Developing mHealth Strategies to Promote Health and Well-being in PLWH

The Positive Links Project

University of Virginia
Charlottesville, Virginia
Newly-diagnosed
University of Virginia Ryan White Clinic

Youth: 25% under age 25

High No Show Rate: 20%
No-show rate

Late Linkage to Care:
Median CD4: 322
Care Challenges at UVA

- Rurality
  - Transportation
  - Poverty
  - Isolation
  - Stigma
- Active alcohol/drug use
- Mental disorders
- Intermittent adherence
- Interventions come too late

Technology can allow intervention related to one or more challenges JUST IN TIME!
Customized Smartphone app

Positive Links 3-pronged approach

Priority access to care

Strength based counseling based on ARTAS
Retention Strategies

• **Shrink distance with technology**
  – Connect users with other PLWH, clinic staff
  – Create a safe and secure place for people to access support of their peers

• **Role induction**
  – Encourage healthy self-monitoring
  – Encourage understanding and owning of HIV care

• **Health technology that meets the market**
  - Upgrade from SMS platform to a smartphone app
  - Develop features with participant buy-in and feedback
Key App Features

• **Daily Queries** for mood, stress, and adherence
• **Functional Features** for behavior tracking, messaging, appointments, information, and community board
• **Weekly Postings** by Positive Links Team
Daily Queries

My Notifications

Did you take your meds today?
Wednesday May 21, 2014 - 10:05 AM

What is your Stress Level right now?
Tuesday May 20, 2014 - 4:00 PM

How is your Mood right now?
Tuesday May 20, 2014 - 11:00 AM

A look back at daily responses

Overview | Mood | Stress | Medication | Goals
--- | --- | --- | --- | ---

Stress

2014-03-10 16:00:03
What is your Stress Level right now?

Low | High

8

Explain (if you like):

Had to work a double shift

Submit
App Features

Appointment reminders and Contact lists

2014-03-12 10:41:16
Check in with Kathryn Dort
When: 2014-03-13 at 08:00:00
Where: UVA Ryan White Clinic
Confirm: Yes No

Positive Links Coordinators
Point person for the Positive Links program; meets with clients to discuss starting treatment, address barriers to care.

Colleen Laurence MPH
Phone: (434) 465-9818
Email: cel2j@virginia.edu

West Complex, Hospital Drive, 5th floor, 1300 Jefferson Park Ave., Charlottesville, VA, 22908

Erin Wispelwey
Phone: (434) 465-9816

Positive Links Coordinators
Ryan White Clinic
Women, Infants, Children & Youth Program
Nurse Practitioners
Psychiatrists
**App Features**

**Resources and Dashboard views**

- **Local Video**
  - Welcome to the Ryan White Clinic
  - 06:53 secs

- **Dealing with Stigma**
  - 02:18 secs

**Resources**

- **Dashboards**
  
  - **14 Day Mood:**
    - Bar chart showing mood over 14 days
  
  - **14 Day Stress:**
    - Bar chart showing stress over 14 days
  
  - **14 Day Medication History:** Took meds 92.9% of the time
    - Bar chart with colored pills indicating intake

**Medication History**

- **March 2014**
  - Calendar with medication intake marked
  - Notes section

**Dashboard Views**

- **Positive Links**
  - Home
  - Positive Links
  - Settings
  - Resources
  - Dashboards
  - Communities

- **Overview**
  - Mood
  - Stress
  - Medication
  - Goals

**Date Range**

- 30 Day
- 90 Day
- 1 Year
App Features

Community Board

Hi manny, how r u? I am new here I am a little nervous about this as a whole... but I also feel this could help me feel at ease a lil bit with my situation.. I am learnin about my status but have not yet started meds... I am still contemplating because I am not a pill taker. . I wish they had it n different forms like gummies lol

Posted by sweetcin on Wednesday February 12, 2014 - 1:46 PM

Ur good I was in ur shoes two and yeah I would love gummies but ur in good hand uva will take care of you its is kinda scary coz I was but then I started talking about it the more it helped me and it will take a few weeks to get ur meds I thought I was gona die from me not taking them but ur body is tough what r ur cd4 and viral load mine was bad but now im good and gone live for a long time but

