

2019 Model Practices

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Size

Select a size: *

Small (0-50,000) Medium (50,000-499,999) Large (500,000+)

Application Information

Local Health Department/Organization Name: *

Florida Department of Health in Miami-Dade County

Title of Practice: *

Miami-Dade Test and Treat

Submitter Name: *

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Select a size::

Small (0-50,000) Medium (50,000-499,999) Large (500,000+)

Practice Categories

Model and Promising Practices are stored in an online searchable database. Applications may align with more than one practice category. Please select the top three that apply most to your practice: : *

- | | | | | |
|--|---|---|---|---|
| <input checked="" type="checkbox"/> Access to Care | <input type="checkbox"/> Advocacy and Policy Making | <input type="checkbox"/> Animal Control | <input checked="" type="checkbox"/> Coalitions and Partnerships | <input type="checkbox"/> Communications/Public Relations |
| <input type="checkbox"/> Community Involvement | <input type="checkbox"/> Cultural Competence | <input type="checkbox"/> Emergency Preparedness | <input type="checkbox"/> Environmental Health | <input type="checkbox"/> Food Safety |
| <input type="checkbox"/> Global Climate Change | <input type="checkbox"/> Health Equity | <input checked="" type="checkbox"/> HIV/STI | <input type="checkbox"/> Immunization | <input type="checkbox"/> Infectious Disease |
| <input type="checkbox"/> Informatics | <input type="checkbox"/> Information Technology | <input type="checkbox"/> Injury and Violence Prevention | <input type="checkbox"/> Marketing and Promotion | <input type="checkbox"/> Maternal-Child and Adolescent Health |
| <input type="checkbox"/> Organizational Practices | <input type="checkbox"/> Other | <input type="checkbox"/> Primary Care | <input type="checkbox"/> Quality Improvement | <input type="checkbox"/> Research and Evaluation |
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Vector Control | <input type="checkbox"/> Water Quality | <input type="checkbox"/> Workforce | |

Overview: Provide a brief summary of the practice in this section (750 Word Maximum)

Your summary must address all the questions below:

- Brief description of LHD- location, demographics of population served in your community.
- Describe public health issue.
- Goals and objectives of the proposed practice.
- How was the practice implemented/activities.
- Results/Outcomes (list process milestones and intended/actual outcomes and impacts.
- Were all of the objectives met?
- What specific factors led to the success of this practice?
- Public Health impact of practice.
- Website for your program, or LHD.

Please use this portion to respond to the questions in the overview section. : *

OVERVIEW

Florida Health Department Miami-Dade County, located in Miami-Dade County, Florida, is the largest county health department in the state with 16 million annual visits and employing 750 people. Its services include Clinical and Nutrition, Wellness Programs, Community Health Planning, Environmental Health, Infectious Disease Services, provided at several locations around the county. It is home to 2.7 million people of which 13.8% are White, 16.2% Black, and 67.7% are Hispanic, Other race/ethnicity is 2.3%. Males are 48.5% and Females make up 51.5% of the population.

Public Health Issue

Miami-Dade Metropolitan Statistical area is ranked #1 in HIV incidence by CDC. In 2017, there was a total of 1195 new HIV diagnoses in the county with 8.3% being White, 32.2% Black and 58.9.9% Hispanic. Women made up 17.2 % and men 71.2% of the cases.

In response, Florida in 2016 began implementation of a 4-point plan to reduce the incidence of new infections: 1) Routinized HIV and STI screening, 2) Test, Treat and Retain in Care, 3) PrEP (Pre-exposure Prophylaxis) and nPEP (non-occupational post-exposure prophylaxis), and 4) Increase HIV awareness through outreach, engagement and messaging.

Goals/Objectives/ Implementation

In support of the State's plan Florida Health in Miami-Dade County was chosen to implement a pilot project for Test, Treat and Retain in Care, the goal of which are to improve the time frame by which patients (usually taking 60-90 days to see a doctor) newly diagnosed HIV or previous positives would access medical care and medication in under 7 working days, resulting in earlier viral load suppression and subsequently improving health outcomes for the patient, reducing disease transmission and lowering the number of AIDS-related events.

