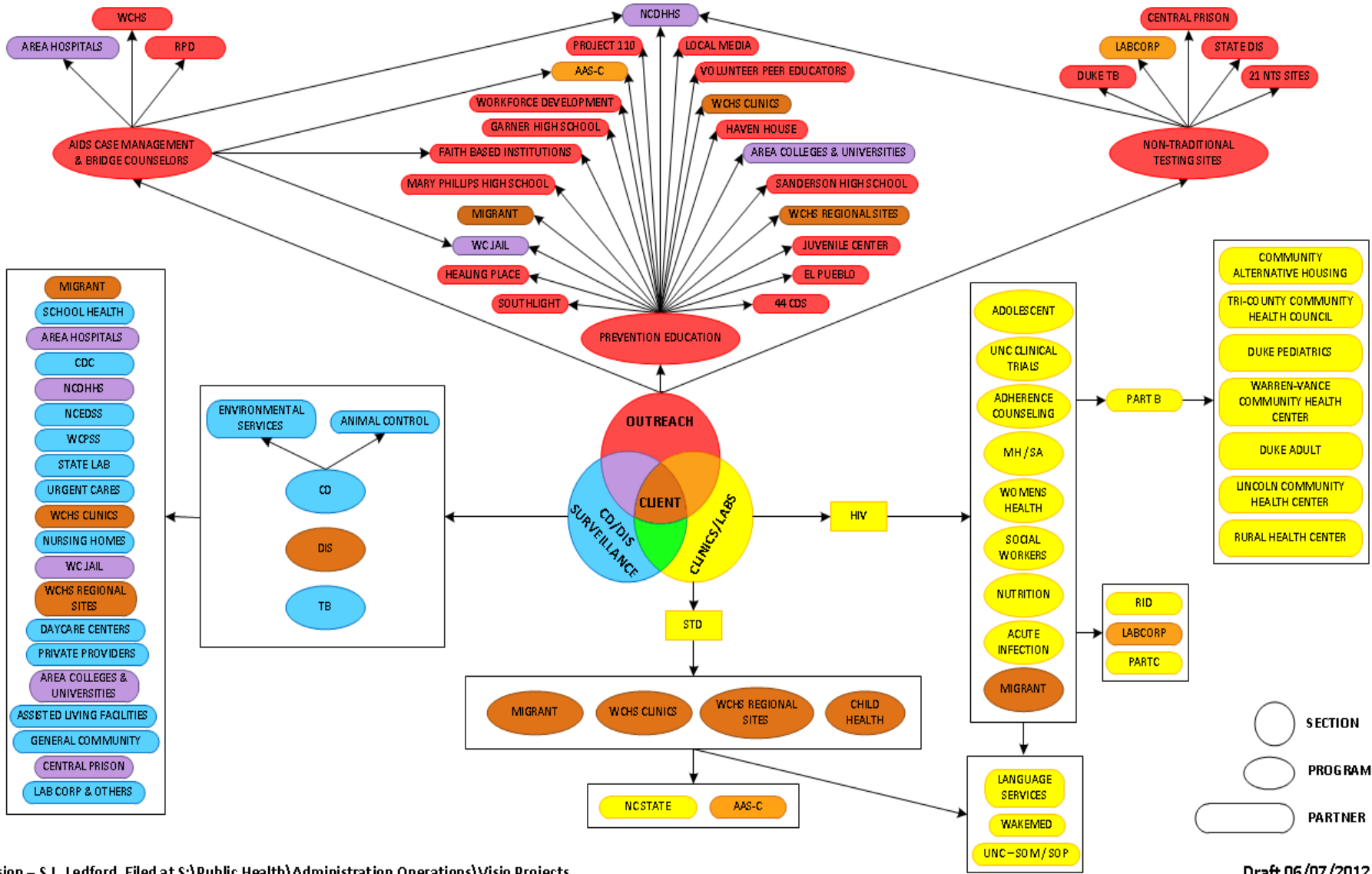


Michael McNeill, Grants / Data Manager  
Sue Lynn Ledford, RN, BSN, MPA, DrPH  
Candidate/PH Division Director