Posted by Peaches on Friday April 4, 2014 - 1:55 PM

I like to think I know. But there is a conflicting opinion on the matter. So all I can say is check with all you resent partners in the past year. Then the fact should be clear. Thats what I did. but nonetheless it is wat is. Just focus on the here and now.you can't change the past

Posted by tweety on Friday April 4, 2014 - 10:12 AM

Hey everyone sorry I haven't written anything in awhile but how is everyone? I all is well as for myself I have my days when things are all good and some are bad. Thanks to my wonderful future hubby and my three beautiful children I strive to move forward towards my future with said I start my new classes to work in the medical assistance field on the 27th of this month.

Posted by Wolfy on Thursday April 3, 2014 - 4:20 PM

Thanks for responding Tweety! Well I did and everyone is fine. There is only one possible

Posted by Wolfy on Friday April 4, 2014 - 3:50 PM
Weekly Postings

2014-03-05 11:05:02
HIV can make a person ill because:

- It makes a person lose weight...
- It reduces the body’s core temperature...
- It attacks the immune system
- It causes a rash

Submit

Quiz Questions

Weekly Summary March 30 - April 5

Meds: 7/7 questions answered. Reported 100% adherence.

Stress: 7/7 questions answered. Average stress 6.1. This is 3.3 higher than last week.

Mood: 7/7 questions answered. Average mood 4.3. This is 2.1 higher than last week.

Are you reaching your health goals? If not let the Positive Links team know how we can help!

https://www.youtube.com/watch?v=QzooK7fO6CY

Posted by PositiveLinksTeam on Monday May 5, 2014 - 2:44 PM

Discussion Topics
Case Study

Tweety

• 21 year old male- diagnosed with HIV in ER
• Met with Positive Links and ID staff immediately following HIV diagnosis
• Followed up at the ID Clinic to link to HIV care next day and to enroll in the Positive Links Project
• Participant’s risk factors include MSM, heterosexual sex and IDU.
• At the time of diagnosis he was homeless and unemployed

• In the last 5 months the participant moved into a recovery home, found employment and regularly attended NA and AA meetings
• He has shown empathy to Positive Links Community
• He provided practical feedback to our team to improve and update app
• He has identified appointment reminders, medication queries and community message board as the most helpful features
12/17/2013
My first thoughts when I found out I have HIV

Tweety
(posted his first day with the phone)

“I am a man who tries to look on the bright side of things as often as possible. And for the most part I can. When I was told I had H.I.V it caught me off guard. I didn't really take it any way. It was as if I was told that it was going to rain. But then I got to my place and it hit me like a brick. Every thing started to come in to light. My last six months began to make sense. [I] found myself getting sicker more then I have ever in my life. I am just now coming to grips with how this HIV thing is flipping my world up side down. I seem to be going through so much hell with no breaks in between that I'm on over load... But I will be damned if I am going to die with out finding true love. Finding true family. This might be a strange reason to be fighting against time but it really is all I want in my life. And I hope the man up stares will allow me that before I kick the bucket.”

Morning Glory

Please b positive ! We all r going thur it! Let's hold hands!

Peaches

Hey tweety when I first found out that I was hiv positive I felt the same way it really hit me hard because I have no idea how I got it I have been in a relationship....He has been tested many times and doesn't have it at all. so when I told him he just flipped out like I was just a bad person but you know I have learned to live my life to the fullest and keep an positive state of mind.
February 12, 2014

1) “I am new here I am a little nervous about this as a whole... but I also feel this could help me feel at ease a lil bit with my situation.. I am learnin about my status but have not yet started meds... I am still contemplating because I am not a pill taker. .. I wish they had it n different forms like gummies lol” (Sweetcin)

2) “Ur good I was in ur shoes two and yeah I would love gummies but ur in good hand uva will take care of you its is kinda scarey cuz I was but then I started talking about it the more it helped me ... I thought I was gona die from me not takeing them but ur body is tough ...and gona live for a long time” (Manny)

