PROVINCIAL BEST PRACTICE IN HIV CASE MANAGEMENT

Provincial Best Practice in the Re-engagement and Engagement in Treatment for Antiretroviral Interrupted and Naïve Populations (RETAIN)

This document aims to provide a standardized practice in re-engagement and engagement in treatment for antiretroviral interrupted and naïve populations (RETAIN). The objective is to provide comprehensive support for people living with HIV who have become disengaged from care, or have delayed engagement in HIV care following diagnosis.

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Provincial Best Practices in HIV Case Management in the Re-engagement and Engagement in Treatment for Antiretroviral Interrupted and Naïve populations (RETAIN)

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Purpose and Intent of this document

Public Health driven HIV Case Management has been used in BC to provide support for people living with HIV who have, for a variety of reasons, not initiated or who have interrupted antiretroviral therapy (ART). The initiative provides public health support and assistance to improve access to care and treatment for those living with HIV who are not accessing treatment.

Client interventions are Health Authority and case-specific. The Provincial RETAIN network provides an opportunity to establish consensus-based provincial Best Practices in HIV Case Management which can be a provincial, national, and international resource.

This document aims to provide and document best-practices approaches to re-engaging PLHIV who have become disengaged from care, or have delayed engagement in HIV care following diagnosis.

RETAIN Initiative Background

The Re-Engagement and Engagement in Treatment for Antiretroviral Interrupted and Naïve populations (RETAIN) Initiative is a partnership among the BC Centre for Excellence in HIV/AIDS (BC-CfE), Medical Health Officers (MHOs) in every Regional Health Authority, and HIV outreach support staff throughout British Columbia.

This Initiative seeks to promote treatment initiation for British Columbians living with HIV, who have never been treated with antiretroviral therapy (ART) and treatment re-initiation for those who have interrupted ART. People living with HIV (PLHIV) can achieve an undetectable serological viral load when receiving consistent treatment. HIV treatment improves quality of life and longevity and virtually eliminates the chances of transmitting HIV to others.

The benefits of antiretroviral therapy (ART) treatment include reduction in morbidity, mortality, and transmission which results in significant improvements to individual health and a virtual elimination of HIV transmission. At any given time in British Columbia, one out of three PLHIV have a detectable HIV viral load. Only two out of three PLHIV in BC remain on consistent ART, which implies that ART interruption remains a major obstacle to improve health outcomes and reduced transmission. Treatment as Prevention® (TasP®) improves the health and longevity of PLHIV thereby curbing the HIV epidemic.

Additionally, delayed ART initiation for newly diagnosed PLHIV remains prevalent. A BC-CfE Canada-wide survey found nearly half of the individuals living with HIV started treatment when they had already reached an AIDS-defining illness.

RETAIN is a new partnership between the BC-CfE and BC Regional Health Authorities. Since 2003, HIV has been a reportable condition in BC. Prior to the implementation of RETAIN, HIV case management (eg. STOP Team) was not informed about treatment interruptions or delayed initiation of ART. Some physicians had elected, at their own discretion, to refer patients to public health outreach teams throughout BC. With the launch of the RETAIN initiative there now is a standard process of routine coordination to support public health response to help reach individuals with HIV who are not accessing or have interrupted treatment.

RETAIN is a component of the provincial STOP HIV/AIDS Project and responds to strategic goals for implementation of Treatment as Prevention® as outlined in the BC Ministry of Health Strategic Framework (From Hope to Health – Towards an AIDS-free Generation).

Context

In developing the practice for re-engaging PLHIV into care, various components were involved in the process to ensure comprehensive and careful steps were considered. This is a general process but may not apply to all communities, for example, First Nations communities.

Medical Health Officer Involvement

Medical Health Officers (MHO) oversee a wide variety of initiatives such as RETAIN. With that, it is important for each health authority to seek guidance and support from the HA specific MHO when implementing and carrying out sensitive public health initiatives. Although this document serves as best practice guidance, some workflows pertaining to privacy and consent should always be reviewed by the HA-MHO. MHOs operate in accordance to the Public Health Act, which supports key public health objectives to promote health and prevent disease and injury. The act provides MHO the authority to protect the public from the spread of communicable disease, which, in the case of PLHIV, means preventing further transmission of HIV. In the situation where a person poses a risk to others as a direct consequence of their dis-engagement to treatment, an MHO has the power and duty to support health authority teams regarding involuntary disclosure of information in order to help re-engage the client to care.

Another important role is to ensure systemic issues that may be barriers to care are explored and addressed to ensure clients are best supported to engage in treatment. For example, dealing with the stigma clients may encounter when engaging with health care providers and advocating for access to needed laboratory services.

British Columbia Centre for Excellence RETAIN Intervention Process

The key components of the RETAIN Initiative involve building a communication mechanism between clinical teams and coordinating case management teams to optimize client engagement into care. With this aim of the project in mind, two phases of the RETAIN Initiative have been implemented:

Phase I – Clinician Alerts

One of two BC-CfE alerts is sent to the Care Provider who is most recently linked to the patient as the prescriber of ART. The client is either ART naive (never been treated with ART) or their ART has been interrupted for 2 months and not yet resumed.

A. ART Naive Alert: When BC-CfE identifies a client with at least one viral load measure and no record of ART initiation.

B. ART Interruption Alert: When BC-CfE identifies a client who has not refilled their ART prescription for more than 60-90 days following the expected refill date.

Phase II - Routine Coordination of Outreach Support

Coordinates routine, province-wide, Public Health directed support for PLHIV who have interrupted ART or who have yet to initiate therapy. This support may include Case Management, Outreach, and other client-specific interventions at the discretion of MHOs in each Regional Health Authority. Stringent criteria are employed to determine who is eligible for public health outreach support. PLHIV will be eligible if:

1) they have interrupted therapy for longer than four months, or

2) they have not yet started treatment more than eight months after a high plasma viral load is reported. This phase is the core component of this project.

Health Authority identified Intervention stages

A RETAIN working group, representative of teams from each Health Authority identified five intervention stages through a process mapping framework that guide the coordination for outreaching and engaging clients to care and treatment.

These five stages outline the continuum of engaging or re-engage clients into HIV care:

Stage 1 - Receive and Review
Stage 2 - Investigation
Stage 3 - Establish Relationship
Stage 4 - Facilitate the Connection to Care
Stage 5 - Monitor the Connection to Care

Beyond these five core stages, Health Authority specific structures dictate roles and responsibilities of the HIV Outreach teams, key members and/or agencies for collaboration, community partnerships, documentation processes, referral services available, information access, and other helpful tools and required resources and infrastructure.