How was practice implemented/activities?

It was determined that community collaboration was needed in order to accomplish the goals as stated. A series of meetings with administrative staff of the LHD, Jackson Health System, South Florida AIDS Network, and University of Miami School of Medicine Special Immunology Department were held to develop the process through which the patient could gain access to care in a timelier manner. Key frontline staff were identified in each of the organizations as contact persons. The processes were identified for each of the collaborating agencies. In March of 2016 the first patient was referred. During the first year, only newly diagnosed patients from the LHD STI clinic were enrolled. As processes were streamlined and clarified the patients referred to the project from the LHD STI clinic and saw the case manager, doctor, had labs drawn, and received their first 30-day supply of antiretroviral therapy (ART), usually on same day.

Results/ Outcomes

Because of the efforts of the collaborating agencies,

- 1) Processes were identified.
- 2) Another success of this project is the retention rate. The warm hand off helps the patient maneuver rather complex systems that tend to turn people away.
- 3) The first referral was received on March 2, 2016.
- 4) In July 2017, the project was expanded to include patients returning to care and referrals from outside the STD unit.
- 5) Because of the success of the pilot project, additional agencies were contracted by the LHD to provide the same service to patients.
- 6) In July of 2018, the project was expanded to include 7 additional agencies within the Miami-Dade HIV/AIDS Partnership. This expands the patient choice of where to get care.
- 7) The number of patients served in the project has increased steadily from 39 patients served in the first year to 93 patients during the second year and 165 patients in the first 11 months of the third year.

Objectives met

The goal of being in the 7-day time frame was well exceeded by the middle of the first year with patients beginning ART on same day as the referral. Viral suppression was shown in one analysis to have taken less time for patient in the project 71 vs 87 days

The specific factor leading to success of this project was the collaboration among the agencies involved.

The public health impact of this project beneficial to patients in that health is improved and maintained, adverse events such as hospitalization and opportunistic infections related to HIV are prevented thus reducing cost of the illness. The benefit to the community results from the suppression of viral load resulting in reduced transmission.

LHD Websites

<http://miamidade.floridahealth.gov/>

<http://miamidade.floridahealth.gov/programs-and-services/infectious-disease-services/hiv-aids-services/index.html>

Responsiveness and Innovation

A Model Practice must be responsive to a particular local public health problem or concern. An innovative practice must be -

1. new to the field of public health (and not just new to your health department) OR
2. a creative use of an existing tool or practice, including but not limited to use of an Advanced Practice Centers (APC) development tool, The Guide to Community Preventive Services, Healthy People 2020 (HP 2020), Mobilizing for Action through Planning and Partnerships (MAPP), Protocol for Assessing Community Excellence in Environmental Health (PACE EH). Examples of an inventive use of an existing tool or practice are: tailoring to meet the needs of a specific population, adapting from a different discipline, or improving the content.

- Statement of the problem/public health issue.
- What target population is affected by problem? (please include relevant demographics)

- What is the target population size?
- What percentage did you reach? What has been done in the past to address the problem?
- Why is the current/proposed practice better? Is current practice innovative? How so/explain?
 - Is it new to the field of public health?
 - Is it a creative use of existing tool or practice?

What tool or practice did you use in an original way to create your practice? (e.g., APC development tool, The Guide to Community Preventive Services, HP 2020, MAPP, PACE EH, a tool from NACCHO's Toolbox etc.)

Is the current practice evidence-based? If yes, provide references (Examples of evidence-based guidelines include the Guide to Community Preventive Services, MMWR Recommendations and Reports, National Guideline Clearinghouses, and the USPSTF Recommendations.)

Please state the Responsiveness and Innovation of your practice : *

Statement of the problem:

Miami-Dade County has received a ranking of #1 in incidence among metropolitan statistical areas by the CDC for several years. Research has shown that early treatment and continued viral suppression both increases the health of the patient and prevents transmission of the virus. One contributing factor is patients not getting into care in a timely manner, which can result in disease progression and allow for transmission of the virus. The goal of this project is to reduce the time it takes for a patient to access medical care and medication, resulting in earlier viral suppression and AIDS related events, reducing transmission of the virus and increasing retention in care. The CDC has set a standard for linkage to care stating that a patient should be able to see a doctor, get labs within 30 days of diagnosis.

