Co-locating Care Management Staff and Peers in Medical Clinics

Intervention Implementation Guide

HRSA
Ryan White HIV/AIDS Program

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This publication lists non-federal resources in order to provide additional information to those considering replication. The views and content in these resources have not been formally approved by HHS or HRSA. Neither HHS nor HRSA endorses the products or services of the listed resources.

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Co-locating Care Management Staff and Peers in Medical Clinics Intervention

This guide examines the Co-locating Care Management Staff and Peers in Medical Clinics intervention facilitated by Alliance for Positive Change (Alliance), a community-based organization, and Ryan Health, a Federally Qualified Health Center (FQHC). These New York City-based organizations launched a medical-community partnership to facilitate a linkage to care program re-engaging HIV clients in care and decreasing missed appointments. Alliance receives funding from the Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) Part A and allocates some of those resources to this project. The intervention also receives funding from Medicaid generated through the Health Home Care Management initiative, which provides care management services for Medicaid enrollees who have two or more chronic medical conditions. Alliance has sustained this program through the use of these funding mechanisms.

Ending the HIV Epidemic in the U.S. Pillar: Treat

HIV Care Continuum Stage: Linkage to Care; Retention in Care

Priority Population: People with HIV Not Engaged in Care

Setting: Co-located in a Federally Qualified Health Center (FQHC) and a community-based organization (CBO)

Clients who qualify for RWHAP services often face significant barriers to engaging in treatment and care.[1,2] Barriers include complex medical histories such as HIV comorbidities, unaddressed mental health concerns, and other chronic conditions, coupled with low socioeconomic status, unstable housing, limited access to transportation, and stigma.[3] These clients may defer care, resulting in missed appointments and declining health, leading to greater use of emergency care, lack of HIV viral suppression, and excess morbidity and mortality.[4,5] Clients facing these difficulties often require enhanced engagement and support efforts, such as those provided by a peer navigator.[6] Mitigating missed appointments and emergency room visits also represents a cost savings opportunity that could result in preventive care and support services for additional patients.[7]

Ryan Health and Alliance worked together to establish a co-located linkage to care intervention to address the challenges created by missed appointments and emergency room care. Alliance Health Home Care Managers and Peer Navigators co-located at both agencies worked to contact and re-engage clients in treatment and care using a list generated by Ryan Health's electronic medical records (EMRs), containing RWHAP clients with chronic conditions who had fallen out of care. The approach facilitated real-time data sharing, onsite case conferencing between Health Home Care Managers and medical providers, and fast-tracked client access to medical appointments.

This guide details vital components of this intervention, outlines the capacity required by organizations to conduct this work, and includes replication steps to support others in their implementation efforts. Finding replicable interventions that meet Ending the HIV Epidemic in the U. S. (EHE) initiative goals and support clients along the stages of the HIV care continuum is critical to future programmatic and client success in HIV care.[8]

ACHIEVEMENTS

Intensive field-based outreach to clients lost to care was integrated into clinical settings, enabling real-time data exchange and onsite case conferencing between Health Home Care Management team members and medical providers. The intervention also fast-tracked client access to medical appointments, resources to address social determinants of health, wraparound services, and, as needed, Home and Community-based Services education to access Health and Recovery Plans (HARPs) services. In 2022, the intervention re-engaged 43 percent of clients in care. Among those enrolled, 98 percent had at least two primary care physician appointments in the past 12 months, and 100 percent were consistently engaged with the care management team every month.

About SPNS

The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services (HHS), is the primary federal agency for improving healthcare to people who are geographically isolated, economically or medically vulnerable. The Ryan White HIV/AIDS Program (RWHAP) Part F: Special Projects of National Significance (SPNS) Program is administered by HRSA's HIV/AIDS Bureau (HAB). The RWHAP SPNS Program supports the development of innovative models of HIV care and treatment to quickly respond to emerging needs of clients served by the RWHAP. RWHAP SPNS advances knowledge and skills in the delivery of healthcare and support services for people with HIV who have not been successfully maintained in care. Through its demonstration projects, RWHAP SPNS evaluates the design, implementation, utilization, cost, and health-related outcomes of treatment models while promoting the dissemination and replication of successful interventions.

Funding Source

The featured intervention receives funding from the Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) Part A and allocates some of those resources to this project. The intervention also receives funding from Medicaid generated through the Health Home Care Management initiative, which provides care management services for Medicaid enrollees who have two or more chronic medical conditions. The Health Home Care Management initiative is a Medicaid program established through the Affordable Care of 2010 Section 2703 (1945 of the Social Security Act).