Some regions have developed a clinical case management team focused on care delivery that offered comprehensive services that include harm reduction, prevention, testing and diagnosis, treatment, care and support. These case management teams consist of interdisciplinary team members who optimize

support services and engagement into care through providing assistance in meeting essential needs such as housing, financial, practical psycho-social, spiritual, nutritional, legal, and healthcare needs. It is also important to acknowledge there are some regions that do not have dedicated case management teams, but rather process RETAIN referrals through the Communicable Disease clinical team member(s).

Privacy Framework

In order to better serve PLHIV in BC select information is confidentially shared between specific BC-CfE staff and public health staff. Public health referrals are not based on physician directed referrals or requests. Through Treatment Interruption Alerts sent to prescribers prior to a RETAIN referral, prescribers have the opportunity to provide any available information or feedback on the circumstances of their patient's treatment interruptions of delays in treatment initiation. The physician can also make attempts to reach their patient over a two-month period. Following this period, the RETAIN initiative will refer an individual to public health for support.

Public health support specified by the RETAIN Initiative aims to ensure all PLHIV have opportunities to access care and treatment. However, the views and decisions of those PLHIV who wish to remain off treatment will be respected. All patient information is kept confidential and is not shared beyond the most trusted public health channels

The RETAIN project was developed with privacy embedded from the design phase all the way through implementation. Highlights of this approach include:

Relying on existing provisions within the Freedom of Information and Protection of Privacy Act (FIPPA) rather than the Public Health Act of BC which:

1. Allows the BC-CfE to ensure transparency and accountability in terms of how personal information is collected, used, stored and disclosed by the RETAIN project.
2. Aligns with the BC-CfE's patient-oriented principles.

Declaring the project a Common or Integrated Program or Activity under FIPPA which:

1. Better reflects the working relationship between the BC-CfE and the Health Authorities;
2. More transparently describes the flow of Personal Information between public bodies; and
3. Ensures the Privacy Impact Assessment (PIA) for the project would be submitted to the OIPC for review, providing greater scrutiny and feedback regarding privacy risks and mitigation strategies.

RETAIN staff worked closely with privacy staff at the BC-CfE and the Health Authorities to design and implement privacy management controls and documentation in a collaborative manner. Ongoing monitoring of the project includes how privacy risks and mitigation strategies are playing out in day-to-day operations, resulting in consultation with privacy staff and updating of privacy documentation. This documentation includes the Privacy Impact Assessment and Information Sharing Agreement. These documents were developed through meetings, consultations, and negotiation with the privacy staff of all the public bodies involved. The RETAIN initiative and all relevant documentation were reviewed by the Health Information Privacy and Security Standing Committee, which represents the Privacy Offices of all BC Health Authorities as well as the Office of the Information and Privacy Commissioner of BC

Privacy management for the RETAIN project is framed not only on legislation, but also on core privacy principles and privacy ethics. Privacy ethics move beyond the specific requirements around the protection of an individual's privacy into the larger notions of how their privacy is balanced with the use of their information to their benefit. One of the successes of the RETAIN project is its ability to improve

communications between health care service providers. These communications between providers in the patient's "circle of care" are an example of how patient expectations, privacy principles, privacy ethics and the law work together to benefit the patient in a privacy-protective manner.

The "circle of care" is the group of healthcare providers treating a patient who need information to provide that care. Consent to share information with providers in the circle of care is generally implied. A patient who accepts a referral to another healthcare provider implies consent for sharing relevant information. This includes sharing with physicians and other healthcare providers who are caring for the patient, but does not include others such as family, friends, police, and so on. Healthcare providers include any practitioners who are employed by a Health Authority or are in a private practice that bills under MSP. It is important to recognize that 'circle of care' can encompass varying roles based on the community. For example, First Nations communities in the North may include home care, patient travel coordinator, health director and community health representative.

Practice Guideline

This Best Practice guideline will emphasize Stage 1 to 3 of the intervention stages. Once clients have re-engaged in HIV care, HIV Case Management work can be referred on an as-needed basis. In most cases, as identified by the HIV Case Management process, Stages 4 and 5 are typically carried out by health care providers (HCP), internal programs or external agencies.

Designation Disclaimer: Both the RETAIN Lead and the HIV Case Management Lead can be used interchangeably. However, given that this is a provincial initiative, the designation of HIV Case Management Lead will be the used throughout this document. Several designations have been created to differentiate and better illustrate roles; however, health authorities are invited to use designations that work best for their HIV Case Management workflow.

Stage 1 - Receive and Review

Two different methods of receiving and reviewing the referral lists have been determined; the appropriate method will be identified depending on various factors such as staff roles, capacity and scope of practice.

1. **First Pass review:** The Case Management lead receives and does a preliminary investigation of the client list. This investigation may include any of the steps indicated in Stage 2 and 3. In some situations, the HIV Case Management Lead will allocate clients to an HIV Case Manager who will then pursue a full investigation and attempt to establish a relationship (see below). In some cases, the HIV Case Management Lead will complete a full investigation (Stage 2 – see below). If the client is not located after those efforts, the HIV Case Management Lead will make a referral to a Case Manager for regular follow-up and/or outreach work.

OR

2. **Distribution List:** The lists are received by an administrator who conducts a basic review, but no investigation. Referrals are made to teams, offices, hubs, and nodes for investigation into each case before proceeding with any outreach.
    - In some HA, the administrator or HIV Case Management Lead automatically sends a referral to a specialized HIV outreach team who will initiate the investigation.

[1] https://www.cmpa-acpm.ca/serve/docs/ela/goodpracticesguide/pages/communication/Privacy_and_Confidentiality/circle_care-e.html

Stage 2 – Investigation

1. Internal Program Contact

Verify current involvement with internal programs. In some HAs, this can be verified via electronic medical records as internal programs document on the same documentation systems. Others may need to contact internal programs directly via telephone.

If specific steps do not apply to your current role, move to the next one:

a) If a current relationship exists between the clients and outreach staff, this person will initiate direct contact with the client to facilitate re-engagement into care.

b) If a current relationship exists between the client and other internal HA programs, the HIV Case Management Lead will consult with the applicable HCP to obtain further details re: client's engagement and enter details in the appropriate EMR or client tracking files.

c) If a current relationship exists between the client and a program that provides HIV outreach services (i.e. STOP), the program may require that no further follow-up is done by the HIV Case Management Lead. This will be assessed on a case-by-case basis according to each program's request.

2. Contact with Most Responsible Provider

Contact via EMR

It is important to clarify that some health authorities have access to medical records where various HCP's also document.

a. If the medical records show current engagement with the heath care provider, no need for further follow-up.
b. If the medical records indicate that the BC-CfE identified MRP is currently providing care but details are unclear, contact the MRP to further assess the client's current state and the possible need for additional support services.
    - Discuss potential referral to other specialized outreach/case management team and request permission to submit referral on behalf of MRP.

