



Actioning the Data for Real World Application – Experiences, Challenges & Opportunities: **University of Alabama at Birmingham (UAB)** **1917 HIV Outpatient Clinic**

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Three Stories of Actioning the Data

- Testing
- Linkage to Care
- Engagement in Care



The 1917 Clinic

Celebrating *29 years* of service!



HIV Testing

“By 2020, 90% of all people living with HIV will know their HIV status.”

- 2005 - In-house and outreach testing at 1917 Clinic (“Graceland”)
 - >8000 testing & counseling sessions
 - Individual and couples testing
 - 3-5% positivity rate (HIV testing)
 - 2017 – HCV Testing option



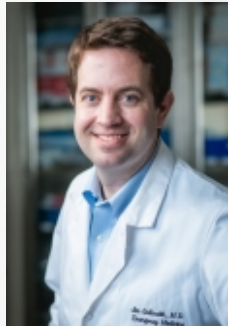


HIV Testing

- 2010 – Expanded Testing Grant:

University Emergency Department Testing –
Linkage to Care by 1917 Clinic

- Before 2010 –
 - Diagnostic Testing only, 40 patients/month
 - 1917 Clinic led pilot to attempt implementation of broader screening efforts
 - Limited resources, buy-in from UED
 - Lacked a champion to lead the efforts on the ED side
- Since 2011
 - Routine, opt-out 4th generation testing, >100,000 tests performed
 - In 2017, 43% of new infections have been acute, 100% linked to care



Linkage to Care

“By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy.”

- Project CONNECT – 2007
 - 31% of patients did not arrive for first medical appointment scheduled by front desk
 - New Patient Orientation (new, transfer, out of care)
 - Scheduled by Chaplain, Social Worker, or Linkage & Retention Coordinator
 - Individual appointment for post-test counseling, overview of the clinic, comprehensive patient history (in person and computerized), lab work, early medical visit when needed



CONNECT: Program Evaluation

Time Period	"No Show"	Unadjusted OR (95%CI)	Adjusted OR (95%CI) ^a
Pre-CONNECT (n=522)	30.7%	1.0	1.0
Post-CONNECT (n=361)	17.7%	0.48 (0.35-0.68)	0.54 (0.38-0.76)

^a Multivariable model controls for age, race, sex, insurance, location of residence and time from call to scheduled visit.



COMPENDIUM OF EVIDENCE-BASED INTERVENTIONS AND BEST PRACTICES FOR HIV PREVENTION

PROJECT CONNECT (CLIENT-ORIENTED NEW PATIENT
NAVIGATION TO ENCOURAGE CONNECTION TO TREATMENT)