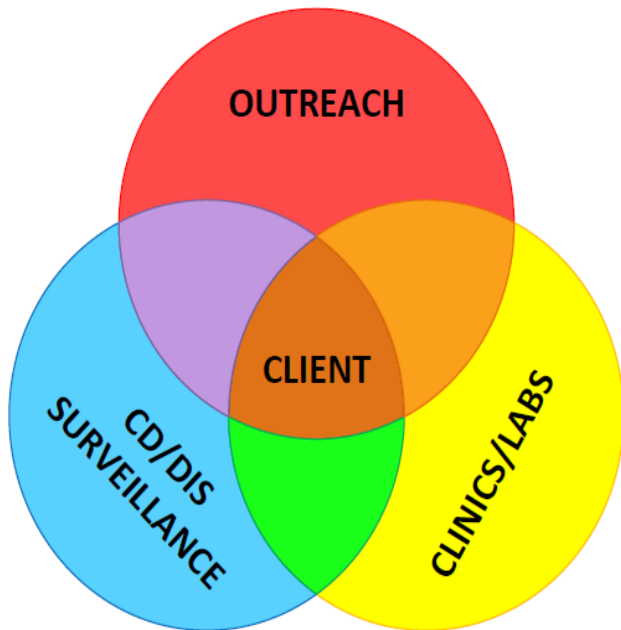
# **Integrated Systems Approach to Improve Linkage / Retention and Viral Load Suppression**