3) “Amen to that Manny. And hello sweetcin. Welcome to the family. And here I thought I was the only one who likes gummies.” (Tweety)
4) “Hi all n thank u for the welcome... I want to start takin meds b it t my biggest fear is not keepin up with them... I have been taken other meds for ova 20 years n I have stopped n started so many times because I get tired if swallowing pills... n I know if I do that I cant choose when n when to not rake them... how long have you been taken meds n do u eva miss a dose??” (Sweetcin)

5) I have been taking these meds for a month and a half or so. I missed a few times and I had to get one of those weekly pill holders. Because I kept forgetting if I toke them are not. But ever sence I got the weekly holder thingy I have been doing good. When the docs see I was missing meds I was shocked they said they might take me off. They kept saying his isnt the bad Maybe we should take him off until he is ready. Oh hell no. I won't to stay like this. So when the through that in my face. I really started to crack down on my meds. They are my life line. As long as you remember that you will do just fine. To thank this all started with a 40 foot fall. Wow life gas a sick sence of humor (Tweety)
Medication adherence by week

*Tweety*

Reported Number of Pills taken

<table>
<thead>
<tr>
<th>Study Week</th>
<th>Reported Number of Pills taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/15-12/21</td>
<td>4</td>
</tr>
<tr>
<td>12/22-12/28</td>
<td>3</td>
</tr>
<tr>
<td>01/01-01/04</td>
<td>5</td>
</tr>
<tr>
<td>01/12-01/18</td>
<td>5</td>
</tr>
<tr>
<td>01/26-02/15</td>
<td>6</td>
</tr>
<tr>
<td>02/02-02/08</td>
<td>6</td>
</tr>
<tr>
<td>02/16-02/22</td>
<td>6</td>
</tr>
<tr>
<td>02/23-03/01</td>
<td>6</td>
</tr>
<tr>
<td>03/02-03/08</td>
<td>6</td>
</tr>
<tr>
<td>03/09-03/15</td>
<td>6</td>
</tr>
<tr>
<td>03/16-03/29</td>
<td>6</td>
</tr>
<tr>
<td>04/06-04/12</td>
<td>6</td>
</tr>
<tr>
<td>04/13-04/19</td>
<td>6</td>
</tr>
</tbody>
</table>

*indicate reported missed doses of ART

*posted on CMB about ID visit this week about missing meds*
<table>
<thead>
<tr>
<th>Date</th>
<th>Name</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/10/2014</td>
<td>Tweety</td>
<td>Ok ive been bissy lately so sorry for my absence. Hope all is well. Im 65 days clean so there is that. Found a guy I realy like and he knows my current position with hiv. Shocked the hell out of me he is clean and willing to move on with this. Bout to move again to a bigger place. So filling real good about that. All in all pretty good year so far.</td>
</tr>
</tbody>
</table>
Successes

• Successfully developed, tested a smartphone app to support PLWH.

  37 participants enrolled to date

• Coordinators and providers have provided care and linkage for participants during crisis moments

• Completed 2 videos with 2 more in production
Challenges

• Tech issues
• Managing crises and disagreements on the community message board
• Low uptake of formal strength based counselling sessions
  - Linkage to mental health services
  - Informal Check-ins with PL coordinators
Lessons Learned

• Link theory and user feedback
• Small changes help keep the app user friendly
• Use data in real time
• Balance technology with strong interpersonal relationships
Thank you

Staff and Patients at the UVA Ryan White Clinic

App Development

Provision of Low Cost Smart phones

And our Funders!
Bronx Health Connect

María Cabán, PhD
Director of Evaluation

Nunzio Signorella, LMSW
SVP, Programs & Partnerships
The Bronx Health Connect Project

• Is an integrated program of low threshold, high intensity engagement and continuous retention in health care for HIV+ homeless/unstably housed individuals who have co-occurring conditions such as substance abuse and mental illness
Our Community

- BOOM!Health serves the South Bronx, which is the poorest Congressional District in the US with some of the nation’s worst health status indicators, including HIV incidence and prevalence

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>New York City</td>
<td>3,141</td>
<td>1,889</td>
<td>114,926</td>
<td>1,578</td>
</tr>
<tr>
<td>Bronx</td>
<td>584 (19%)</td>
<td>452 (24%)</td>
<td>26,613 (23%)</td>
<td>477 (30%)</td>
</tr>
</tbody>
</table>

# Health Inequity: Race/Ethnicity

In NYC, 76% of those living with HIV/AIDS are Black or Hispanic.