Contact via Fax

If the HIV Case Management Lead is unable to verify current engagement with MRP via EMR/electronic messaging systems, follow faxing RETAIN guidelines:
Fax the 'Appendix B - RETAIN Prescriber Fax Cover Sheet' and applicable "RETAIN Fax Page 2" to Prescriber on Record that is provided through BC-CfE RETAIN linkage. The information obtained from this fax is meant to assist the HIV Case Management Lead in identifying clients requiring further follow up.

a. After initial fax is sent, allow 1 month for prescriber to respond.
b. If no response, send 2nd fax package and contact the MRP office to advise that HIV Case Management Lead has sent another fax requesting further information. MRPs can choose to complete the questions within the fax or discuss with HIV Case Management Lead directly.
c. If the MRP requests, the HIV Case Management Lead will work with the MRP to determine an engagement/re-engagement strategy. This may include sharing resources such as local services for MRP to review with client, or the HIV Case Management Lead contacting client directly on the MRP's behalf to assist in engagement/referral to other services.
d. If MRP indicates client is engaged with an external program related to HIV care or if determined

that client would be an appropriate referral to an outreach team, then, with MRP consent, the HIV Case Management Lead can contact the external program for further details or make a referral on behalf of the MRP.

e. If client is no longer in the prescriber's care, assess if they have any details regarding client's updated demographics or next known primary care providers.

If the HIV Case Management Lead is unable to determine a primary MRP for this client, the HIV Case Manager or HIV Case Management Lead can assist the client in finding a new MRP.

New Most Responsible Provider Identified via Fax

The HIV Case Management Lead may be notified by previous MRP that the client is now connected to a new MRP. In some cases, the HIV Case Management Lead can also identify a new MRP via EMR. If the HIV Case Manager has identified that the client is receiving care from another MRP, then:

Consult EMR(s) to possibly identify client's current address and MRP (i.e. Are they still living in the health authority jurisdiction?)

a. If address indicates client is no longer living in jurisdiction, refer to Transferring Client Care to other Jurisdiction
b. If a client is receiving care from another MRP, and there is no evidence that HIV care is being provided by this MRP, this does not prevent communication to the MRP about the client and HIV management.

3. Direct Client Contact

Depending on the method for receiving, reviewing and investigating, the HIV Case Management Lead or HIV Case Manager may contact the client on behalf of the Most Responsible Provider. This may include:

- If client's phone number or email address is known: Phone, text, or email attempts will be made. Consult Appendix D- Generic Conversation Template
- If address is known: Send standard "RETAIN letter template" on the HA letterhead – consult Appendix C - Client Letter Template
- If no response after three separate attempts:
    - If the health authority has capacity to outreach the client at the listed address, it is encouraged to do – consult External Agency Contact and Appendix A RETAIN Steps
    - If client is not located, the client is considered as lost to care and yearly follow-up should be conducted by the HIV Case Management Lead and/or HIV Case Manager.
- In some exceptional situations, emergency contacts can be contacted; however, it is recommended to consult with your supervisor, MHO and the BC-CfE Leads.

If the HIV Case Management Lead or HIV Case Manager connects with client and it is identified they are a new client for the Health Authority outreach team:

- The HIV Case Management Lead or HIV Case Manager can provide confidentiality disclosures to the patient.

These are samples of how the HIV Case Manager could respond to having the information of a client:

- "We work with the treating provider and are reaching out to offer support…"
- "We received your personal health information from another health authority so we could contact you about your treatment and care options in this region. The Freedom of Information and Protection of Privacy Act (FIPPA) authorizes them to share your information with us so we can help with your

ongoing treatment and care. If you have any questions about this collection of your personal information you can contact Medical Health Officer for HA at (000) 123-456. If you have general questions about our collection of your information or your privacy you can visit www. HA.ca/privacy or call (000) 123-456.

4. External Agency Contact

- If the client is not located through listed pathways, the HIV Case Manager can attempt to locate the client in community via external agencies or outreach to client's last listed address.
- Before contacting external agencies, consider the clients social history and clinical background. Past clinical documents can provide additional insight and information related to the client's whereabouts, usual hangouts and services or populations with whom the client(s) is/are known to associate.
- Not all teams responsible for RETAIN clients have the staffing capacity to visit the client at home or conduct outreach. In some circumstances, RETAIN teams have been able to engage other outreach teams (such as mental health teams, intensive case management teams, assertive outreach teams) in helping to connect with the client in community.
- Before conducting a home visit, consider that outreach visits may be acceptable to clients if they live in an area where such visits are commonly provided such as in larger urban, inner city areas; however, if client's past addresses illustrate a history of market housing in a residential neighborhood for example, conducting a home visit could be stigmatizing and/or not welcomed. Comparatively, if a client is known to frequent Vancouver's Downtown Eastside, has a history of living in supported housing/single room occupancies and has visited various shelters in the area, consider outreach at listed housing addresses and shelters.
- If determined appropriate, outreach can be conducted at home addresses, shelters, drop-in centres, homeless encampments, hospital, probation office, court, jail, methadone and other private clinics.

5. Resources to consider to aid the investigation

- Electronic Medical Records
- Court Services Online (CSO)
- Internet: Google, Social Media
- MSP healthNetBC database
- Emergency Department "Designated Medical Profile" (Familiar Faces Program)

Other considerations:
Some cases may warrant Public Health intervention related to health risk to others. Refer to Guidelines for Medical Health Officers: Approach to people with HIV/AIDS who may pose a risk of harm to others.

Refer to Definitions for more resource options.

Stage 3 - Establishing Relationships

Once client has been successfully contacted, establishing a supportive relationship is critical.

a. Members of teams responsible for RETAIN clients should work with the priorities of the client. In many circumstances, re-engaging in HIV care may not be their highest priority. Housing, dealing with mental health and/ or substance use issues, applying for disability benefits and obtaining ID and/or status card may be more of a priority for clients. RETAIN teams can build relationships with clients which may eventually lead to re-engagement in HIV care by helping them to navigate such services. Explore current circumstances (priorities, concerns, provider/support people), and any need for additional supports and assist linking the client to relevant resources as available (social supports, housing, mental health and substance use, etc).
b. If team members are able to establish a relationship and help clients book medical appointments, assist with transportation or address childcare care needs in order to re-engage in care, it is important that team members follow-up to ensure that clients attend these appointments, and ultimately start taking their medications again. The exact duration of follow-up for clients depends on the individual and the capacity of the teams responsible for RETAIN clients.
c. Some clients may decline offers of support by RETAIN teams, or Aboriginal Patient Navigator where available, once they've been contacted. In such circumstances, members of RETAIN teams should offer to check in on clients at regular intervals (again depending on the client and the capacity of teams) to see if circumstances have changed which may eventually lead them to accept assistance in re-engagement. Again, providing navigation assistance for other health or social services may provide a means of doing this.
d. Engage the client in discussions about HIV and HIV treatment. For individuals who have previously taken ART, explore factors that resulted in cessation of ART and what would have helped to sustain HIV care.