# Wake County Integrated HIV-STD Services



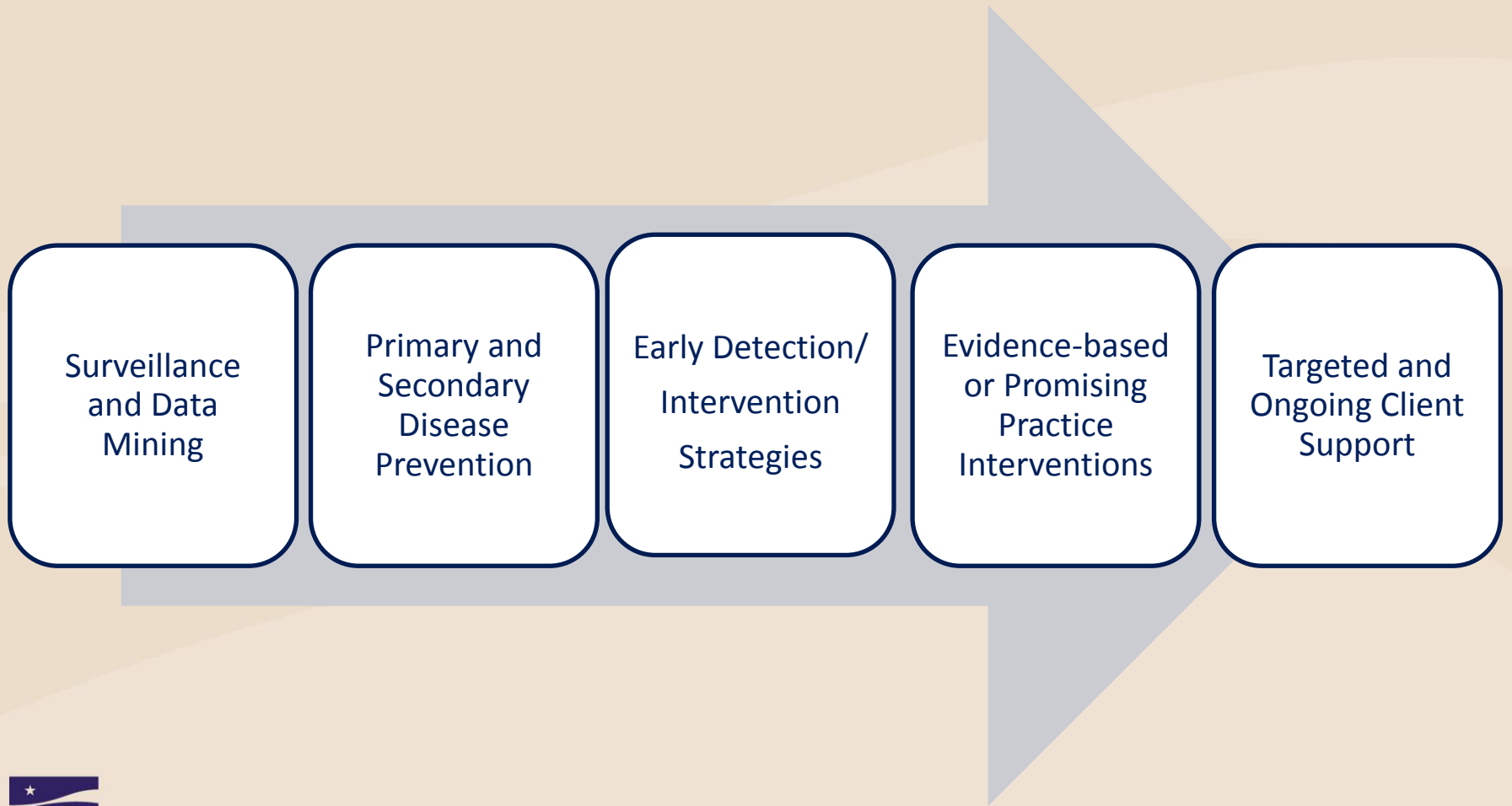
# HIV/ STD Integrated Core Team

## Coordinated and Focused Strategic Plan



- ❖ Surveillance
- ❖ Prevention
- ❖ Early Detection
- ❖ Accelerated Interventions
- ❖ On-going Support and Monitoring

# Core Functions of Team





# 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**



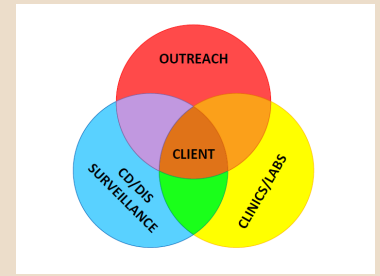
# Qualitative Data:

- 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

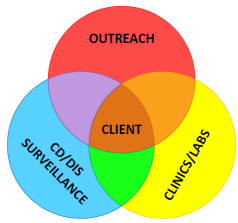
# Evidence Based Strategies and Promising Practices that are Client Specific

- 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



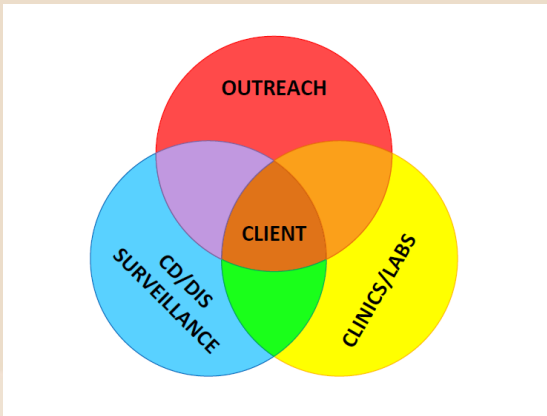
- How to connect the dots? (clients, data, service links)
- Who needs the linkage to services? (the #'s tell us)
- What will work best? (ask the experts and the clients)
- How to accomplish better links to service? (coordinated systems approach)