In the Bronx, 94% of PLWHA are Black or Hispanic.

<table>
<thead>
<tr>
<th>Location</th>
<th>Race/Ethnicity of PLWHA as of 12/31/2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Black</td>
</tr>
<tr>
<td>New York City</td>
<td>51,154</td>
</tr>
<tr>
<td></td>
<td>(44%)</td>
</tr>
<tr>
<td>Bronx</td>
<td>12,402</td>
</tr>
<tr>
<td></td>
<td>(47%)</td>
</tr>
</tbody>
</table>

What’s Innovative?

• BOOM!Health works collaboratively through a formal partnership with an onsite primary care and mental health clinic, the HELP/PSI Health and Wellness Center, and an onsite pharmacy providing medication education and treatment adherence counseling, Evers Pharmacy
“One-Stop-Shop” Model

• Improves treatment adherence and health literacy for persons living with HIV/AIDS and strengthens linkage to HIV care for individuals who are newly diagnosed by removing gaps in the treatment cascade
Supportive Services

• The “One-Stop-Shop” Model is supplemented by BOOM!Health’s supportive services inclusive of, but not limited to, intensive outreach, health coordination, peer support, adherence reminders, recovery programs, legal services, food and nutrition counseling, high-impact prevention services, housing placement, and harm reduction counseling.
Challenges

• IRB submission and approval
• Working with external providers to obtain medical visits and lab reports
• Development of a user friendly database to collect both national/local evaluation measures and ongoing participants’ service utilization information
• Training and buy-in of local evaluation measures
Successes

• Development of a team engaged in outreach, health navigation, and care coordination thus improving participants’ entry and retention in care

• Integration and collaboration with onsite medical and pharmacy care providers

• Implementation of medication adherence tools that are culturally competent within the context of patients’ lives, enhancing education and counseling
BHC Participants

• 24 individuals have enrolled

• Demographics
  – Gender: 71% Male; 25% Female; 4% Trans
  – Race: 50% Hispanic; 42% Black; 4% White; 4% Multiple
  – Housing: 42% Stable; 58% Unstable
  – Mental Health: 42% Ever Diagnosed
  – Substance Use: 50% Report Use in Past Year

• 71% in care; 17% out of care; 12% newly diagnosed
BHC Treatment Cascade

- **71% of enrolled** are in care (In Care)
- **67% of enrolled** are on ART (On ART)
- **94% of linked** have a VL suppressed (VL Suppressed)
- **25% of enrolled** have a VL suppressed
- **35% of linked** have a VL suppressed

- Enrolled: 24
- In Care: 17
- On ART: 16
- VL Suppressed: 6
The Story of F ...

- F, 35 y.o., male, Hispanic/Puerto Rican
- Homeless-residing at a Single Room Occupancy (SRO) hotel in the Bronx
- Diagnosed with HIV in April 2012
- Suffered from a personality disorder, paranoid type, as evidenced by a pervasive mistrust in others, as well as major depression and internalized stigma, causing him to be reclusive and disengaged from any support
and the BHC Health Navigator

• The RiC BHC Health Navigator made several attempts to engage F through supportive counseling, and he agreed to go to the onsite HELP/PSI Health and Wellness Center

• Reluctant at first, F fully engaged in HIV treatment, psychiatric care, and pharmacy services, all onsite
Lessons Learned

- Bronx Health Connect is one additional service option for BOOM!Health’s participants. In the past year, BHC staff have increased their collaboration efforts with other BOOM!Health staff and programs.

Knowledge of and collaboration with all programs can increase integration of services, care coordination, and enhance an organization’s overall service delivery.
THANK YOU to the Bronx Health Connect RiC Team and our Participants
Retention in HIV Care: It Takes a Village...

Michael J. Mugavero, MD, MHS
c
Associate Professor of Medicine
University of Alabama at Birmingham
May 28, 2014
Which of the following factors best predicts long-term health outcomes (e.g., mortality) among persons newly initiating outpatient HIV medical care?