Evidence-Informed for Linkage to HIV Care

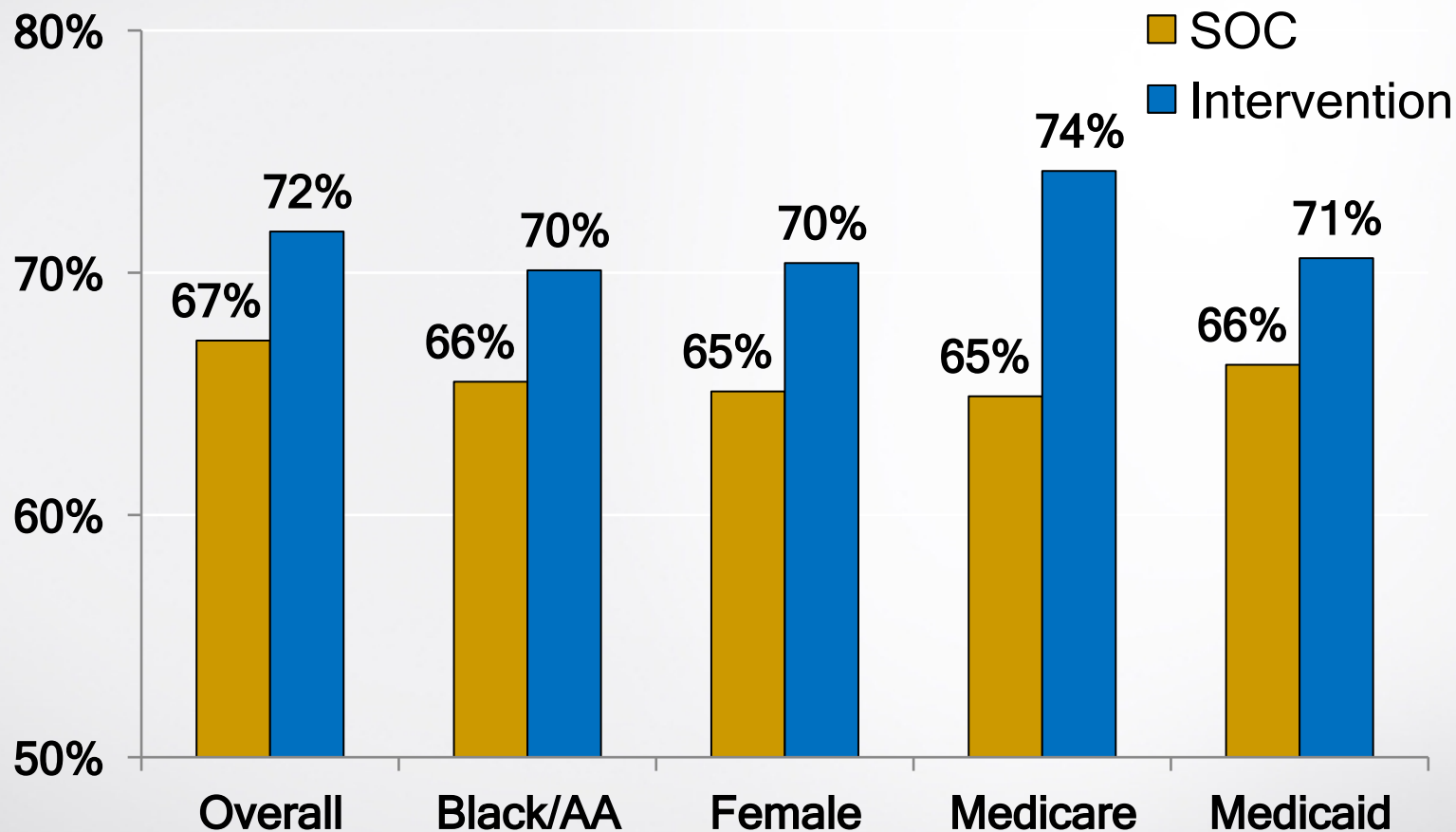


CDC/HRSA RIC Intervention

“Emphasis should be placed on the importance of adherence to care rather than focusing solely on adherence to medications (B-II).” (Aberg et al, 2009.)

- Phase I. Clinic-wide intervention
 - Posters & brochures: Waiting rooms & exam rooms
 - Brief messages: From all clinic staff
 - Pre-intervention vs. post-intervention evaluation
- Phase II. Pt-centered behavioral intervention
 - Enhanced contact: Personal reminder calls
 - 7- and 2- days before visits, w/in 24-48 hours of missed visits
 - Two session skill building modules: problem solving, provider communication and organizational skills
 - Randomized-controlled trial

RIC Phase II: Improved visit adherence

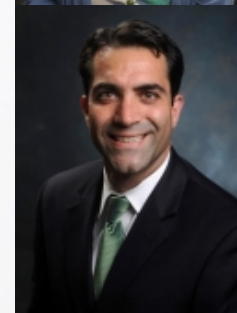


Gardner LI et al. *Clin Infect Dis* 2014;59; Shrestha RK et al. *JAIDS* 2015; 68

Engagement in Care Planning Team



- Developed in April 2016 to strategize 1917 Clinic linkage, retention, and re-engagement projects
- Includes Prevention+, Social Services, RISC, Clinic Leadership
- Assimilated Harriette Pickens and Shyla Campbell's positions and renamed as Linkage & Retention Coordinators (LRCs)
- Found common space for expanded team of Linkage & Retention Coordinators
- Hired two additional LRCs Tommy Williams and Dominique Hector





Engagement in Care: Linkage & Retention Coordinators (LRCs)

- Coordinate linkage, retention, and re-engagement to HIV healthcare and other related services
- Build and maintain community partnerships for additional referrals and collaboration
- Operates in partnership with 1917 Clinic Prevention Education & Social Services Team

Engagement in Care

“By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.” – UNAIDS

In 2016, 72% of all patients at 1917 Clinic were virally suppressed.