# 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.**

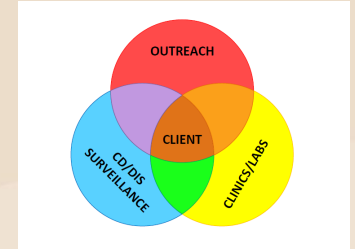


HIV/ STD/ CD

# 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)



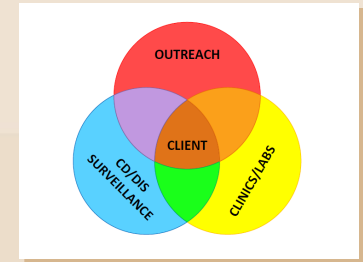
# Bridge Counseling

## 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:

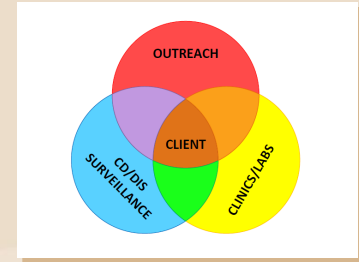
- Systematic monitoring of successful entry into HIV care.
- Systematic monitoring of retention in HIV care.
- Brief, strengths-based case management (bridge counseling) for individuals with a new HIV diagnosis.
- Intensive outreach for individuals not engaged (lost to care) in medical care.
- Use of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