Target Population

The target population for this project are persons either newly diagnosed with HIV or HIV+ persons who have experienced an interruption in their care and are seeking to re-engage. The patients are drawn from the LHD STD clinic, persons contacted for partner services by Disease Intervention Specialists and referrals from the community at large. There is no specific demographic other than the person must be HIV+. The demographics of the patient group reflect the demographics served by the larger clinic. The patients speak English, Spanish or Creole. The Miami-Dade patient group is composed of Hispanics 55.0% of the patients served, followed by 38.0% Black, 6.0% White and 1.0% Other. Men are the largest group making up 74.0%, Women are 25.0% and Transgender M to F, 1.0%. MSM comprise the largest percentage of patients at 47.0% followed by Heterosexual exposure at 43.0%; Bisexual exposure, 5.0%. 3.0% have IDU as the primary risk factor with an additional 2.0% with additional risk behaviors (sexual). Since its beginning in March 2016 through December 6, 2018, the project has served 297 patients.

The process used in the past to refer patients to medical care and case management, was for staff to give the patient a referral slip to take to the agency of their choice, with the patient being given an appointment weeks or even 2 or 3 months in the future to see a case manager, then another several days or week to see the doctor, followed by another wait for labs results and finally getting the prescription and going to the pharmacy. The result was the patient often not following up with the appointments and not getting into care in a timely manner. The goal of this project was to improve on the process by which the patient would gain access ART and thereby prevent them from falling through the cracks.

Once the patient has completed the initial visit including starting ART, the case manager works with the patient to establish a long-term plan. During the next 12 months, lab results are collected from the medical record to monitor the patients progress and engagement in care.

Why is this practice better?

The Miami-Dade Test and Treat project is based on the RAPID Program which started in July 2013 at San Francisco General Hospital, San Francisco, CA and was designed to speed up the process of patients getting into care, particularly "high needs" patients such as those with substance abuse, mental health and homelessness, who are at risk for falling through the cracks in the healthcare system. In the Miami-Dade Test and Treat project, patients presenting to the Health Department STD clinic and accept referral to the Test and Treat project are escorted to the patient's choice of case management agency where a case manager begins the process by opening the patient case, next the patient sees an MD or AARNP who performs the initial medical exam and prescribes ART. Next, baseline labs are drawn (CD4, Viral Load and Geno/Phenotype) and the case manager rejoins the patient to escort to the hospital pharmacy to receive the first 30-day supply of ART. Receiving these services during a single visit instead of several appointments strung out over weeks or even months is preventive of the patient being lost to care. Additionally, patients have access to psychological/ psychiatric help if needed. In this project a staff person from each office/ unit serving the patient provides a "warm hand-off" from one step to the next so that the patient is not lost or isolated in the large hospital complex comprised of many large buildings and offices.

Health and Human Services Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents living with HIV recommend the "initiation of ART (antiretroviral therapy) for all individual with HIV, regardless of CD4 T lymphocyte count, to reduce the morbidity and mortality associated with HIV infection. ART is also recommended for individuals with HIV to prevent HIV transmission."¹ Research studies have indicated a clear benefit of early initiation of ART regardless of CD4 count and increase the probability of restoring normal CD4 counts, a normal CD4/CD8 ratio, and lower level of immune activation and inflammation as well as preventing morbidity and mortality.²⁻⁹

Several studies and clinical trials also have indicated that ART can significantly lower the transmission of HIV. One of the largest studies of HIV-serodiscordant couples, HPTN 052, showed a sustained 93% reduction in transmission within couples when the partner with HIV was taking ART as prescribed and viral load was suppressed.^{10,11} The CDC in its HIV Basics states: “There is also a major prevention benefit. People living with HIV who take HIV medication daily as prescribed and get and keep an undetectable viral load have effectively no risk of sexually transmitting HIV to their HIV-negative partners. This is called treatment as prevention (TasP), using HIV medication to prevent sexual transmission of HIV.”¹²

1. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV: Downloaded from <https://aidsinfo.nih.gov/guidelines> on 12/8/2018
2. INSIGHT START Study Group, Lundgren JD, Babiker AG, et al. Initiation of antiretroviral therapy in early asymptomatic HIV infection. *N Engl J Med*. 2015;373(9):795-807. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/26192873>.
3. TEMPRANO ANRS Study Group, Danel C, Moh R, et al. A trial of early antiretrovirals and isoniazid preventive therapy in Africa. *N Engl J Med*. 2015;373(9):808-822. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/26193126>.
4. Le T, Wright EJ, Smith DM, et al. Enhanced CD4+ T-cell recovery with earlier HIV-1 antiretroviral therapy. *N Engl J Med*. 2013;368(3):218-230. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/23323898>.
5. Hunt PW, Martin JN, Sinclair E, et al. T cell activation is associated with lower CD4+ T cell gains in human immunodeficiency virus-infected patients with sustained viral suppression during antiretroviral therapy. *J Infect Dis*. 2003;187(10):1534-1543. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/12721933>.
6. Mocroft A, Phillips AN, Gatell J, et al. Normalisation of CD4 counts in patients with HIV-1 infection and maximum virological suppression who are taking combination antiretroviral therapy: an observational cohort study. *Lancet*. 2007;370(9585):407-413. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17659333>.
7. Kelley CF, Kitchen CM, Hunt PW, et al. Incomplete peripheral CD4+ cell count restoration in HIV-infected patients receiving long-term antiretroviral treatment. *Clin Infect Dis*. 2009;48(6):787-794. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/19193107>.
8. Lange CG, Lederman MM, Medvik K, et al. Nadir CD4+ T-cell count and numbers of CD28+ CD4+ T-cells predict functional responses to immunizations in chronic HIV-1 infection. *AIDS*. 2003;17(14):2015-2023. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/14502004>.
9. Robbins GK, Spritzler JG, Chan ES, et al. Incomplete reconstitution of T cell subsets on combination antiretroviral therapy in the AIDS Clinical Trials Group protocol 384. *Clin Infect Dis*. 2009;48(3):350-361. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/19123865>.
10. Cohen MS, Chen YQ, McCauley M, et al. Prevention of HIV-1 infection with early antiretroviral therapy. *N Engl J Med*. 2011;365(6):493-505. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/21767103>
11. Castilla J, Del Romero J, Hernando V, Marinovich B, Garcia S, Rodriguez C. Effectiveness of highly active antiretroviral therapy in reducing heterosexual transmission of HIV. *Journal of acquired immune deficiency syndromes*. 2005;40(1):96-101. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/16123689>.
12. HIV.gov; HIV Basics; HIV Treatment as Prevention. Available at: <https://www.hiv.gov/hiv-basics/hiv-prevention/using-hiv-medication-to-reduce-risk/hiv-treatment-as-prevention>

LHD and Community Collaboration

The LHD should have a role in the practice’s development and/or implementation. Additionally, the practice should demonstrate broad-based involvement and participation of community partners (e.g., government, local residents, business, healthcare, and academia). If the practice is internal to the LHD, it should demonstrate cooperation and participation within the agency (i.e., other LHD staff) and other outside entities, if relevant. An effective implementation strategy includes outlined, actionable steps that are taken to complete the goals and objectives and put the practice into action within the community.

- Goal(s) and objectives of practice
- What did you do to achieve the goals and objectives?
 - Steps taken to implement the program
- Any criteria for who was selected to receive the practice (if applicable)?
- What was the timeframe for the practice were other stakeholders involved?
- What was their role in the planning and implementation process?
 - What does the LHD do to foster collaboration with community stakeholders? Describe the relationship(s) and how it furthers the practice goal(s)
- Any start up or in-kind costs and funding services associated with this practice? Please provide actual data, if possible. Otherwise, provide an estimate of start-up costs/ budget breakdown.

The impetus for this project began with the HIV/AIDS 4-point plan to reduce the incidence on new HIV infections and retain HIV+ patients in care.