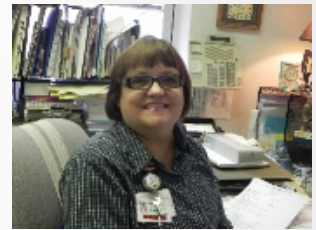
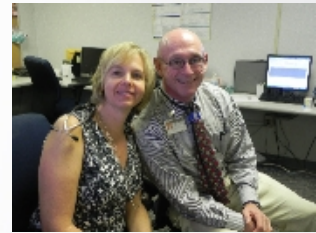
- Initial focus of LRCs has been linking patients to care and re-connecting people out of care
- Re-initiated reminder calls and follow-up for any New Patient Orientation (NPO) visit for new, transfer, & reconnect patients
 - Decreased NPO No Shows to less than **15%**
- Designing EMR tools to track all communication

Project CONNECT: New Patient Orientation Personalized Reminder Calls

	NPO Scheduled	No Shows	Percentage
Pre-Reminder Calls	87	35	40.24
Post-Reminder Review 1	80	16	20.00
Post-Reminder Review 2	87	11	12.64
Post-Reminder Review Total	182	27	14.83

Engagement in Care – Team Approach

- Every patient is assigned a healthcare team that includes:
 - NP/Fellow
 - Attending Physician
 - Nurse
 - Social Worker
 - Nutritionist
 - Linkage & Retention Coordinator (May 2017)
- Additional team may include mental health providers, research staff, women's health, specialty clinic providers, pharmacists, and partner services



Engagement in Care: D4C

- “Missed HIV medical care visits predict poor clinical outcomes and higher mortality.”
- “Past visit attendance can identify those at increased risk for future missed visits, allowing for proactive allocation of resources and tailoring of interventions to those at greatest risk.”

(Pence et al, Who will show?, 2017)

- At 1917 Clinic, in 2016, 57% of patients were retained in care based on HRSA definition

(Percentage of clients with an HIV diagnosis who had at least one HIV medical care visit in each 6 month period of the 24 month measurement period, with a minimum of 60 days between the first medical visit in the 6 month period and the last medical visit in the subsequent 6 month period.)

Engagement in Care: D4C – Just Initiated!

- Part I – Follow up calls to any “No Show” patient within 48 hours
- Part II – Personal reminder calls to any patient at risk of a “No Show” appointment based on previously missed appointments

Number of Patients	3,275	%
Patients with 1 No Show visit	631	19%
Patients with 2 No Show visits	308	9%
Patients with 3 No Show visits	144	4%
Patients with >3 No Show visits	91	3%

Alabama Regional Quality Group

“The Alabama Regional Quality Management Group exists to ensure that those living with HIV/AIDS in the state of Alabama receive quality healthcare through the collaboration of healthcare partners throughout the state. This collaboration aims to continuously improve the quality of HIV care consistent with recognized national standards and current HIV research”



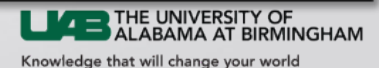


CDC-PS-15-1502

CDC-PS-15-1509



HIV front line providers meeting, BAO, Dec 2015 and Nov 2016, Birmingham, AL



Thank you

UAB 1917 Clinic & UAB CFAR

Michael Mugavero, Co-Director, UAB CFAR

James Raper, 1917 Clinic Director

Turner Overton, 1917 Medical Director

Sonya Heath, CDC/ADPH Testing & LTC

Engagement in Care Team

Prevention+ Team

Kathy Gaddis & Social Services Team

Alfredo Guzman & Informatics Team

Patient Advisory Board

Alabama Department of Public Health

Jefferson County HIV/AIDS Community Coalition

Alabama Regional Quality Group

HIV Prevention Network, Area IV

Questions?

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