1. Plasma HIV-1 RNA at care entry
2. Missed visits (no show) in the first year
3. ART initiation in the first year
4. CD4 count at care entry
5. 1 and 3
6. 2 and 4
Case presentation

✓ 21 y/o diagnosed with HIV 06/2009
✓ Established care and started ART 08/2009
✓ Excellent initial response to treatment

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV VL c/mL</td>
<td>115,000</td>
<td>384</td>
<td>&lt;48</td>
<td>&lt;48</td>
</tr>
<tr>
<td>CD4 count</td>
<td>78</td>
<td>251</td>
<td>376</td>
<td>455</td>
</tr>
</tbody>
</table>
Case presentation

✓ Several missed visits and then lost to care
✓ Re-engaged after lengthy gap...
✓ Cough, weight loss, night sweats, KS lesions

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV VL c/mL</td>
<td>&lt;48</td>
<td>22,700</td>
<td>80,300</td>
<td>200,000</td>
</tr>
<tr>
<td>CD4 count</td>
<td>455</td>
<td>248</td>
<td>108</td>
<td>64</td>
</tr>
</tbody>
</table>
Early missed visits and mortality

Study of UAB 1917 Clinic patients initiating outpatient HIV care, 2000 - 2005 (N=543)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>HR (95%CI)(^a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“No show” visit in 1(^{st}) year</td>
<td>2.90 (1.28-6.56)</td>
</tr>
<tr>
<td>Age (HR per 10 years)</td>
<td>1.58 (1.12-2.22)</td>
</tr>
<tr>
<td>CD4 count &lt;200 cells/(\mu)L</td>
<td>2.70 (1.00-7.30)</td>
</tr>
<tr>
<td>(\text{Log}_{10}) plasma HIV RNA</td>
<td>1.02 (0.75-1.39)</td>
</tr>
<tr>
<td>ART started in 1(^{st}) year</td>
<td>0.64 (0.25-1.62)</td>
</tr>
</tbody>
</table>

\(^a\) Cox proportional hazards (PH) analysis also adjusts for sex, race/ethnicity, insurance, affective mental health disorder, alcohol abuse, and substance abuse.
<table>
<thead>
<tr>
<th>Measure</th>
<th>Missed visit data?</th>
<th>Ease of calculating</th>
<th>Follow-up time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missed visit</td>
<td>Yes</td>
<td>Easy</td>
<td>~1 day</td>
</tr>
<tr>
<td>Appointment adherence</td>
<td>Yes</td>
<td>Moderate</td>
<td>~1 yr</td>
</tr>
<tr>
<td>No-show rate</td>
<td>Yes</td>
<td>Moderate</td>
<td>~1 yr</td>
</tr>
<tr>
<td>Persistence: Visit per 3, 4 or 6 month intervals</td>
<td>No</td>
<td>Moderate</td>
<td>≥1 yr</td>
</tr>
<tr>
<td>Gaps</td>
<td>No</td>
<td>Easy</td>
<td>~1 yr</td>
</tr>
<tr>
<td>HRSA/HAB</td>
<td>No</td>
<td>Moderate-to-difficult</td>
<td>1 yr</td>
</tr>
<tr>
<td>DHHS</td>
<td>No</td>
<td>Moderate-to-difficult</td>
<td>2 yrs</td>
</tr>
</tbody>
</table>

Guidelines for Improving Entry Into and Retention in Care and Antiretroviral Adherence for Persons With HIV: Evidence-Based Recommendations From an International Association of Physicians in AIDS Care Panel

Melanie A. Thompson, MD; Michael J. Mugavero, MD, MHS; K. Rivet Amico, PhD; Victoria A. Cargill, MD, MSCE; Larry W. Chang, MD, MPH; Robert Gross, MD, MSCE; Catherine Orrell, MBChB, MSc, MMed; Frederick L. Altice, MD; David R. Bangsberg, MD, MPH; John G. Bartlett, MD; Curt G. Beckwith, MD; Nadia Dowshen, MD; Christopher M. Gordon, PhD; Tim Horn, MS; Princy Kumar, MD; James D. Scott, PharmD, MEd; Michael J. Stirratt, PhD; Robert H. Remien, PhD; Jane M. Simoni, PhD; and Jean B. Nachega, MD, PhD, MPH