Stage 4 – Facilitate the Connection of Care

If individual is willing to engage in care, develop a plan to sustain ongoing engagement in care such as facilitating linkages to a provider or refer to appropriate services (e.g. outreach team, primary care, specialist care, laboratory monitoring, Mental Health and Substance Use service, social assistance, First Nations Benefits, housing, nutrition, etc.)

If individual chooses not to engage with HIV/health care, attempt to develop a plan for ongoing connection and support:

- If client is interested in the HIV Case Manager following up with them again; continue monthly follow-up.
- If client declines definitively or refuses support, HIV Case Manager will follow-up with client in six months.

Client Privacy Consideration

- Unless otherwise indicated (confirmed by EMR, lab work, etc.), HIV Case Managers and outreach staff should always assume that service providers are not aware of the client's status.
- Consider using a generic identifier when discussing with other services providers (i.e. outreach nurse, outreach social worker, outreach worker, etc.)
- When leaving voicemails, leave brief and generic messages with limited details (consult 'Appendix D - Generic Communication Template')
- Do not email identifying information. Always use initials and EMR numeric identifiers.

HIV Outreach for RETAIN in Collaboration with BC First Nations Communities

There are multiple models of health service delivery in BC's 203 self-determining First Nations communities. The First Nations Health Authority (FNHA) plans, designs, manages, and funds the delivery of First Nations health programs and services in BC, most of which are focused on health promotion and disease prevention[1]. Health programs and services are different in each community. Some communities have health care providers such as Community Health Nurses, Physicians and Nurse Practitioners (NPs). Other communities do not have these health care providers. With respect to reportable communicable disease (CD) follow-up, the Regional Health Authorities (RHAs) hold the legal authority and responsibility for receiving CD lab reports, making case determinations, and directing the appropriate CD management[2].

FNHA has centrally-employed health staff including Medical Officers and specialized CD Nurses who work in resource roles to support health care providers in communities. FNHA health staff can assist RHA MHOs and their teams and health care providers in communities to carrying out RHA MHO-directed case follow-up activities as needed and requestedv. For HIV and other sexually transmitted and blood borne infections (STBBIs), the FNHA STBBI Nursing Team can help make connections and liaise in cases involving collaboration between RHAs and health care providers in communities.
The FNHA STBBI Nursing Team can also provide clinical practice support and resources to Community Health Nurses and other community health care providers.

If caring for an individual residing in a BC First Nations community (or if they reside in a BC First Nations community based on their address or other contact information), it may be helpful to reach out directly to the health care providers working in community (e.g., call the Community Health Nurse). Because RHAs are responsible for the RETAIN Program, keep in mind that nurses in First Nations communities may not be familiar with the program. If seeking support in connecting with community health care providers, or are unsure who to call, the FNHA STBBI Nursing Team can facilitate. FNHA's five regional offices also provide engagement and clinical support to communities within each geographic health region, and able to help in connecting people to relevant community health care providers[3].

Here are some suggestions to support collaboration between RHA MHOs and their teams and health care providers in First Nations communities:

- Purposefully build professional relationships with health care providers working in First Nations communities in your area. Use professional relationships to consult and engage with them.
- Some communities have Community Health Nurses, Physicians, or Nurse Practitioners working in community who are part of the circle of care for HIV positive individuals. Reach out to these professionals as needed.
- Community Health Nurses may be particularly helpful in connecting with community members living with HIV who do not have cell phones, nor easy access to internet, nor a permanent mailing address.
- Health centres in rural First Nations communities may not have physicians or NPs on staff, which means that community members living with HIV may receive their HIV care through a clinic in a nearby municipality or even travel to Vancouver or other larger centres for care.
- In some cases, even though there are health care providers in their community, community members living with HIV may choose to get all HIV-related care at facilities outside their community and they may choose not to share their health information with the local health care team. Be mindful of this possibility and the individual's wishes.
- Ensure client confidentiality is upheld in all your communications. Consider carefully who is within the circle of care for the individual. Health care providers involved in the care of the individual are part of the 'circle of care' because they are allowed to view personal health information that is relevant to

care and treatment. Political and administrative leadership in and outside of Health Organizations do not fall within the circle of care[1].

- As is the case in many small communities, remember that people may be closely connected and may know each other well, or have family connections. Keep conversations with staff who are not part of the circle of care generic and brief. This is particularly important to remember when speaking with front desk staff, pharmacy staff, laboratory staff, and other health care and support staff who are not part of the individual's circle of care.
- RHA Indigenous HIV Prevention Programs work closely with health centres in First Nations communities and may be able to help HIV Case Management Lead/HIV Case Managers navigate healthcare.
- Most RHAs will have an Indigenous Health Program that may also be able to connect you to relevant First Nations communities, health centres, or resources.
- For connecting with individuals who use substances, RHA harm reduction coordinators or harm reduction services may be a helpful resource[4].
- Cell and internet service are not always reliable in rural/remote communities.

Management of Disengaged or Lost to Care RETAIN Clients

Throughout the process listed above, HIV Case Managers and outreach staff working with RETAIN clients may identify clients that are not currently on ART but may be engaged with HIV services in other ways (client may be refusing ART but is periodically seeing a physician).

- The HIV Case Management Lead and/or HIV Case Manager should continue on-going follow up until client is engaged or re-engaged.
- A RETAIN file should only be closed if the client has been located and re-engaged in HIV care (exceptions include death and transfer to another HA).

For clients that the MRP indicates are in process of engagement, (i.e. MRP is actively trying to engage and link to treatment), HIV Case Management Lead or HIV Case Manager should continue to follow up with MRP every six months.

For clients where the MRP indicates has refused ART, HIV Case Management Lead or HIV Case Managers should follow up at a minimum every six month.

For clients that the MRP indicates are lost to care and HIV Case Management Lead or HIV Case Manager is unable to locate further information based on steps above, the client's case file should remain open and follow-up should occur at the minimum annually or more frequent.

For clients with any special circumstances or if MRP requests specific timeline for follow-up, HIV Case Managers should adjust timelines accordingly.

[1] https://www.fnha.ca/Documents/COVID-19-Adapted-Regional-Health-Authority-Communicable-Disease-Protocol.pdf
[2] https://www.fnha.ca/Documents/FNHA_AboutUS.pdf
[3] https://www.fnha.ca/about/regions
[4] https://towardtheheart.com/

Case management timeline for RETAIN-referred clients (see Appendix 1A for step details)

This timeline provides a general guideline in regards to which steps should be carried out. Given the context of this work, it is strongly recommended to consider carrying out additional steps if the HIV Case Management Lead/HIV Case Manager believes it is clinically appropriate. For example, some HA have a higher capacity to outreach (leave messages at shelters, drop-ins, etc.); therefore, it is encouraged to assess the client's history and clinical background, and carry out steps that are appropriate and relevant in locating the client.