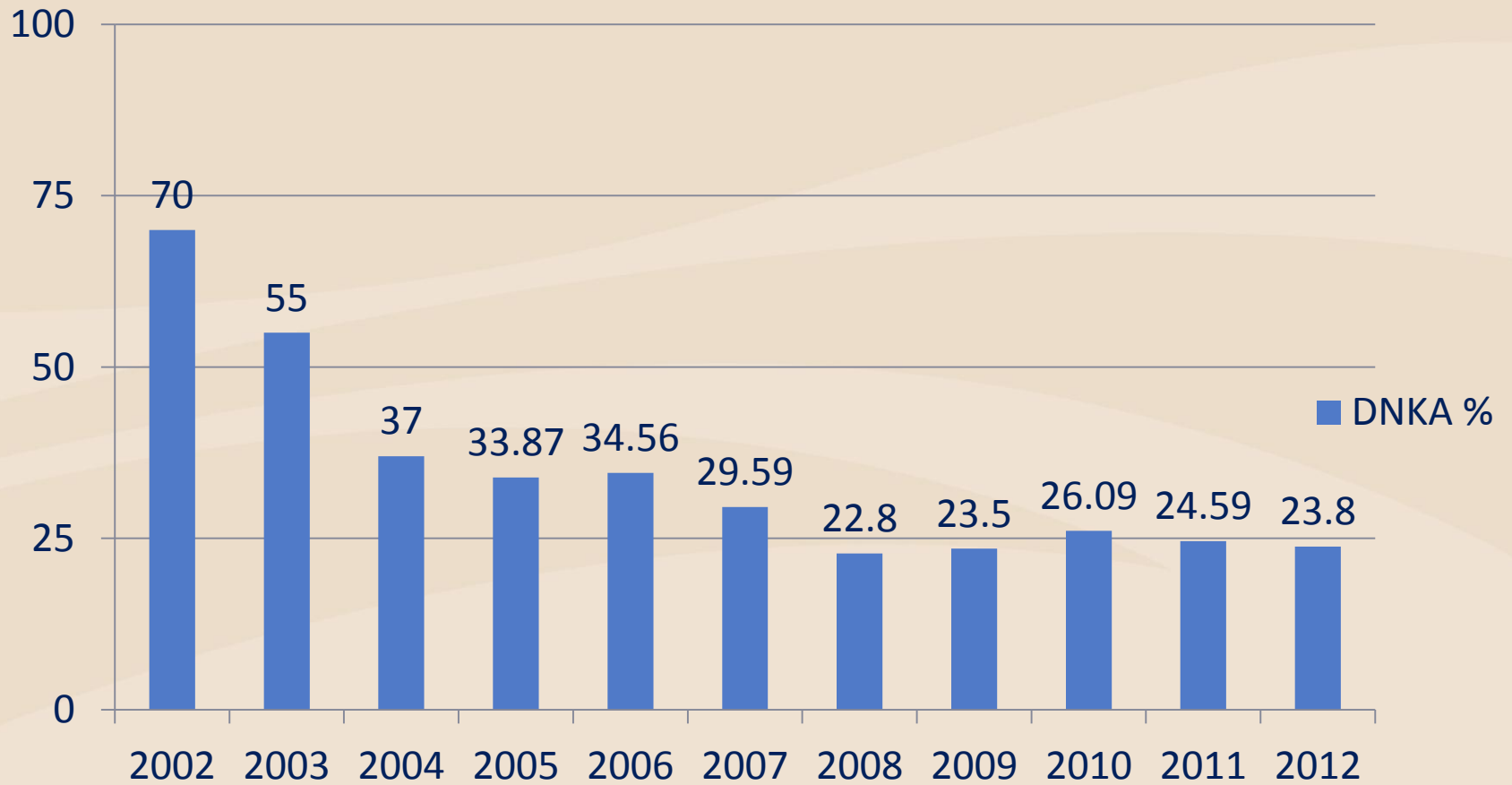


- Epi- Surveillance
- Cross trained staff
- Co-morbidity enhanced awareness and testing
  - TB
  - Hep C
  - Other STI's
- Collaboration in multiple research studies