To achieve goal and objectives, implementation required the collaboration of the State Health Department Program office and the LHD for the purpose of funding, and with local organizations for the delivery of the rapid access services. The LHD was able to build upon collaborative relationships already in existence from previous and ongoing projects and programs. A process map was developed and agreed upon by the participating agencies defining specific staff responsibilities. The pilot project was implemented with the collaboration of organizations involved in the project: South Florida AIDS Network, Jackson Health System and Hospital, University of Miami School of Medicine Department of Special Immunology. As the project grew and the need for more organizations was identified, giving the patient more choice in where to access care. Meetings were held with Federally Qualified Health Center (FQHC) organizations to encourage participation and with the County Office of Management and Budget, administrators of the Ryan White Part A Grant, in which the administrators supported adopting the rapid access to care process.

HIV+ Patients were recruited from the LHD clinics as well as referrals from the community. Collaboration with and among the provider organizations was necessary for the patients to receive services across the three different organizations. The initial case management, doctor visit and baseline labs are paid by Ryan White Part A. To facilitate the speed of enrollment, the county administrators implemented a new billing code for the project in the Ryan White Part A program, allowing services to begin while the patient is applying for eligibility. Medications are covered by Ryan White Part B funds made available by the State Health Department to the LHD. Training and technical assistance is provided to the Ryan White Part A providers from LHD staff as well as the State Medical Director.

Start-up costs were minimal. There was no extra service provided to patients, other than a re-arranging of the time frame in which those services were delivered. Patients received the same services as they would ordinarily, but on the same day rather than over an extended period and multiple appointments.

After the second year, the program was expanded to include seven additional organizations. The State Health Department made available funds to the LHD to cover the cost of the initial 30-day supply of ART to these organizations at 340B pricing. The LHD in turn contracted with the seven organizations to provide the rapid access process to their patients. Ryan White Part A again covered the cost of the initial case management, medical and lab visit. By participating as a member in the Miami-Dade HIV/AIDS Partnership and its committees, the LHD fosters good collaborative relationships with the other members and stakeholders in the community.

Evaluation

Evaluation assesses the value of the practice and the potential worth it has to other LHDs and the populations they serve. It is also an effective means to assess the credibility of the practice. Evaluation helps public health practice maintain standards and improve practice. Two types of evaluation are process and outcome. Process evaluation assesses the effectiveness of the steps taken to achieve the desired practice outcomes. Outcome evaluation summarizes the results of the practice efforts. Results may be long-term, such as an improvement in health status, or short-term, such as an improvement in knowledge/awareness, a policy change, an increase in numbers reached, etc. Results may be quantitative (empirical data such as percentages or numerical counts) and/or qualitative (e.g., focus group results, in-depth interviews, or anecdotal evidence).

- What did you find out? To what extent were your objectives achieved? Please re-state your objectives.
- Did you evaluate your practice?
 - List any primary data sources, who collected the data, and how? (if applicable)
 - List any secondary data sources used. (if applicable)
 - List performance measures used. Include process and outcome measures as appropriate.
 - Describe how results were analyzed.
 - Were any modifications made to the practice as a result of the data findings?

Please enter the evaluation results of your practice : *

This project uses primary data sources for evaluation. Evaluation relies on the following data points:

- Date first positive diagnostic test
- Date test result disclosure
- Date of Last negative HIV test result
- Date of clinic contact/referral
- Date of first clinic visit
- Date of first clinic medical provider visit
- Date of Baseline labs (Viral Load and CD4)
- Date of first ART prescription
- Name of ART prescribed
- Date of first Viral Suppression <200 cells/mm³

- Linkage to primary HIV care within 30 days and documentation maintained in care, through data collection over 12-month period
- Engagement in care at 12 months
- Viral suppression <200 cells/mm³ and

To gather the information, access to several databases was needed and LHD staff was granted read only privileges to those residing in other organizations. Beginning with the LHD data bases: To gather the patient demographic and initial HIV test information, the LHD Health Management System (HMS) for the patient record and State Health Department Patient Reporting Investigating Surveillance Manager (PRISM) are used. The CDC Enhanced HIV/AIDS Reporting System(E-Hars) database is checked for any past HIV+ tests reported to determine if the current test is a new diagnosis. E-Hars, HMS and PRISM are used verify the patient is HIV+. The patient referral is entered into the Miami-Dade CHD domain in the state CareWare database.