Phase 1: Processing All Attempts

- In the first month following a referral through RETAIN, steps 1 through 12 are carried out, if applicable.

Phase 2: Monthly Checks

- For the next 2 months the following steps will be checked monthly: 1, 7, 8, 9, 11 and 12. If no activity is found move on to Phase 3, if client has been surfacing then remain in Phase 2.

Phase 3: Bimonthly Checks

- For the next 6 months steps 1, 7, 8, 9, 11 and 12 will be checked bimonthly. If no activity is found move on to Phase 4, if client has been surfacing then go back to Phase 2.

Phase 4: Lost to Care

- Client is now determined as being lost to care. Client should remain on the RETAIN list and follow-up should occur annually.

Transfer Client Care to Other Jurisdictions

- Clients confirmed to have relocated to another health authority will be updated in the RETAIN Excel Client Spreadsheet.
- HIV Case Management Lead to fax RETAIN Initiative Inter-HA Client Referral Form to the HIV Case Management Lead in the new HA.
- The BC-CfE must also be notified. Contact the RETAIN Project Coordinator with RETAIN ID via:
  Phone: 604-682-2344 ext: 66286
  Secure fax: 604-806-9044
- Email the HA HIV CASE MANAGEMENT LEAD with RETAIN ID to notify the transfer of location.

Stage 5 – Monitor the Connections to Care

Once the client is connected to care, the HIV Case Manager should continue providing case management support or refer to appropriate services to ensure retention to care. Depending on the health authority's capacity, the HIV Case Managers may be able to provide:

- Outreach supports which may include assistance with blood work, medication dispensing, appointment accompaniment and psychosocial supports. This may include navigating social systems such as housing, legal, or welfare. For clients within First Nation Health Authority assistance may include obtaining status card if lost, child care needs, transportation and food security.
- Attend regular rounds with care providers, stay up-to-date on missed appointments, and attend multidisciplinary case conferences.
- Ensure the care provided is client-centered and empowerment-based.

It is also important to keep in mind there is a varying interdisciplinary nature amongst each outreach team. Therefore, clients should be assigned to the discipline based on needs and identified risks.

Documentation

Initial Documentation

- Upon initial investigation, if the client is located and determined to be engaged in care via EMR, no documentation is required.
- If the HIV Case Management Lead or HIV Case Manager is required to further investigate, all interactions below should be documented:
    - Communication with HCP
    - Communication with internal/external agencies
    - Contact/Attempt to locate client
    - Referring to another agency
    - Outcomes
        - Refusing ART
        - Moved/transferred to another HA
        - Deceased
        - Re-engaged in care (prescription given)
        - Other
            - e.g. if incarcerated, identify if client is in provincial or federal facility and note release date to ensure continuity of care

Ongoing Documentation

To ensure consistency, use listed document title for documentation

- RETAIN Follow-Up
- RETAIN Contact Attempt (Attempts to locate the client)
- RETAIN Collateral (External/Internal Agencies)
- RETAIN Heath Care Provider
- RETAIN Outreach Visit (Client seen on outreach)
- RETAIN Client Contact (Client contact via telephone/text/email

Resources

HIV Resources

Province wide

- British Columbia Centre for Disease Control (BCCDC)
- British Columbia Centre for Excellence in HIV
- Pacific Aids Network

Fraser Health

Internal Programs:

- Fraser Health, Sexual Health and Blood Borne Infections Program

External Programs:

- Positive Health Services
- Positive Living Fraser Valley
- Oak Tree Clinic
- Sto;Lo Primary Care Centre

Interior Health

Internal Programs:

- Health Outreach Team-Regional Offices and Clinics
- Infectious Disease Clinics-Kelowna/Kamloops

External Programs:

- OneSky Community Resources (Penticton)
- Living Positive Resource Centre (Kelowna)
- ANKORS-East and West (Cranbrook and Nelson)
- ASK Wellness Society (Kamloops)
- Turning Points Collaborative (Vernon)

Island Health

Internal Programs:

- Health Outreach Program (HOP) – Port Alberni
- Positive Health Central Island (Nanaimo)
- Street Outreach (South Island)

External Programs:

- AIDS Vancouver Islands (South, Central, and North Island)
- CoolAid Clinic – Victoria
- Nanaimo Area Regional Service for Family (Services Based at Harris House Health Clinic) - NARSF
- Positive Wellness North Island (PWNI)

Northern Health:

External Programs:

- The Cedar Project
- Positive Living North

Vancouver Coastal Health

Internal Programs:

- VCH – STOP Team

External Programs:

- AIDS Vancouver
- Oak Tree Clinic (Based out of BC Children's Hospital)
- John Ruedy Clinic (JRC) (Based out of St-Paul's Hospital)
- Kilala Lelum Health Centre
- Vancouver Aboriginal Health Society

First Nation Health Authority

- About FNHA: https://www.fnha.ca/Documents/FNHA_AboutUS.pdf
- FNHA Regions: https://www.fnha.ca/about/regions
- Nurse Specialist in HIV and STBBI: STBBI@fnha.ca
- Regional Offices : https://www.fnha.ca/about/regions
- COVID -19 Communicable Disease Protocol: https://www.fnha.ca/Documents/COVID-19-Adapted-Regional-Health-Authority-Communicable-Disease-Protocol.pdf

Health Authority Supporting Documents:

- Texting and/or mobile messaging policy
- Privacy and confidentiality policy

Others Resources

- Court Services Online - Electronic Court Registry to verify nature of charges, next court dates and incarceration: https://justice.gov.bc.ca/cso/esearch/civil/partySearch.do
- Medical Service Plan Database - confirms if an individual's MSP is active or inactive. This tool also provides listed contact information: https://healthregistry.moh.hnet.bc.ca/

Culturally-safe HIV resources:

- San'yas Indigenous Cultural Safety: https://www.sanyas.ca/training
- BCCDC Chee-mamuk: http://www.bccdc.ca/our-services/programs/chee-mamuk#Resources
- Canadian Aboriginal AIDS Network: https://caan.ca/en
- Youthco Yuusnewas: http://www.youthco.org/yuusnewas
- Environmental public health guidance for encampments during the COVID-19 pandemic: https://ncceh.ca/sites/default/files/Homeless%20encampment%20guidance%20document_July_ENJY%20%282%29.pdf

Definition

1. Circle of Care –A group of health care providers or member of the care team, both within and outside the specific health authority, including family members who are providing care. Disclosures within the circle of care do not require consent. However, information disclosed should be shared on a "need-to-know basis" (i.e. Within the "circle of care" or for "continuity of care")

2. Electronic Medical Systems (EMR) – Electronic Medical Records specific to each region and health authority. Some examples include Paris, IntraHealth Profile EMR, CareConnect, Meditech, Cerner/ Powerchart, EHealth, Panorama, and Jurisdictional Registry.