Both Alliance and Ryan Health have been able to offset other costs by taking on aspects of the program "in-kind."

To learn more about the Ryan White HIV/AIDS Program, visit: **https://ryanwhite.hrsa.gov**.

To learn more about Medicaid, visit: **https://www.medicaid.gov**.

Getting Started

This table provides a general overview of the Co-locating Care Management Staff and Peers in Medical Clinics intervention so readers can assess the necessary steps required for replication. This intervention facilitates linkage to care through the co-location of services for those with HIV with complex medical health care needs.

INTERVENTION AT-A-GLANCE	
Step 1	**Bring Partners Together and Generate Buy-in** Convene community and clinical partners to delineate how the intervention will be facilitated, including how staff will work together, track, and coordinate intervention activities. Bring staff together and coordinate the review of the intervention to ensure an understanding of its purpose and partner expectations.
Step 2	**Establish Co-location Team** Establish a Health Home Care Management team consisting of a Health Home Care Manager (and Assistant Health Home Care Manager and Health Home Care Coordinator, as appropriate) and Peer Navigators at the clinical partner location trained in reading electronic health records (EHR), HIPAA compliance, informed consent, etc. Establish staff oversight for each intervention component.
Step 3	**Embed Team at Clinical Partner Site** Identify agreed-upon space at the clinical provider location for community staff. Generate standard operating procedures and evaluation metrics.
Step 4	**Work with Clinical Provider to Generate a List of Clients Who Need Services** The clinical partner generates a list of clients who have missed appointments; experienced two or more emergency department visits in the past year; and/or have fallen out of care using EHR and population health databases.
Step 5	**Review the Needs of Identified Clients Requiring Services** Participate in case conferencing at the clinical partner location to address clients' needs identified through EHR and population database record reviews.
Step 6	**Implement Provider Peer Navigation** Engage identified clients at the clinical partner location, participating in onsite case conferencing, access to medical appointments and wraparound services. Contact clients not at the clinical provider location through virtual and in-person engagements. Ensure client "alignment" with clinical care (two or more consecutive visits in a 12-month period).
Step 7	**Conduct Regular Team Meetings** Hold cross-organizational team meetings for stakeholders from both the community and clinical partners to review and refine protocols and review evaluation metrics.

RESOURCE ASSESSMENT CHECKLIST

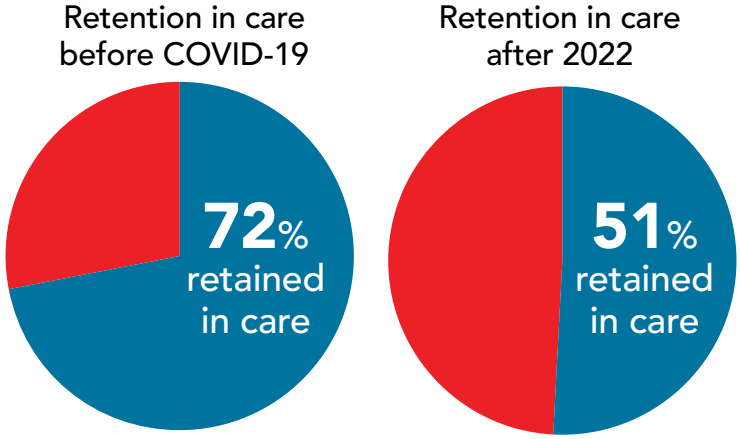
Prior to implementing the intervention, organizations should walk through the following Resource Assessment (or Readiness) Checklist to assess their ability to conduct this work. If organizations do not have the recommended readiness, they are encouraged to develop their capacity so that they can successfully implement this intervention. Questions to consider include:

- ❑ Does your organization have a relationship with a potential clinical partner, such as a Federally Qualified Health Center (FQHC), FQHC-lookalike, hospital, or other medical facility?
- ❑ Does your organization have experience working with clinical providers and/or assigning staff to work onsite at a clinical facility?
- ❑ Does your organization have experience working with people with HIV with two or more chronic conditions?
- ❑ Does your organization have experience connecting clients with HIV testing, treatment and care and other services, such as those related to housing, recovery, job placement and readiness, and self-sufficiency?
- ❑ Does your organization leverage peer navigators or counselors to work with clients? If not, are you able to leverage current staff to serve in this role?
- ❑ Are your staff culturally responsive, compassionate, and interested in working with persons with HIV not currently engaged in care?
- ❑ Are your staff interested in receiving training to work in a clinical setting to facilitate the delivery of co-located services?
- ❑ Are your staff trained in Motivational Interviewing techniques to help clients re-engage in care? If not, are you able to provide training?
- ❑ Does your organization have experience collecting, maintaining, and disseminating client data to facilitate case conferencing between care managers, peer navigators and medical providers?