Once the patient leaves the LHD to attend the initial case management appointment and doctor visit, they are entered into another three databases. LHD staff persons were granted 'read only' privileges to those databases: the Ryan White Part A case management database (CaseWatch) for tracking the patient progress, the JHS patient medical record (Cerner Power Chart) for tracking medical appointment and labs, and the State CareWare database (SFAN Domain) for tracking patient care. Program staff was also given read only permission to the AIDS Drug Assistance Program (ADAP) database, PROVIDE, for the purpose of monitoring medication pick-ups of patients who were eligible to participate in the medication program.

Performance measures:

The key performance measures are viral suppression including the time to first viral load test returning a result <200 cells/mm³, the sustained suppression evidenced by subsequent viral load results and engagement in care evidenced by at least 2 doctor visits/ viral load results-3 months apart during a 12- month period. This indicates the patients are engaged in their care and maintaining health.

By measuring the time frames of specific treatment events (HIV Test, clinic/case manager visit, provider visit, date of prescription, and subsequent labs with their values, the patient's treatment path can be tracked and the time frame to viral suppression and continued suppression can be measured. The results indicate how soon the patient achieves (or not) a suppressed viral load.

One analysis of data has been completed and the abstract¹³ has been submitted to and accepted by the 2019 Conference on Retroviruses and Opportunistic Infections (CROI). This study aimed to evaluate HIV care outcomes, including viral load (VL) suppression (<200 copies/mL) and retention in HIV care (2 or more HIV-related labs, medical visits or prescriptions at least 3 months apart), for persons whose HIV was diagnosed in Miami-Dade County in 2017.

The methods of analysis used clinical and epidemiological data reported to the Florida Department of Health HIV/AIDS surveillance system and were matched to lab, medical visit and prescription records in Ryan White Program databases, county health department health records and Medicaid claims. HIV care outcomes among antiretroviral-naïve patients whose initial HIV diagnosis was in Miami-Dade County in 2017 and who engaged in HIV care (n=950), including patients in Test and Treat (n=80), were evaluated to determine the impact of T&T. The results indicate that patients in the Test and Treat were more likely to achieve viral suppression within 6 months of diagnosis (87.5% vs. 66.1%) and be retained in care (91/3% vs. 81.6%) For patients with a suppressed viral load within 6 months of diagnosis, the average number of days from diagnosis to viral suppression was lower for the Test and Treat (71 vs. 87) When evaluating patients retained in care, higher rates of viral suppression (90.4% vs. 76.1% and more rapid viral suppression (72 vs. 89 days).

The study concluded that patients participating in the Test and Treat project were more likely to achieve viral suppression within 6 months of diagnosis and progress to viral suppression more rapidly. Rapid access to ART following HIV diagnosis can help reduce HIV-related mortality, improve health outcomes of those living with HIV and reduce HIV transmissions through viral suppression.

13. Karalee Poschman^{1,2}, Emma C. Spencer², David Goldberg³, Kira A. Villamizar³, Tiffany Adams², Jeffrey A. Beal². Impact of HIV Test AND Treat Initiative in Antiretroviral-Naïve Patients in Miami-Dade County, Florida.

1. Centers for Disease Control and Prevention, Division of HIV/AIDS Prevention, HIV Incidence and Case Surveillance Branch, Atlanta, Georgia
2. Florida Department of Health, Division of Disease Control and Health Protection, Bureau of Communicable Diseases, HIV/AIDS Section, Tallahassee, Florida.
3. Florida Department of Health in Miami-Dade County, Miami, Florida.

Sustainability

Sustainability is determined by the availability of adequate resources. In addition, the practice should be designed so that the stakeholders are invested in its maintenance and to ensure it is sustained after initial development (NACCHO acknowledges that fiscal challenges may limit the feasibility of a practice's continuation.)