3. External Agencies – Programs that are not affiliated with the health authorities but may be involved in client care. This includes but is not limited to HIV specific programs, community centres, drop-in centres, shelters, transitional and supported housing, outreach teams, and treatment/detox facilities.

4. Health Authority – The health authorities govern, plan and deliver health-care services within their geographic areas

5. Health Care Providers (HCP) – Individual or team providing psychosocial and/or medical support which can also include Most Responsible Provider (MRP) or 'Prescriber on Record' – refer to definition 7.

6. Internal Programs – Programs/Teams that remain under the health authorities' umbrella and collaborate within the care of mutual clients. For example, communicable disease and/or specialized programs.

7. Prescriber on Record – This prescriber is on record in the RETAIN patient list as being in contact with this patient for HIV treatment purposes; therefore, it is appropriate to reveal the purpose of the follow-up.

8. Most Responsible Provider (MRP) – physician /nurse practitioner, or other regulated healthcare professional, who has overall responsibility for directing and coordinating the care and management of a client at a specific point in time.

9. HIV Case Manager – Responsible for RETAIN follow-up. Regular collaboration and communication with HIV Case Management Lead to assure that client status is noted and communicated to the BC-CfE. HIV Case Manager discipline/role include but are not limited to communicable disease or public health nurses, social workers, outreach workers, and case managers.

10. RETAIN Lead List – Provided to the HIV Case Management Lead working with the team/health authority

by means of a password protected file. The form will include details of clients including their last known location, ARV administration history and basic personal details. Weekly updates of clients on the RETAIN list that have completed blood work or have picked up ARVs is provided by the BC-CfE to the HIV Case Management Lead.

11. HIV Case Management Lead also known RETAIN Lead - Responsible for all RETAIN workflow coordination within the health authority as well as all direct communication with the BC-CfE. RETAIN Lead disciplines/ role include but are not limited to communicable disease/primary care/ public health nurses, social workers, outreach workers, business analysts, clinical coordinators and case managers.

12. Re-engagement – Client has a history of disengaging from care (no longer engaging with service providers and noted treatment interruption). Recent and on-going attempts to re-engage the individual in all aspects of healthcare (seeking medical treatment and re-initiating treatment).

13. Engaged in care – The client is seeking healthcare and is monitored by a health care provider/team. An individual can be engaged in care without being on treatment.

14. Previously engaged – The client has been in care with health provider at some point after HIV diagnosis.

15. Lost to Care (LTC) – A client is considered LTC when services providers are unable to locate the individual. The individual is not receiving appropriate medical care and monitoring and therefore treatment has never been initiated or has been interrupted. An individual who is actively seeking medical care but is not on treatment is not considered LTC.

16. Rural Communities – Within rural areas, population densities and living conditions can vary greatly. Included in rural areas are: small towns, villages, populated places with <1,000 population according to current census data, agricultural lands, remote and wilderness areas. By this definition, health care access is often limited and challenging due to location. Privacy and confidentiality can be of concern due to small populations and access to fewer clinical or community-based resources.

17. Urban Centres – Population centres that can range from 1000 to 100,000 persons or more. All areas outside population centres are classified as rural areas. Given the population density of these areas, larger and varied options are available in terms of healthcare and other community-based resources.

18. Follow-Up – The steps and procedures the HIV Case Management Lead/HIV Case Managers implement to re-locate and re-engage individuals into the system of HIV care including primary care, treatment re-initiation, clinical monitoring and follow-up.

19. Aboriginal Patient Navigator: The Aboriginal Patient Navigator (APN) assists Indigenous Peoples and their families to access high quality, culturally safe health care services. This may include helping patients understand the hospital care system, spiritual connection, discharge planning, community and hospital linkage, promoting access to community services and provision of support.

20. HIV Peer Navigator: A person living with HIV professionally trained to assist other people living with HIV who are newly diagnosed, who helps with re-engagement with community services and navigating multiple health care needs.

References

Information Privacy & Confidentiality retrieved from
http://shop.healthcarebc.ca/vch/VCHPolicies/D-00-11-30025.pdf

Public Health Act retrieved from
https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/legislation/public-health-act

Guidelines for Medical Health Officers: Approach to people with HIV/AIDS who may pose a risk of harm to others retrieved from
http://www.bccdc.ca/resource-gallery/Documents/Communicable-Disease-Manual/Chapter%205%20-%20STI/MHO-guidelines-PLWH-risk-of-transmission.pdf

Source Statistics Canada retrieved from
https://www12.statcan.gc.ca/census-recensement/2011/ref/dict/geo042-eng.cfm
Source Statistics Canada retrieved from https://www12.statcan.gc.ca/census-recensement/2016/ref/dict/geo049a-eng.cfm

Definition of Health Authority retrieved from
https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/partners/health-authorities

