THE HIV, HOUSING, & EMPLOYMENT PROJECT

ISSUE BRIEF:

INTEGRATING NAVIGATORS INTO CARE SYSTEMS

"Navigator" is a broadly used term encompassing a number of staff titles such as Community Health Worker, Peer Navigator, and Patient Advocate. Navigators are typically non-medical roles within a clinic/agency and depart from traditional case management models by focusing on identifying and addressing client barriers to care and other immediate needs. Navigators can work on a variety of interventions across the HIV Care Continuum to link and engage persons living with HIV (PLWH) into HIV care, support adherence to care plans and medications, and to help PLWH achieve viral suppression. Navigators like other community health workers are able to serve as a bridge between the health care system and the person to address social service needs such as housing and employment in addition to medical needs[1].

Delineation of Roles and Responsibilities:

The integration of Navigators begins with a clear delineation of roles and responsibilities in relation to other staff in order to insure coordinated service delivery and avoid duplication of services. Navigators work closely with Medical Case Managers to support clients in accessing services and resources offered by case managers. Navigators also support clients and the clinical care team by conducting appointment reminder calls, assisting with transportation, coaching clients on ways to interact with health care providers and the larger care and service system, providing HIV education, and accompaniment to appointments. Navigators are different from case managers in that they are more likely to work out in the community rather than one system. They may have smaller caseloads and can help with providing more intensive services such as connection to housing or behavioral health treatment, when case managers do not have time due to larger caseloads. Once identified and outlined, roles and responsibilities should be distributed to all staff to support a shared understanding, and should be revisited and updated as project needs and resources dictate[2,3].

Inclusion in Team:

Navigators play an important role in the clinical/agency care team. Because of the close, trusting relationship they build with clients, Navigators may be more likely to have conversations with clients that identify circumstances that challenge their ability to effectively engage and remain in systems of care. Navigators should be included when discussing daily patient panels and/or during ongoing patient care plan meetings. Clients may also need support throughout the day, including after business hours. It is therefore important to establish care team protocols for when it is appropriate for a navigator to address client emergencies and for communicating with each other during, and after business hours. As part of the care team, Navigators can also play a vital role in quality improvement activities at the clinic/agencies. As the member of the care team who can provide education and follow up reminders to

Additional Resources

This brief provides a general overview of best practices for integrating a Navigation model/intervention into a clinic or services agency. For more information, see the following links:

Tips for outreach worker safety: https://www.homelesshub.ca/resource/tips-outreach-workers-outreach-workers

Staffing and supervision for effective interventions: https://effectiveinterventions.cdc.gov/stepstocare/topics/staffing-and-supervision

Best practices in integrating peer navigators into HIV models of care: https://www.aidsunited.org/data/files/Site_18/PeerNav_v8.pdf

Peer Re-Engagement Project: https://ciswh.org/project/minority-aids-initiative-retention-and-re-engagement-in-hiv-care-project/

The GMT initiative: https://www.amfar.org/uploadedFiles/_amfarorg/Articles/Around_The_World/GMT/2015/GMT%20Patient%20Navigation%20071015.pdf

Patient navigator program tools: https://aidsetc.org/resource/patient-navigator-program-tools

Engagement in care toolkit: https://aidsetc.org/page/engagement-care-toolkit-evidence-based-interventions

[1] Sarango, M., de Groot, A., Hirschi, M., Umeh, C. A., & Rajabiun, S. (2017). The Role of Patient Navigators in Building a Medical Home for Multiply Diagnosed HIV-Positive Homeless Populations. *Journal of public health management and practice : JPHMP*, *23*(3), 276–282. doi:10.1097/PHH.0000000000000512

[2] Dohan, D, Schrag, D. Using navigators to improve care of underserved patients: current practices and approaches. *Cancer.* 2005; 104: 848– 855.

[3] Katherine Pincura & Chidinma Okafor (2019) Defining the linkage specialist role in the HIV care cascade, Journal of HIV/AIDS & Social Services, DOI: 10.1080/15381501.2019.1599749

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patients, navigators may have information about resources and needs to improve services for persons who are at risk for falling out of care.

Access to Electronic Health Records (EHR) and Client Data Systems:
Full permissions to internal EHRs or client data systems is key to supporting the work of the Navigator. The Navigator must have the ability to read provider and staff documentation of client visits, care plans as well as be able to document their client visits with patients. This supports easy and systematic sharing of information regarding a client's health, immediate problems/challenges, and service needs. In addition, read and write access to EHR and other data systems professionalizes the Navigator role and solidifies the role as equal to others on the care team.

Clinical Supervision:
In addition to administrative supervision provided to staff, many programs also provide clinical supervision, to mental health, behavior health, and case management staff. However, very few provide clinical supervision to Navigators. Clinical supervision is important for Navigators in the care team since this type of supervision supports and guides the development of one's professional skills and gives tools to address the challenges with engaging patients in care and treatment. The high needs of clients and the effort required to build relationships with clients can be intense and challenging, and can affect the daily life and mental health of Navigators. At a minimum, Navigators should have a regularly scheduled monthly one-on-one clinical supervision appointment with a licensed mental health practitioner (MSW, LCSW) who is not their administrative supervisor. In addition, Navigators should have access to clinical supervisors in person or by phone as needed during business hours.

Working Inside and Outside of the Clinic/Agency Walls:
The role of the Navigator requires flexibility to meet the needs of the position and of the protocols of the clinic/agency. Because of the nature of the position, the Navigator must be able spend time outside of the agency walls and at times outside of the traditional agency hours. Activities may include outreach to locate clients, meetings with clients at public places such as the library, a coffee shop or other service agencies, accompaniment to client appointments, and meetings with partner agencies to build and maintain client referral networks. It is strongly recommended agencies develop policies to guide and support staff safety when working outside of the office such as:

- Prior to leaving the office, will make sure cell phones are charged and other staff are informed of the locations to be visited with an estimated timeline and route.
- Staff will work in pairs using a buddy system approach to maintain contact and safety.
- Keep personal items to a minimum and dress appropriate for the task.

Champion:
A champion is a person in a position of authority (such as a clinic administrator, a medical director or agency director) who supports and advocates for the adoption and integration of a Navigation model. In many cases, Navigators are representative of the community they are working with and may not have higher education or credentials. The champion should work with human resources to draft and approve a job description and qualifications to identify and hire the appropriate Navigator. The champion will also introduce and continually promote the Navigation model with agency/clinic staff as a resource that can assist high acuity clients in accessing needed resources, and engaging and remaining in HIV care. The champion should also promote the Navigation model with partner agencies, local and state funders, local consortium, and community groups.

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