Setting the Stage

Research has shown that ongoing engagement in treatment and care can help ensure people with HIV achieve optimal health outcomes,[9] including viral suppression, management of co-morbid and chronic conditions, and access to wraparound services, such as housing and transportation support.[10] Despite the myriad benefits of treatment and care, the Centers for Disease Control and Prevention (CDC) report that only 62 percent of people with HIV are linked to medical care.[11] COVID-19 exacerbated challenges to engagement in care, resulting in an increase in missed appointments and, as a result, a decrease in retention in care among people with HIV (defined by HRSA as two visits with a gap of 90 days or more during the first year following diagnosis) from 72 percent before the pandemic to just over 51 percent in 2022.[12]

62% of people with HIV are linked to medical care.



People with HIV who miss their initial clinical visit[13] and/or follow-up appointments during the first two years of HIV treatment are less likely than those who keep appointments to achieve virologic suppression.[14] These clients also tend to have higher rates of hospitalization, morbidity and mortality.[15,16] These outcomes disproportionally impact people with HIV from sexual and gender minorities, youth, and racial and ethnic minority groups[17] due to their greater likelihood of low socioeconomic status, unstable housing, limited access to transportation, and stigma.[18] These factors are often further complicated by complex medical conditions and histories characterized by unaddressed HIV, comorbidities, and other chronic conditions.[19]

Missed appointments speak not only to the personal challenges faced by clients and their communities but also to gaps in care provided by clinical organizations. Providers have limited time to meet with patients and engender trust, leaving them little opportunity to fully understand client needs, deliver optimal care, and encourage them to return.[20] People with HIV often benefit from enhanced engagement and support, such as that provided by a peer navigator, to re-engage in care and attend HIV care appointments.[21,22,23]

Description of Intervention Model

CHALLENGE ACCEPTED

The Challenge: Leverage a partnership with a clinical organization to identify and re-engage people with HIV who have two or more complex, chronic health conditions and missed appointments.

"Doctors cannot see the home life of the client. However, peer navigators can. Instead of white coats, we wear sneakers, jeans, and sweatshirts, go into the community, and relate to clients. We provide them education and help them come in for care."

Cynthia Rossi,
Director of Care Management and Treatment Support,
Alliance for Positive Change

In the Co-locating Care Management Staff and Peers in Medical Clinics intervention, a community organization works with a clinical partner, such as a hospital, to identify, share information, re-engage, and fast-track linkage to medical appointments and wraparound services for people with HIV who have fallen out of care. Rather than work in silos, the intervention calls for active interconnectivity between community organizations and a clinical partner through dedicated co-location of Health Home Care Management staff at the clinical partner site.

The approach facilitates real-time data sharing, onsite case conferencing between Health Home Care Management team members and medical providers, and fast-tracked client access to medical appointments. Health Home Care Managers participate in clinical case conferences about clients with HIV who have fallen out of care and in need of peer navigation support, as identified by the clinical partner through EHRs. Sharing details from peer navigation encounters with clinical staff provides insight into clients' lived circumstances including barriers to care, supporting the delivery of tailored treatment

plans and the establishment of accurate medical records. For instance, community managers might share that a client has moved to a new clinic or is experiencing substance use issues and unstable housing, enabling clinical staff to update their client's medical records and adjust their treatment plans, as appropriate.

Overall, establishing care management teams with Health Home Care Management staff provides clinical personnel with in-depth knowledge about clients' medical and social support needs, resulting in tailored linkage to care, treatment, support, and faster "alignment" with medical care (two or more consecutive visits in a 12-month period).

Intervention Steps

1. *Establish the community-clinic partnership.* Before programmatic activities can begin, community organizations must identify a suitable clinical partner and establish a relationship. Negotiations will need to occur concerning how best to fund these activities, where Health Home Care Management staff will be located at the clinic site, and with whom they will work. Partners may wish to conduct interviews and focus groups with staff, review client EHRs and peer navigation reports, as well as state and local epidemiological data and ending HIV epidemic plans, such as Getting to Zero and Ending the HIV Epidemic in the U.S. (EHE), to determine the prevailing needs to be met through this partnership.