- Direct interface with hospital
- Disease Intervention Specialist (highly integrated)
- Field Delivered Therapy

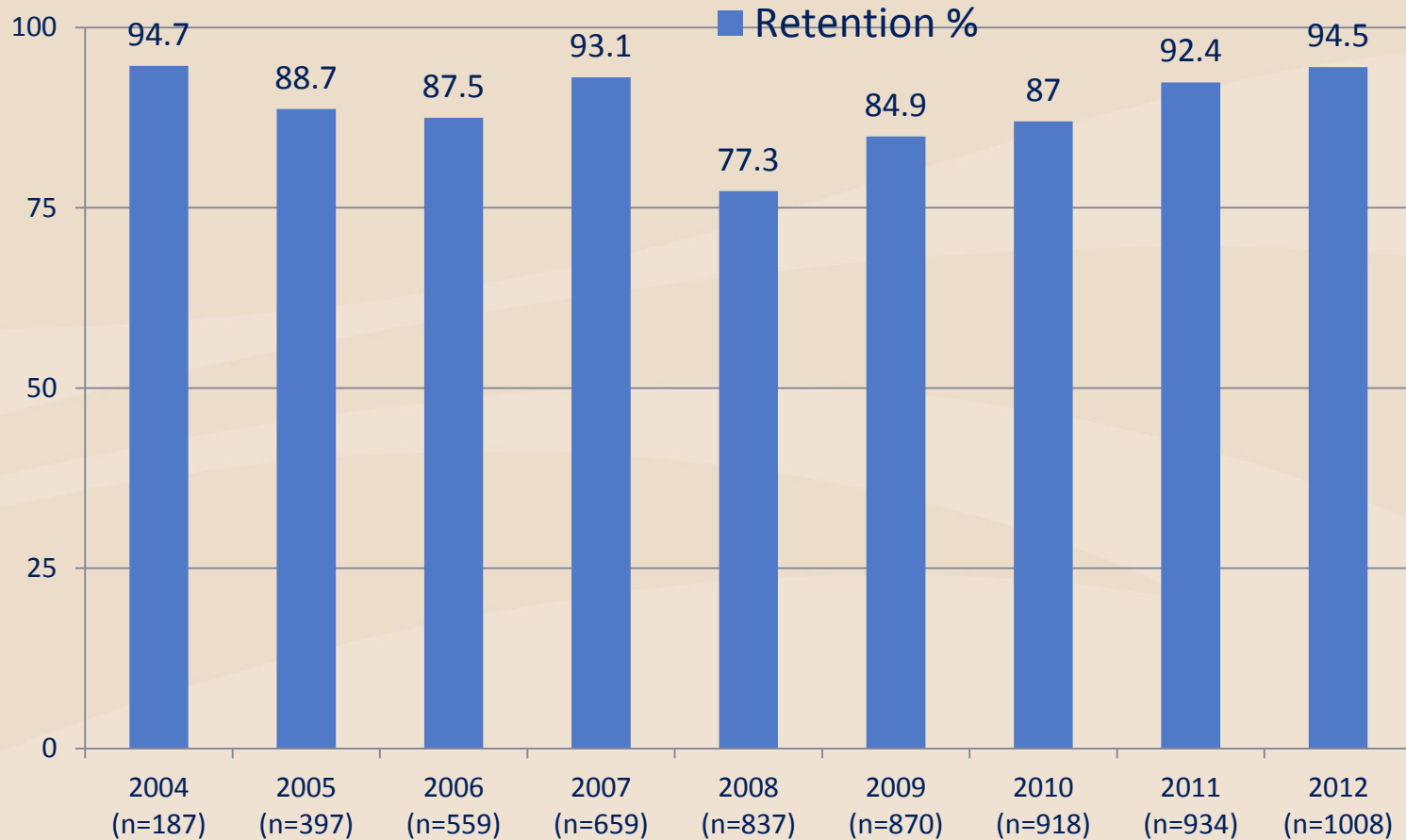
Why does it matter?

