Adherence 2017
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PROACTive Linkage, Retention, Re-engagement, and Adherence Program in Broward County, FL

Yvette A. Gonzalez MPH CCHW
INTRODUCTION

• In 2015 Broward County had the second highest diagnosis of (HIV) infection.
• The highest prevalence rate of diagnosed HIV in the United States (US).
• In 2015, there were 657 reported new HIV infections
  – 87% linked to care
  – 68% of the estimated 19,585 individuals living with HIV are currently retained in care in Broward County.
DESCRIPTION

• PROACT was created in October of 2012
  – Linkage to Care Coordinators
  – One MDOT Nurse
  – Peer Navigator
• In June 2013 added the Perinatal Program
• In July of 2014 FDOH Broward Country launched the inaugural HIV DIS program the first in the State of Florida.
• In January 2017 added Peer Navigators
• In May 1st, 2017 added “Test & Treat” with Linkage and Re-engagement Specialists (LRS).
• In June 2017 will add PrEP Navigators
Referrals

- DOH- Contracted Providers
- CBOs
- HIV care Providers
- Local Ryan White Part A
- EHARS
**PROACT REFERRAL FORM**

**Client Information**

- **Name:** Last, First, Middle Initial
- **Telephone:**
  - **Home:** ( )
  - **Cell:** ( )
- **Date of Birth:**
- **Best mode of contact:**
  - **Home phone**
  - **Cell phone**
  - **Home/community visit**
- **Best time to call:**
  - **Morning**
  - **Afternoon**
  - **Evening**
  - **Any Time**
- **Primary Language:**
  - **English**
  - **Spanish**
  - **French**
  - **Creole**
  - **Portuguese**
  - **Other:**
  - **Client has/needs interpreter**
- **Address/Street:**
- **City, State, Zip Code**
- **Gender:**
  - **M**
  - **F**
  - **Transgender**
- **Ethnicity:**
  - **Hispanic**
  - **Non-Hispanic**
  - **Other:**
  - **Unsure/Unreported**
- **Race:**
  - **White**
  - **Black/African American**
  - **Other:**
  - **Native American**
- **Insurance Carrier Name:**
- **Group #:**
- **Plan #:**
- **Member #:**

**Emergency Contact**

- **Name:**
- **Relationship:**
- **Phone:** ( )

**Reason for Referral**

- **Newly diagnosed**
- **Previously diagnosed/new to care**
- **Problems with insurance eligibility**
- **Missed care or additional care needs**
- **Needs help navigating healthcare system**
- **Patient unable to get AIDS care**
- **Traveling or at risk of HIV infection**
- **TEST AND TREAT Program**
- **Concerns re lab results**
- **New diagnosis**
- **Self-reported medication interruption**
- **Unable to manage medications independently; moderate for OOT**
- **Requires other medication regimen assistance (e.g., pillbox)**
- **Not sure: Please assess client for services**
- **PREP Navigation Services**
- **Other:**

**For PREP Services Information, only**

- **Client’s last HIV ( ) Test:**
  - **Rapid**
  - **EIA**
  - **VL**
- **Date:** / / 
- **Has the client had exposure to HIV within the last 30 days?**
  - **YES**
  - **NO**
- **Has the client taken HIV PREP before?**
  - **YES**
  - **NO**
- **Does the client have a primary care provider?**
  - **Name:**
- **Is the client pregnant?**
  - **YES**
  - **NO**
- **Is the client seeking pregnancy?**
  - **YES**
  - **NO**

**Comments:**

- **Referral Date:**
HIV DIS

- They research individuals that are out of care.
- Provide service to all HIV + individuals that reside in Broward County.
- They provide field visits when clients do not answer phones.
- They inform the HIV/AIDS organization with outcomes of the clients lost to care.
- ADAP/Pharmacy DIS see over 100 clients a month.
- The other two HIV DIS see about 40 cases a month.
Linkage Coordinators

- Referrals are received from the STD program, HIV DIS, and community organizations.
- Eligibility is that you are HIV +.
- Provide transportation and/or bus passes.
- Each Linkage staff sees around 30-40 clients a month.
- Clients are documented on the DOH and PE database.
PEER Navigators

• Referrals for basic needs
• Transport clients to the provider.
• Educates clients on HIV and medication compliance.
• Add clients to HPCC database
Linkage and Re-engagement Specialists (LRS)

- Referrals from STD and/or service providers of a new diagnosis or lost to care.
- Appointments made to see a provider the same day.
- Transport client to provider.
- Facilitate access to the medications.
- Follow up appointments are made.
- Client is followed for one year.
- Documentation of CD4 and VL at baseline and at closure.
- Clients added to DOH and PE database.
Lessons Learned

- Establishing PROACT has facilitated the provision of seamless services.
- PROACT can improve outcomes across the HIV Continuum of Care
- Monitoring outcomes across the continuum is necessary to be able to evaluate program effectiveness.
Recommendations

• A comprehensive linkage, retention, re-engagement and adherence program should be established.

• Specialized positions within a program such as PROACT facilitate the effective provision of services.

• The utilization of a tailored data-base is part of the necessary program infrastructure.
Contact Information

Yvette A. Gonzalez
Director of PROACT and the Perinatal Prevention Program
Phone 954-467-470110 x 5541
Yvette.Gonzalez@flhealth.gov