2. *Identify priority populations and their needs.* The community and clinic partner need to establish parameters concerning the client population of focus as well as the data to be used to generate lists of clients needing to be re-engaged in care. This particular intervention focused on clients who missed one or more appointments in the last nine months; had two or more emergency department visits in the past year; or had otherwise fallen out of care. Partners may consider collecting information from clients (via interviews or surveys) to determine gaps and needs of the priority population.

3. *Develop a co-location strategy and staffing policy.* Generate policies and procedures to ensure staff alignment and management at both locations. Establish schedules for co-located staff including with whom they will be working onsite and determine how resources will be managed between each location.

a. Alliance refers to their co-located teams as hubs, which are led by a supervisor, generally called a Health Home Care Manager--a position funded through Medicaid. The manager may be supported by an Assistant Health Home Care Manager and a Health Home Care Coordinator. Each of these positions is matched

with a Peer Navigator who works primarily from the community partner office and in the field.

4 *Identify staff training needs.* Staff must complete rigorous training before implementation of the intervention. Co-located Health Home Care Management staff working at the clinical partner site must undergo patient engagement training, such as peer navigation and cultural responsiveness. In addition, they must complete training fulfilled by clinical staff, including EHR management, HIPAA compliance, informed consent, and clinical investigation training (e.g., through the Collaborative Institutional Training Initiative or CITI Program). Community and clinical partner staff may need additional communication training to facilitate reporting and records management on community-clinical case management briefings and grand rounds.

5 *Generate client list.* The intervention begins with a list of clients generated by the clinical partner based on the established priority population and data parameters. This intervention is designed to re-engage people with HIV with two or more chronic conditions who have missed appointments and visited the emergency room.

6 *Assess client needs.* Co-located community personnel (care managers and peer navigators) work with medical providers on case reviews and grand rounds, which are real-time exchanges of information about clients' current lived circumstances and their clinical and wraparound service needs. This results in up-to-date EHRs and fast-tracking to services, as needed.

7 *Engage in peer navigation.* Once clients are identified, peer navigators, who work directly with the co-located Health Home Care coordination team, leverage their training in Motivational Interviewing and health promotion to re-engage clients in care and wraparound services. Peer Navigators use an escalation approach to engaging clients who have fallen out of care. They first contact clients via telephone, attempting to initiate contact for up to three days. If they cannot connect with the client via telephone, a letter is sent to their last known address. If there is no response after two weeks, the Peer Navigator will conduct an in-person visit, meeting clients where they are, engendering trust through shared lived experience and communication skills. The information they glean about clients' lives and circumstances can help the Health Home Care and clinical team adjust treatment and care delivery.

STAFFING REQUIREMENTS & CONSIDERATIONS FOR REPLICATION

Staffing/Organizational Capacity

The following staffing requirements focus on the needs of the community organization. Staff at these organizations usually operate as a "Hub," led by a Health Home Care Manager, a supervisory position funded through Medicaid dollars, which supports medical, behavioral and wraparound support services for people with HIV with chronic conditions who have fallen out of care. The Health Home Care Manager oversees 50–55 client cases and may be supported by an Assistant Health Home Care Manager, who can help oversee 45–49 client cases, and a Health Home Care Coordinator, who can co-manage 40–45 client cases. Each of these positions is matched with a Peer Navigator who works with clients directly in the field and helps facilitate communication between the community and clinical partner.

- *Health Home Care Manager:* The Health Home Care Manager works onsite at the clinical location, coordinating with clinical staff to review cases of clients with HIV who have fallen out of care. The Health Home Care Manager presents updates during case conferences and grand rounds; updates client medical records; and works with Peer Navigators to ensure clients are re-engaged in care and connected to wraparound services. Additionally, the Health Home Care Manager alerts clinical partners of clients who cannot be found, have moved, or shifted to different medical providers.
- *Assistant Health Home Care Manager:* Co-located at the clinical location, the Assistant Health Home Care Manager reports to the Health Home Care Manager, supporting the review and presentation of data during case conferences and grand rounds and working with Peer Navigators to facilitate outreach to clients, updates to their EHRs, and connection to services.
- *Health Home Care Coordinator:* Reports to the Assistant Health Home Care Manager, supporting data sharing with the clinical partner team during case conferences and grand rounds and working with Peer Navigators to re-engage clients who have fallen out of care.
- *Peer Navigator:* Leverages Motivational Interviewing and health promotion strategies to engage communities and individual clients needing HIV and wraparound services, including screening, enrollment, linkage to care, and accompaniment to appointments. They work directly with the co-located Health Home Care Management team, providing detailed information about the lived experiences and circumstances that clients may not share with clinicians.