# **DATA MONITORING AND CLIENT OUTCOMES**

# DNKA Rate

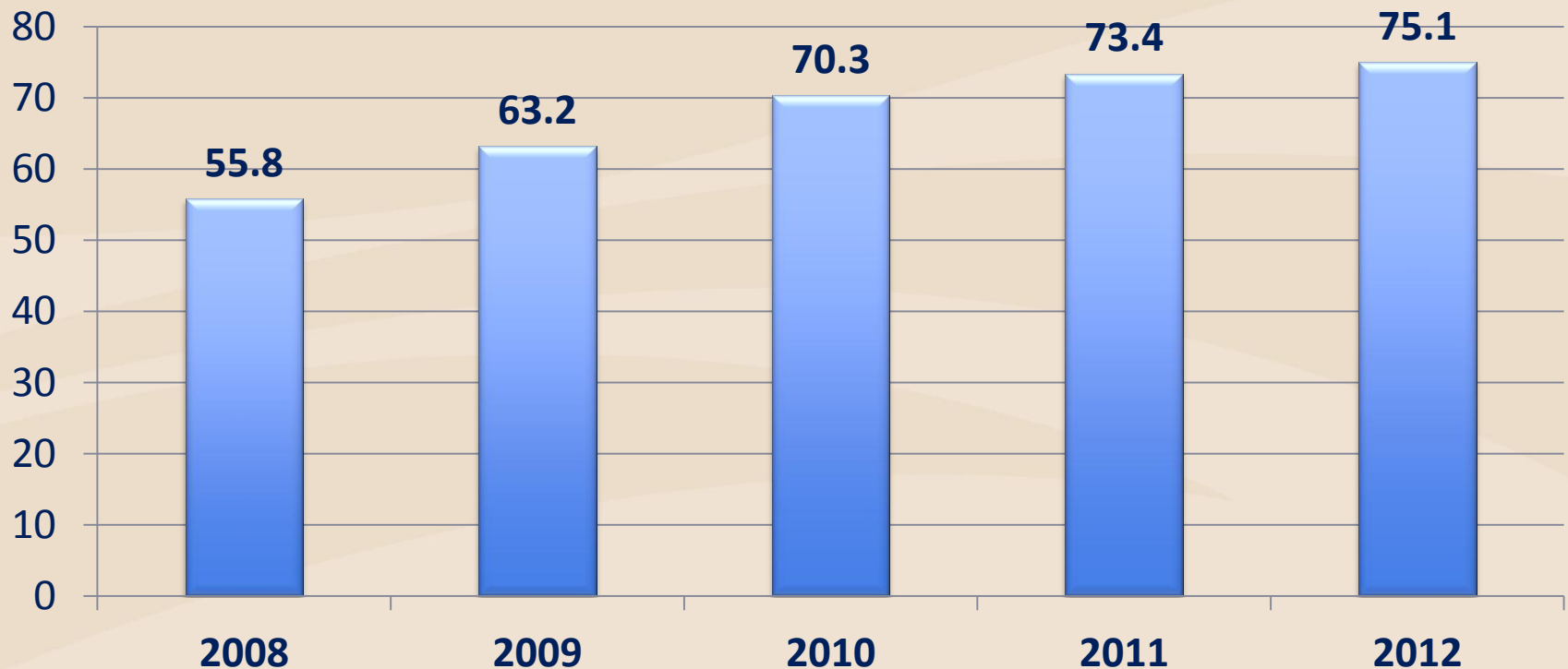


# Client Retention Rates



# Importance of Linkage to Care and Viral Load

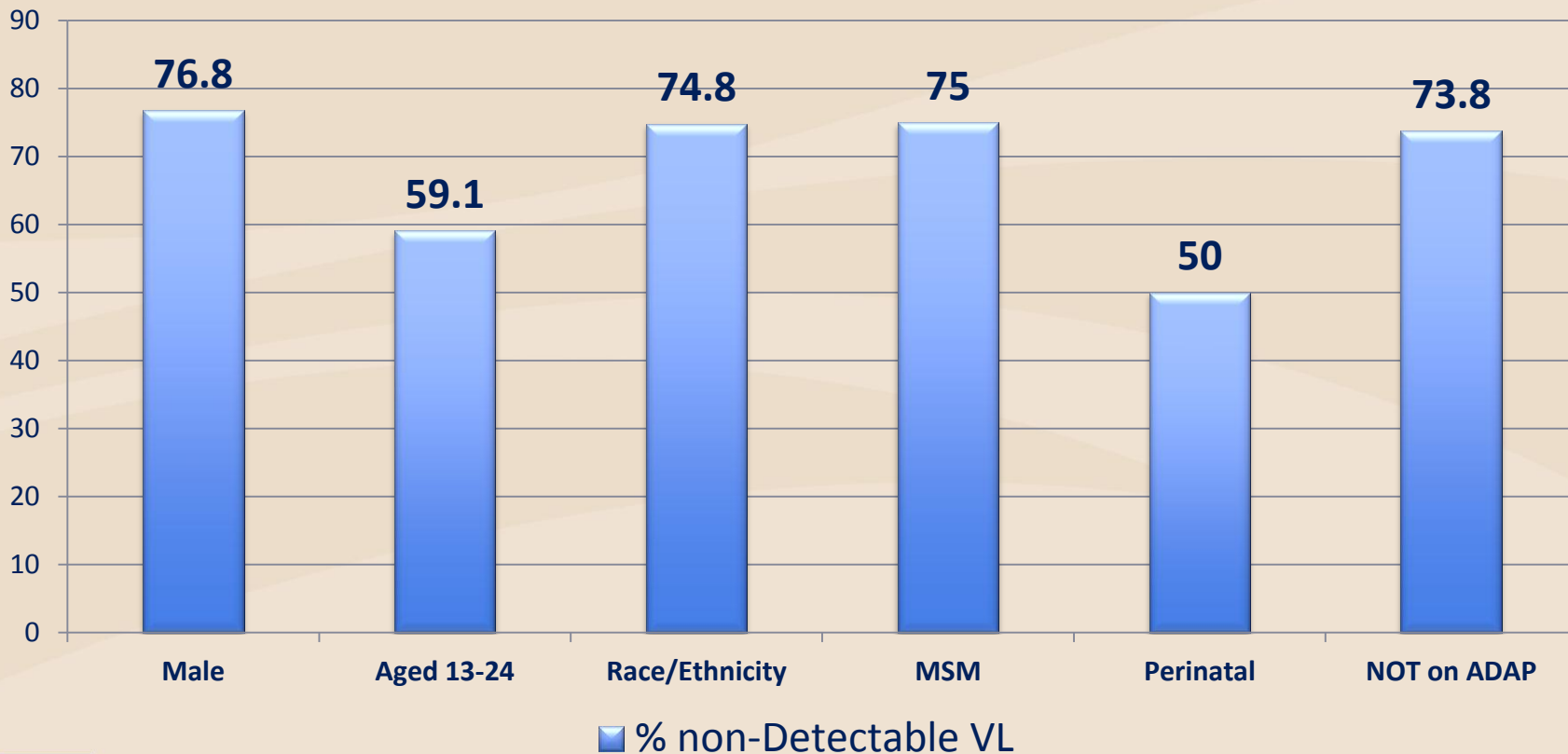
**% non-Detectable VL (all patients)**



■ % non-Detectable VL

# Importance of Linkage to Care and Viral Load 2012 breakdown:

**% non-Detectable VL (all patients)**



# 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

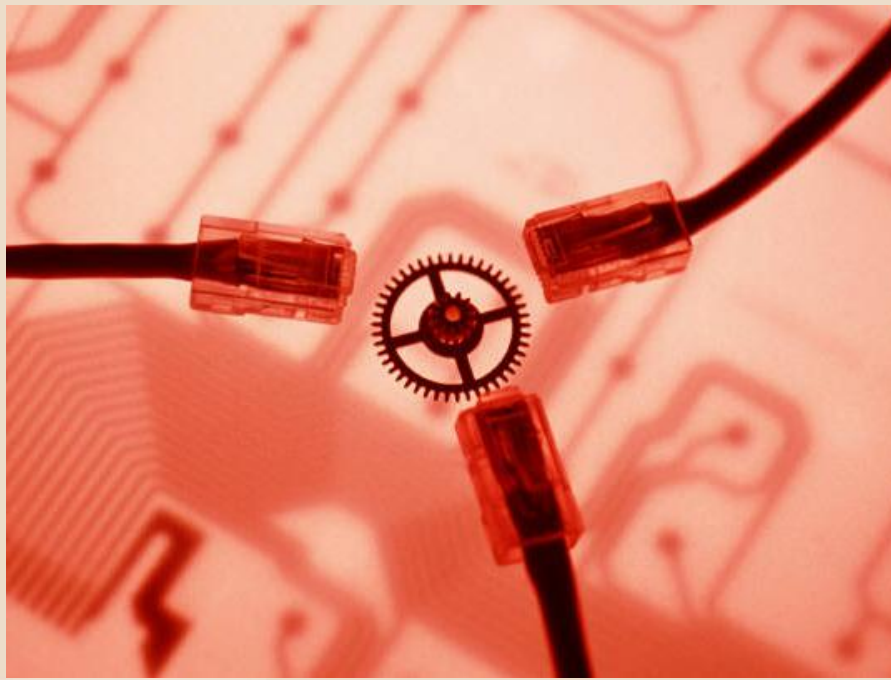


# Core Team Linkage to Care Successes

- **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



Connecting the pieces



## Questions for our group

**Thank you.....**

**Michael McNeill, Grants / Data Manager,  
Wake County Human Services**

**[Michael.McNeill@wakegov.com](mailto:Michael.McNeill@wakegov.com)**

**Sue Lynn Ledford RN BSN MPA DrPH  
Candidate**

**PH Division Director Wake County  
Human Services**

**[Sue.ledford@wakegov.com](mailto:Sue.ledford@wakegov.com)**