Programmatic Approaches for Successful Linkage to HIV Care

Amanda Giacomazzo, Laurel Challacombe & Laurie Edmiston, CATIE

What are the findings from this evidence review?

- There is strong evidence to support the effectiveness of short-term strengths-based case management for successful linkage to care.
- There is moderate evidence to support the use of counsellors or linkage to care coordinators for successful linkage to care.
- There is no evidence to support the effectiveness of financial incentives for successful linkage to care.

May 1st & 2nd, 2020

PRESENTED BY

Amanda Giacomazzo, Knowledge Specialist
Contact: agiacomazzo@catie.ca
I have no conflicts of interest

CATIE
Canada's source for HIV and hepatitis C information
La source canadienne de renseignements sur le VIH et l'hépatite C

BACKGROUND

Following a positive HIV test, a client needs to be linked to an HIV clinician for guidance on care and treatment. Early linkage to care can optimize outcomes, including individual (e.g., improved health) and public health outcomes (e.g., reduced transmission of the virus).[1]

The International Panel on HIV Care Continuum Optimization recommends 'immediate referral to HIV care following an HIV-positive diagnosis to improve linkage to antiretroviral therapy (ART). '[1] Research literature defines successful linkage to care as care initiated anywhere from one to 12 months following an HIV diagnosis.[2] This variation is likely related to study publication date, with newer studies adopting shorter timeframes that align with more recent guidelines.

Linkage to care is an important component of the HIV treatment cascade in that it can help people diagnosed with HIV become engaged in HIV care, thereby increasing the likelihood that they will initiate treatment and eventually achieve viral load suppression.

Linkage to care programs can help to overcome the barriers that limit a client's ability to connect to a healthcare provider following a diagnosis of HIV.

BACKGROUND

Program elements identified for optimal linkage to care include (but are not limited to):

- Immediate referral following a positive diagnosis,[1,3] including the use of active referrals (e.g., a tester who makes an appointment for clients and accompanies them to appointment)[3];
- Use of strength-based case management [3,4,5];
- Use of peer support,[6] health navigators[1,6] or case managers[1,6] and linkage support from people with high cultural and linguistic concordance[3];
- Intensive outreach to those who do not engage in care within one month of diagnosis and transportation services to help clients attend clinic visits[1];
- Support for HIV disclosure and streamlined services[6];
- Monitoring of successful entry into HIV care.[4]

METHODOLOGY

- An evidence review was undertaken to summarize research information on linkage to care after an initial HIV diagnosis.
- The key search terms used were HIV, link, linkage and human immunodeficiency virus infection (Embase search term). Searches were limited to research literature published between January 2015 and July 2018 and were focused on North America. Articles were identified using PubMed and Embase as well as through the review of reference lists of relevant articles.
- Literature published before 2015 was included if it was a review article or guideline, or if the article related to interventions that supported Center for Disease Control and Prevention (CDC) evidence-based or evidence-informed interventions.

FINDINGS

Use of linkage coordinators or counsellors

- Two randomized controlled trials, eight observational, one mixed-methods and two qualitative studies indicate that the use of coordinators or counsellors to assist clients one-to-one with linkage to care can be effective.
- The use of short-term strengths-based case management (i.e., working with a case manager that focuses on a client's strengths), has been shown to be effective in linking clients to HIV care through the Antiretroviral Treatment Access Study (ARTAS) intervention.
- ARTAS uses strengths-based case management, provided by a professional case manager, to link people diagnosed with HIV to an HIV clinician. ARTAS provides time-limited assistance and includes five case management sessions over 90 days or until a client is linked to care. The approach includes a case manager: building an effective working relationship with clients; identifying client strengths; meeting clients at a location where they feel comfortable; coordinating and linking clients to community resources; and advocating on clients' behalf for medical care and other services.[7,8,9,10]
- The CDC qualifies the ARTAS intervention as an evidence-based intervention based on results of a randomized controlled trial and a longitudinal cohort study that found positive results.[8,9]

Use of financial incentives

- Results of one randomized trial indicate that financial incentives do not significantly increase linkage to care;[11] however, a qualitative study of the same intervention found favourable attitudes about financial incentives among both clients and service providers.[12]

WHAT DOES THIS MEAN FOR SERVICE PROVIDERS?

Organizations looking to develop linkage to care programs for people following a positive HIV diagnosis should consider linking people to care immediately after diagnosis, although programs may find different ways to operationalize this recommendation.

Approaches that can be integrated into linkage to care programming include the use of:

- active referrals and strength-based case management
- coordinators or counsellors
- peer support, health navigators or case managers

Overall, research shows that more one-to-one or intensive interventions generally lead to better linkage to care than passive referrals to an HIV clinician. Attention should be paid to the local context in which programs are delivered and the needs of individual clients when developing these programs.

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