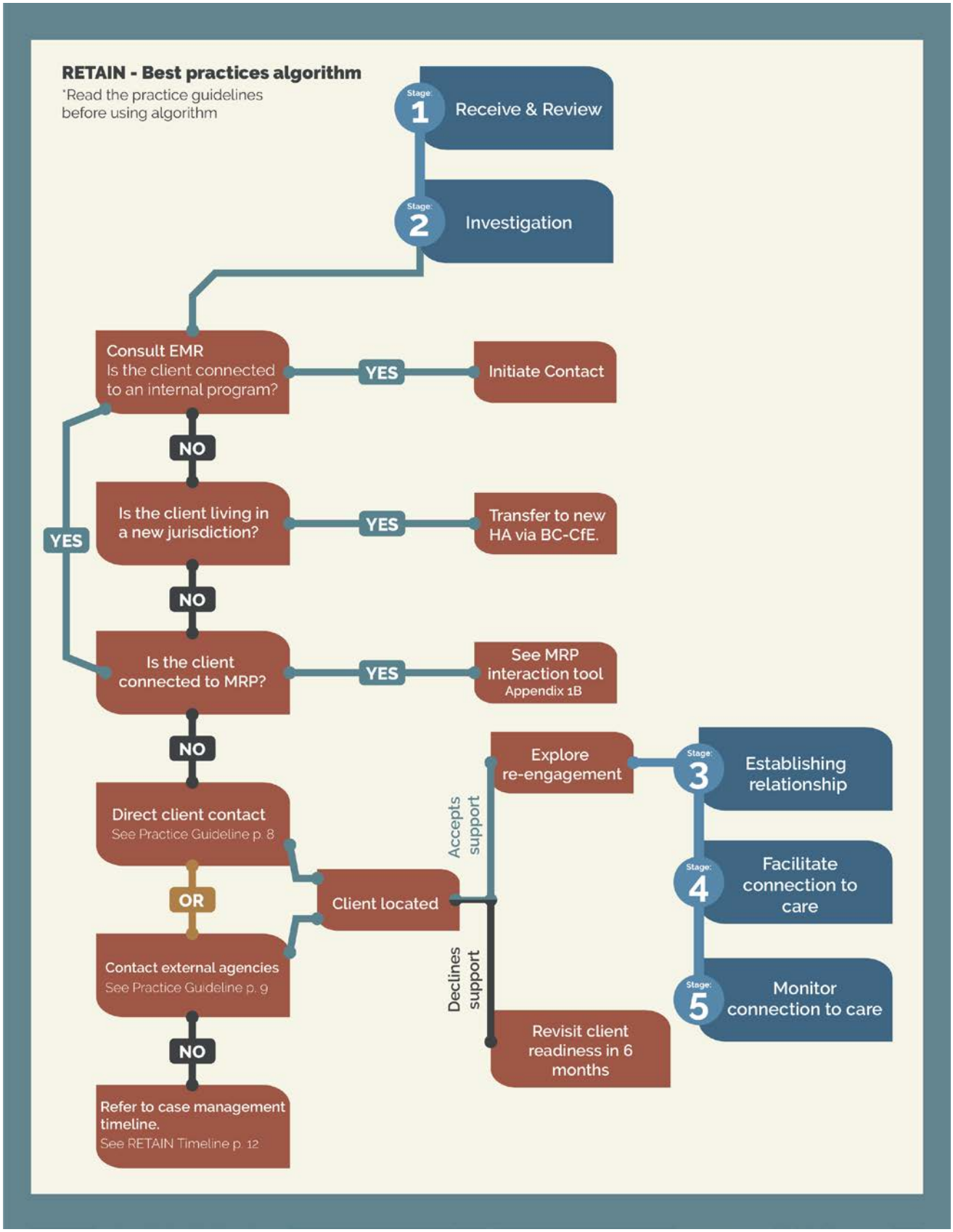
Peer Navigator Definition retrieved from
https://www.aidsvancouver.org/peer-navigation-program#:~:text=A%20Peer%20Navigator%20is%20an,considered%20an%20episodic%2C%20manageable%20illness

Aboriginal Patient Navigator Definition retrieved from
https://www.indigenoushealthnh.ca/initiatives/APLs
https://www.interiorhealth.ca/YourStay/AmenitiesAndServices/Pages/AboriginalPatientNavigator.aspx

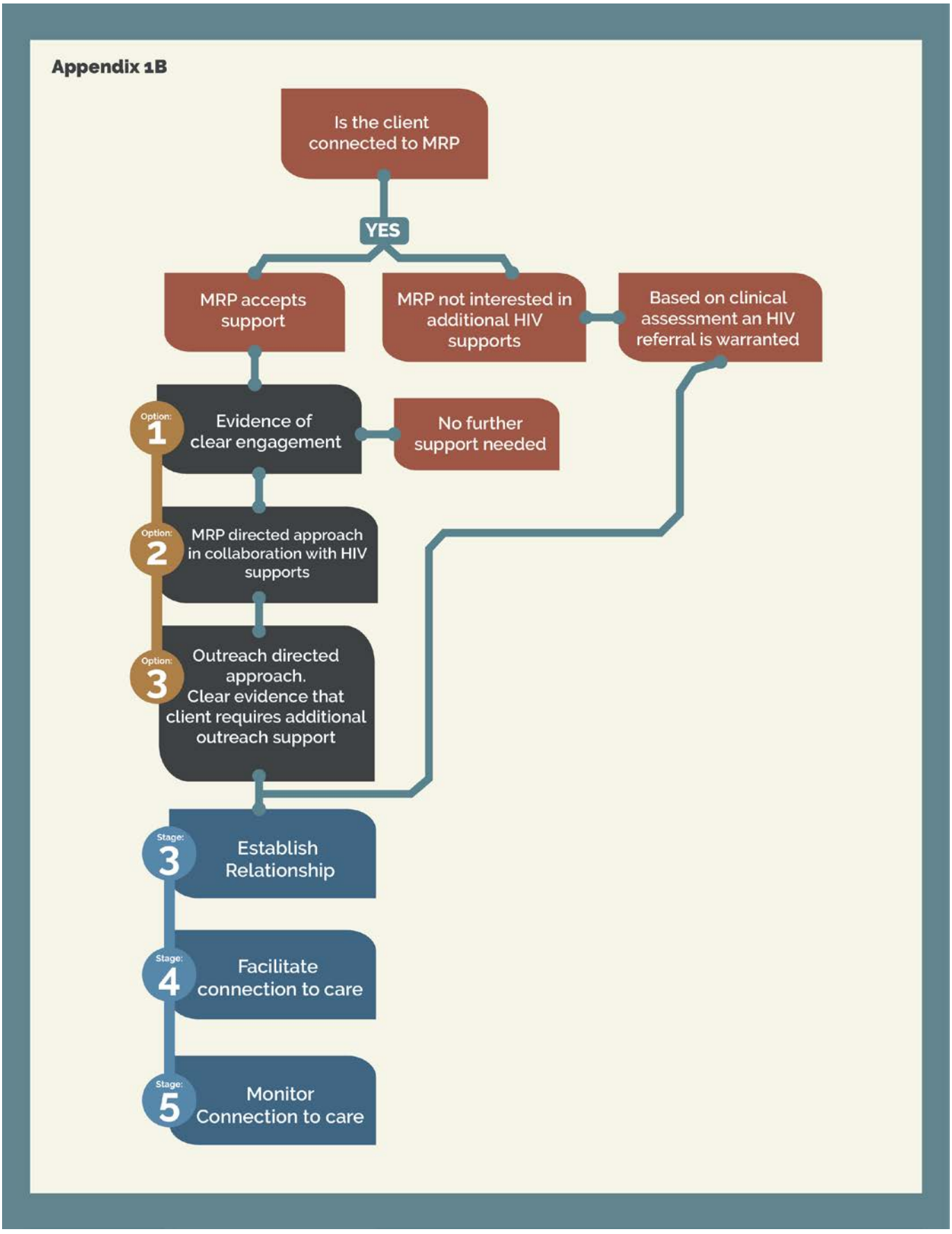
Appendix A-1 - RETAIN Steps to Locate Client

Appendix A-1 - RETAIN Steps to Locate Client

Appendix A-2.1 – RETAIN Pathway to Locate Client



Appendix A-2.2 MRP Interaction Tool



Appendix B – RETAIN Prescriber's Fax Cover Sheet

Health Authorities Logo

Office of the Chief Medical Health Officer - Prevention

Contact Information

FAX COVER SHEET URGENT CONFIDENTIAL ORIGINAL TO FOLLOW

Date:

MEDICAL CONFIDENTIAL

To: HCP – Prescriber's Name From: HIV Case Management Lead/HIV Case Manager

Fax:

Total number of pages including cover page 2

Dear Doctor/Nurse Practitioner,

As you are aware, RETAIN is a new partnership among the BC Centre for Excellence in HIV/AIDS (BC-CfE), Medical Health Officers and Public Health Nurses within the provincial health authorities with the goal to re-engage clients who are lost to care and treatment. Our team is supporting prescribers with referrals to Outreach Team or other services as appropriate.

