Restructuring Linkage-To-Care: Finding a Model That Works For You And Your Clients

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HISTORY

NO/AIDS Task Force/CrescentCare (NATF) was founded in 1983 in response to the HIV/AIDS epidemic in New Orleans. We recently became a Federally Qualified Health Center and took on the name CrescentCare as an umbrella name for all of the services offered by our agency.

As an AIDS service organization we offer linkage-to-care, primary medical care, support groups, case management, legal services, emergency financial assistance, transportation, housing assistance, and a food/clothing pantry, and more - to clients who have been diagnosed HIV positive. We currently offer free, confidential, rapid HIV testing at 3 healthcare clinics around New Orleans as well as at bars in the French Quarter, local consulates, local universities, and at street outreach/community events via a medical mobile unit.

OBJECTIVES

On July 13th 2010 the National HIV/AIDS Strategy set forth a goal of increasing national linkage to care rates from 65% to 85%.[1] The CDC recommends that HIV testing programs offer services to link and retain people living with HIV/AIDS in medical care.[2] Prior to 2012, NATF linked newly diagnosed HIV positive clients to internal primary medical care services through a CDC-funded Comprehensive Risk Counseling Services Coordinator and a state-funded HIV Counseling & Testing Coordinator. This method sustained a 50% linkage to care rate. To try to improve linkage rates and meet the National HIV/AIDS Strategy, NATF implemented a HRSA funded Linkage-to-Care program in 2012 that included a Patient Navigator position.

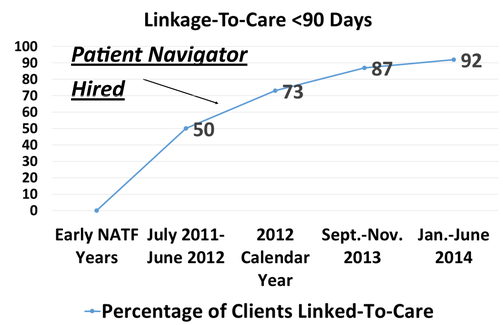
METHODS

Streamlining the linkage to care process through one person created a simpler and more reliable approach for HIV counselors, case managers, providers, and clients. Tools for success included a cell phone with texting capability, transferring the database to Microsoft Excel, maintaining working relationships with the local Health Department, and a bilingual (English-Spanish) Patient Navigator trained in HIV counseling and testing to be available during HIV testing hours.

We have worked to keep patient navigation flow as simple as possible by creating intuitive intake paperwork and regularly re-train HIV testing/counseling staff so that the risks of clerical errors as a barrier to entering care are minimized. We work closely with/use relationships with local Disease Intervention Specialists to help follow up with hard to reach clients, and continuously evaluate data and linkage-to-care rates for sub-populations in our community, in order to identify the most effective ways that we can improve linkage efforts.

RESULTS

In August 2012 a Patient Navigator was hired and by December 31st the linkage rate for newly diagnosed clients within 90 days of their first test increased to average 73% for the 2012 calendar year. In 2013 the linkage to care rate rose to 87% (September 1, 2013-November 30, 2013). *During this period, linkage within 180 days of the first test was 89%. 2012-2014 the median number of clients testing positive was N=98.*



CONCLUSIONS

Hiring a Patient Navigator can help increase linkage-to-care rates.

Streamlining the linkage to care process through one person created a simpler approach for HIV counselors, case managers, providers, and most importantly, for the clients. When the Patient Navigator first meets with a client, s/he completes as much of the intake as possible. Additional sessions may increases the perceived barriers in the process of accessing care and some clients quickly lose interest if they need to keep coming back before they receive care.

As a result of the taking an individual approach to linkage-to-care, our agency increased its linkage-to-care rates in 90 days among newly diagnosed clients from 50% to 87% in just over a year (2012-2013). ***Update: Jan. 2014 – June 2014 linkage-to-care had an average of 92% (N=48). The highest quarter (April 2014-June 2014) hit a peak of 96% linkage to care (N=24).***

A designated linkage-to-care position is important and there are multiple models that can achieve good results even with limited resources.

Unmeasured program improvements include clear protocols for linking newly diagnosed clients to care and re-engaging out-of-care clients in medical services, increased knowledge among case management and prevention staff of the linkage-to-care process, improved access to Partner Services and the State Office of Public Health's DIS program, improved program monitoring and evaluation, and the ability for the Patient Navigator to use flex-time in order to talk/text with clients during non-traditional work hours.

Citations

[1] http://aids.gov/federal-resources/national-hiv-aids-strategy/overview/
[2] http://www.cdc.gov/hiv/prevention/programs/pwp/linkage.html