- Lessons learned in relation to practice.
- Lessons learned in relation to partner collaboration. (if applicable)
- Did you do a cost/benefit analysis? If so, describe.
- Is there sufficient stakeholder commitment to sustain the practice?
 - Describe sustainability plans.

Please enter the sustainability of your practice : *

Except for the LHD adding one staff person, the pilot project utilized existing staff and resources. Test and Treat rearranged the order and time frame in which those services were provided. Patients receive a case management appointment, doctor visit, baseline labs, and a 30-day supply of ART, all in one visit instead of attending multiple appointments over time. In 2018, two more staff were added including one data entry person.

The challenges that arose included the willingness of an organization to alter long established protocols for enrolling patients in services. HHS guidelines emphasize that this approach is “resource-intensive, requiring “on-call” clinicians, nurses, social workers, and laboratory staff to coordinate the patient transportation, clinical evaluation, counseling, insurance coverage, laboratory testing...”

It takes good coordination and willingness of the staff to “make room” for the Test and Treat patient in the schedule.

In major metropolitan areas such as Miami, FL, this approach can be instituted within full service medical establishments such as FQHC clinics or through collaborative efforts as demonstrated in this paper.

Several physicians were hesitant to prescribe ART without having geno/phenotype tests and funding for the initial ART. These challenges were met with meetings and technical assistance by the LHD and education by state HIV/AIDS Medical Director.

The State Health Department made available funds for the medications. Funding for the initial 30-day supply of ART was necessary because the patient population is often without insurance/under-insured and may qualify for Ryan White Care Act funding for medical care or insurance plans take time for ART authorization. However, the process for applying for Ryan White Part A funding and Ryan White Part B funding (ADAP) often is time consuming taking several weeks. By waving the eligibility criteria for the initial assessment, the patient can receive medication quickly and then proceed to complete the steps for eligibility determination and utilize whatever health options which are available.

The project expanded after 2 years to include seven additional organizations. Funding remains available from Ryan White Care Act and State of Florida for the project to continue. Several small studies 14-16 in South Africa and Haiti support that same day initiation of ART may be helpful in helping patients engage and stay in care with sustained viral suppression. No large randomized controlled trials have been conducted in the United States yet. We are encouraged to continue to develop and refine this model of care and treatment initiation by our positive experience of almost 3 years.

14. Rosen S, Maskew M, Fox MP, et al. Initiating antiretroviral therapy for HIV at a patient’s first clinic visit: The RapIT randomized controlled trial. PLoS medicine. 2016;13(5):e1002015. Available at: <https://www.ncbi.nlm.nih.gov/>

15. Koenig SP, Dorvil N, Devieux JG, et al. Same-day HIV testing with initiation of antiretroviral therapy versus standard care for persons living with HIV: A randomized unblinded trial. PLoS medicine. 2017;14(7):e1002357. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/28742880>.

16. Pilcher CD, Ospina-Norvell C, Dasgupta A, et al. The effect of same-day observed initiation of antiretroviral therapy on HIV viral load and treatment outcomes in a US public health setting. Journal of acquired immune deficiency syndromes. 2017;74(1):44-51. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/27434707>.

Additional Information

How did you hear about the Model Practices Program?: *

- | | | | | |
|--|---|---|--|---|
| <input type="checkbox"/> I am a previous Model Practices applicant | <input type="checkbox"/> At a NACCHO conference | <input checked="" type="checkbox"/> Colleague in my LHD | <input type="checkbox"/> Colleague from another public health agency | <input type="checkbox"/> E-Mail from NACCHO |
| <input type="checkbox"/> Model Practices Brochure | <input type="checkbox"/> NACCHO Connect | <input type="checkbox"/> NACCHO Exchange | <input type="checkbox"/> NACCHO Exhibit Booth | <input type="checkbox"/> NACCHO Website |
| <input type="checkbox"/> Public Health Dispatch | | | | |

Have you applied for Model Practices before?: *

- No, this is my first time applying. Yes, I have applied in the past.

If you answered yes to the question above, please let us know the year and award type. :