Attached is a list of clients for whom you are the last known provider. Please complete the list and fax it to (000-123-4567) at your earliest convenience. Alternatively, I can also be reached at (000-123-4567).

Thank you,

HIV Case Management Lead/HIV Case Manager Contact Info

Appendix C - RETAIN Client Letter Template

(Insert Health Authority Logo)

Date:

Dear _____

My name is _____. I work as an (RN, SW, ORW) with Health Authority. In my role, I help individuals reconnect with their health care provider and/or assist individuals to access any health or social services they may need.

If this letter is being sent by a Case Management Team (ei. STOP) use:

The Health Authority has nurses, social workers and outreach workers available to assist with housing applications, finances, food/meal supports, connection to community resources and health care services.

If this letter is being sent by a Communicable Disease Nurse/Public Health use:

I am contacting you on behalf of HSP to offer you supports in seeking medical and social supports.

Please call us at **000-123-456** if you would like any assistance or to confirm that you are already receiving the health care services and other supports you need.

Kind regards,

Enter Health Authority Signature
Address and Contact Information

Appendix D - RETAIN Generic Communication Template

Templates of phone conversation, text or messages/voicemail when contacting clients, (current and new) HSP and other community resources.

Voicemail to client: "I am an [outreach nurse, social worker, outreach worker] with [Health Authority], calling on behalf of [HSP] regarding health matters. Please call me back at [insert phone #) at your earliest convenience."

Voicemail to emergency contacts: "I am an [outreach nurse, social worker, outreach worker] with [Health Authority], calling on behalf of [HSP] regarding routine health follow-ups for [client name]. Please call me back at [insert phone #] at your earliest convenience."

Conversation with HSP: "I am an [outreach nurse, social worker, outreach worker] with [Health Authority] . I was asked by Dr. [insert HA specific MHO name here] to follow-up and connect with you regarding individuals who may have interrupted their HIV treatment. I was wondering if you have a few minutes to discuss [insert client names] current engagement in care?"

Conversation with new HSP or MOA: I am an [outreach nurse, social worker, outreach worker] with [Health Authority]. I help individuals reconnect to health and social services and I was wondering if [insert patient name here] is a regular client to this clinic? Could I also speak with his HSP?"

Leaving messages (paper or in person) with other community services providers: "I am [outreach nurse, social worker, outreach worker] with [Health Authority] and I help individuals reconnect to health and social services I was wondering if you have had any contact with [insert client name]. May I leave a message for this person? If he/she/they is seen, can a message be given to them?"

Sending an email: Copy/paste RETAIN Letter Template for use in an email.

Text messages (please refer to HA specific text and/or mobile messaging policies prior to use): I am [outreach nurse, social worker, outreach worker] with [Health Authority] calling on behalf of [HSP] regarding health matters. Please call me or text me back at [insert phone 3] at your earliest convenience."

Text message to client recently transferred from another health authority (please refer to HA specific text and/or mobile messaging policies prior to use):

We received your personal health information from another health authority so that we could contact you about your treatment and care options in this region. The Freedom of Information and Protection Privacy Act (FIPPA) authorizes them to share information with us in order to help you secure ongoing treatment and care. If you have any questions about this collection of your personal information you can contact _____ Medical Health Office for Health Authority at _____. If you have general questions about our collection of you information or your privacy you can visit [insert health authority privacy website] or call _____.

We would like to provide healthcare support for you and are able to refer you to appropriate health and social services. You can reach me at _____.

Appendix E – RETAIN Initiative Inter- HA Client Referral

BRITISH COLUMBIA CENTRE for EXCELLENCE in HIV/AIDS | Vancouver CoastalHealth | northern health | fraserhealth Better health. Best in health care. | island health | Interior Health

RETAIN Initiative Inter-HA Client Referral

Referred to:	**Referred from:**	**Referral date:**	
Last Name:	**First and Middle Name:**	**Date of Birth (dd/mmm/yy):**	**PHN:**
RETAIN ID:	**ART Status (Interrupted/Naïve):**	**Most Recent pVL:**	**Date of most recent pVL: (dd/mmm/yy)**
Dispense date of last ARV prescription (dd/mmm/yy):	**Physician notes (from physician alert returned to the BC-CfE HIV/AIDS):**		
Client contact information (if known)			
Current Primary Care Provider (if known):	**Contact information:**		
Additional Details:			

Please fax referrals to: Vancouver Coastal Health: 604-297-9672 | Fraser Health: 604-930-5414 | Interior Health: 250-549-6310 | Northern Health: 250-649-7071
Island Health - Central (250-755-7924), North (250-331-8513), or South (250-388-2228)

Inter-HA care transfer of clients referred through the RETAIN Initiative:

- Care can be transferred to a new HA if the client is believed to have moved from the HA to which they were initially referred.
- Designate Nurses may complete a Referral Form to relay all relevant information regarding the client to the appropriate Designate Nurse contact at the recipient HA.
- Designate Nurses will contact the identified Designate Nurses at the recipient Health Authority via phone, and subsequently, secure fax (see below for HA specific contact information).
- Following Care Transfer the BC-CfE must be alerted of the transfer via: duplicate secure fax, phone call or email with RETAIN ID to the RETAIN Project Coordinator, or alert through the RETAIN Intervention Report assembled by the HIV Case Management Lead at each Health Authority.

Vancouver Coastal Health
Secure fax: 604-297-9672
Phone: 778-879-3335

Fraser Health
Secure fax: 604-930-5415
Phone: 604-587-6788

Interior Health
Secure fax: 250-549-6310
Phone: 1-866-778-7736

Northern Health
Secure fax: 250-649-7071
Phone 1-855-565-2990

Island Health
Central Island CD Program Office
Toll free: 1-866-770-7798
Local telephone: 250-740-2616
Secure fax: 250-755-7924

North Island CD Program Office
Toll free: 1-877-877-8835
Local telephone: 250-331-8555
Secure fax: 250-331-8513

South Island CD Program Office
Toll free: 1-866-665-6626
Local telephone: 250-388-2225
Secure fax: 250-388-2228

BC-CfE HIV/AIDS
Contact: Hayden Kremer,
RETAIN Project Coordinator
Phone: 604-682-2344 ext: 66883
Secure fax: 604-806-9044