HIV ReConnect

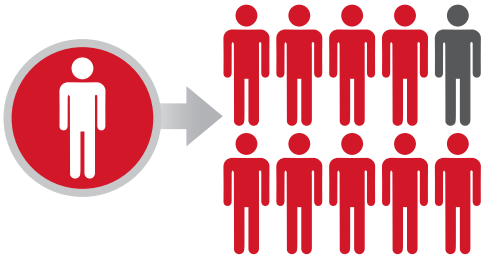
Increasing retention and re-engagement

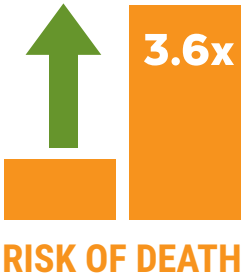
In San Francisco, youth, gay and bi-sexual men of color, transgender women, the marginally housed or homeless, and injection drug users are at the highest risk of falling out of HIV care.

Viral suppression & retention matters

28% of HIV positive individuals in San Francisco are **not virally suppressed**.[1]

People living with HIV and not in care are linked to over **9 out of 10** of new HIV transmissions.[2]





Missing 2 HIV care appointments within 2 years of diagnosis **increases the risk of death by 3.6 times**.[3]

HIV Navigation can help

HIV Navigation is a support service to assist out of care HIV+ clients with engagement in medical care and treatment. Based on individual needs, navigators help to **identify and reduce barriers to care**, including access to insurance, benefits, and other support services. Navigators usually offer **mobile services in the community** for a limited period of time.

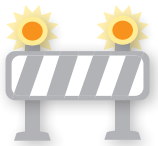
Providers and Frontline Workers are key to retaining clients in care

Build client trust

- Provide a human connection—ensure clients know they are cared about.
- Listen to personal beliefs about HIV and health care.
- Connect via phone or in person multiple times during the first few months in care.

Identify clients who need skill-building and support them with:

- Understanding HIV treatment and the importance of being in care
- ART adherence
- Communicating with medical providers and support teams



Assess needs and barriers to care

- Mental health & substance use
- Intimate partner violence
- Stigma and social isolation
- Housing/shelter
- Food insecurity
- Health care coverage and public benefits

Red Flags

Consider HIV Navigation for clients with:

- Inconsistent viral load suppression or not taking ART regularly
- No visits with an HIV medical provider during the past 6-months and/or no appointment scheduled
- Transfers from one system to another (e.g. jail to community; private provider to public clinic)
- History of being out of care since diagnosis
- Changes in their care team (e.g. medical provider, pharmacy, wrap-around support team) or health care coverage

*Re*Connect checklist:

Update client contact information regularly.
Use the contact sheet found at:
tinyurl.com/ExpandedContactSheet

Document, track, and act on missed visits.
Reach out within 24-hours when clients miss appointments.

Refer client to a social worker or case manager to help address barriers to care engagement.

Talking to clients about HIV Navigation—tinyURL.com/HIVNavigationOptionsInSF

- Assess the client's perception of what it means to be "out of care."
- Assess the client's adherence to ART and engagement in support services.
- Ask "What can we do to make this easier or better for you?"

REFERENCES:**1.** San Francisco Dept. of Public Health. 2015 HIV Epidemiology Annual Report. Published September 2016. **2.** Skarbinski, J. et al (2015). Human Immunodeficiency Virus Transmission at Each Step of the Care Continuum in the United States. *JAMA Intern Med.* 175(4), 588. doi:10.1001/jamainternmed.2014.8180. **3.** Mugavero et al. (2014). Beyond Core Indicators of Retention in HIV Care: Missed Clinic Visits Are Independently Associated with All-Cause Mortality. *Clin Infect Dis.* 59(10).

GETTING TO ZERO SAN FRANCISCO

POPULATION HEALTH DIVISION
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

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