37 Evidence-based recommendations

- 5 Recommendations for entry into & retention in care
- Emphasis on special populations
- Recommendations for future research

Thompson MA et al. *Ann Intern Med* 2012;156
## Guidelines for Linkage & Retention

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Strength/Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitor entry into HIV care</td>
<td>IIA</td>
</tr>
<tr>
<td>Monitor retention in HIV care</td>
<td>IIA</td>
</tr>
<tr>
<td>Brief, strength-based CM for linkage (ARTAS model)</td>
<td>IIB</td>
</tr>
<tr>
<td>Intensive outreach for retention</td>
<td>IIIC</td>
</tr>
<tr>
<td>Peer of paraprofessional patient navigation for retention</td>
<td>IIIC</td>
</tr>
</tbody>
</table>

Thompson MA et al. *Ann Intern Med* 2012;156
CDC/HRSA RIC Intervention: 6 sites

✓ 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 hrs of missed visits
  ➢ Skill building modules: problem solving, provider communication and organizational skills
  ➢ Randomized-controlled trial
How to Stay Connected

- Keep all of your scheduled clinic appointments.
- Work as a team with your health care providers.
- Talk openly and honestly with your health care team.
- Ask questions that are important to you.

Why Is It Important to Keep All of Your Clinic Appointments?

Your Health Depends on It!

At your appointments

- We can check your health and make changes to your treatment plan if needed.
- We can give you the best medical care.
- You can take control of your health.

In one large study, people with HIV who attended all of their clinic appointments lived longer.

Source: Clinical Infectious Diseases, 2007.

Remember—it is important to come to all of your clinic appointments whether you feel sick or feel well.

Ways to Remember Your Clinic Appointments

- Write all of your appointments in a calendar.
- Put reminders or alerts in your cell phone.
- Put your reminder card in a place where you will see it often.
- Make sure we have your correct telephone number and address.
- Let us know right away if your telephone number or address changes.

If something comes up and you can’t keep a clinic appointment, please call us at least 2 days in advance. It is important to reschedule if you miss an appointment.
RIC Phase I: Improved visit adherence

- Overall: 3.0%
- New or Re-engaging: 7.6%
- Detectable viral load: 5.5%
- CD4<350: 5.1%

Gardner LI et al. *Clin Infect Dis* 2012;55
RIC Phase II: Improved visit adherence

Gardner LI et al. *Clin Infect Dis* 2014;e-pub 2014 May 15
RIC Phase II: Improved visit adherence

Successful personal reminder contacts

Gardner LI et al. *Clin Infect Dis* 2014;e-pub 2014 May 15
COMMUNITY CLINIC

Jefferson County
HIV/AIDS COMMUNITY COALITION

Engagement in HIV Care

- HIV-infected*: 14,426
- HIV-diagnosed+: 11,815
- Linked to care+: 457 of 661
- Retained in care$: 5,344
- Suppressed VL (≤200 copies/mL): 3,947

* Number of individuals infected with HIV
+ Number of diagnosed individuals
+ Percentage of diagnosed individuals linked to care
$ Percentage of linked individuals retained in care
£ Percentage of retained individuals with suppressed viral load
Vision Statement: To be a model for effective and efficient HIV/AIDS prevention, advocacy, care, education and research.

Mission Statement: To serve as a network of active stakeholders working together towards a unified and healthy community response to HIV/AIDS.
Summary

✓ Prognostic value of missed visits

✓ Early retention: vulnerable time → teachable moment

✓ Proven interventions for linkage and retention:
  ➢ Linkage case management (ARTAS)
  ➢ Intensive outreach
  ➢ Patient navigation
  ➢ Clinic-wide messaging & culture
  ➢ Enhanced personal contact

✓ It takes a village (or a coalition!): Integration across agencies and across the continuum of care (cascade)
Questions?
Thank you for joining us today!

The next webinar in our RiC Informing the Field series will be in July 14, 2014. We will be highlighting the work of The Open Door in Pittsburgh, PA.

For more information about AIDS United’s RiC initiative please visit: www.aidsunited.org

For more information about sector transformation, please email scruse@aidsunited.org.