Staff Characteristics

Core competencies include:

- Experience in re-engaging people with HIV who have two or more chronic conditions and/or have fallen out of care
- Willingness to engage in diverse training to work in a co-located (clinic-based) position
- Ability to communicate and work in team settings with diverse staff in community and clinical settings, as well as with clients who may be experiencing challenges in engaging in care
- Knowledge of relationships between HIV health outcomes and comorbidities, chronic conditions, behavioral health needs, stigma, care engagement and social determinants of health

Replication Tips for Intervention Procedures and Client Engagement

This section provides tips for readers interested in replicating the intervention and, where applicable, examples for further context. Tips to successfully replicate the Co-locating Care Management Staff and Peers in Medical Clinics intervention include the following:

Hire strong leaders. Individuals leading this work will need to be able to facilitate working relationships with both the community and clinical locations, as well as the community. That necessitates hiring managers who have experience working with the community being served. They also should have experience supervising Peer Navigators and, ideally, working with medical providers in a clinical setting. Intervention leads must be able to clearly communicate client needs in clinical team settings, such as case conferences and grand rounds, ensuring clients' EHRs are updated, and their care plans are tailored.

Strategically approach training. This intervention demands a unique level of training for all involved staff. In addition to community-based training related to case management and peer navigation, such as Motivational Interviewing, intervention staff working in clinical settings must also undergo health worker training in EHR management and culturally responsive care delivery. Facilities are encouraged to have staff complete a peer training institute, like that operated by Alliance, and leverage trainings provided through the CITI Program. Other trainings, such as time management, may demand a more customized curriculum drawn from organizational experience and human resources courses.

Leverage funding streams. Identify flexible funding streams that augment what is available through the RWHAP, such as the Medicaid Health Home Care Management program. Additional resources, such as Federal, state, and local rent subsidy programs and private grants, can expand the services the community-clinical partnership can provide clients.

Share resources and information. This intervention depends on the community-clinical partners' ability to clearly share information. Establish evaluation parameters to monitor operations and hold regular cross-team meetings to share updates and discuss areas for improvement. In addition, hold annual retreats for community-clinical staff, where they can review and strategize improvements to intervention logistics, protocols, and case conferencing approaches for more complex clients.

Securing Buy-in

To secure the buy-in of leadership, staff, and other relevant stakeholders for the intervention, consider the following:

- ***Cleary detail the gaps in care experienced by clients*** and how this co-located intervention will address them more quickly and effectively.
- ***Emphasize how tailored treatment plans help clients with chronic conditions*** and a track record of missed appointments come into alignment with medical care more quickly. These clients are subsequently better positioned to experience fewer missed appointments and better patient outcomes.
- ***Ensure that all stakeholders are at the table*** from the start of the negotiation process. These may include funding managers as well as organizational Board representatives.
- ***Leverage the services of a consultant*** to help facilitate intervention planning and implementation, as needed, and hold regular meetings to ensure all partners remain informed and involved.

Overcoming Implementation Challenges

Challenges that may arise when implementing this new intervention include the following:

- ***Staff burnout and turnover.*** This intervention demands a high level of skill, attention to detail, and engagement with staff working across two agencies and in the community. High staff turnover can lead to a loss in institutional knowledge. This can be mitigated through ongoing training and record keeping, ensuring that junior staff can be readily promoted, and newly recruited staff have the resources necessary to learn the job quickly.
- ***Power imbalances.*** Community and clinical settings will most likely need to anticipate possible power dynamics between their organizations. Clinical settings often are better resourced than their community counterparts. They may encourage community personnel to leave their organization and join the clinical organization at a higher salary or not take the information provided by the Health Home Care Management team fully into account. Health Home Care Management staff, in turn, may not find the right tone in community client needs during case conferencing and grand rounds, either coming on too strong or deferring too much to medical providers. These issues can be addressed through training, regular partner meetings, and annual retreats to re-evaluate intervention operations.
- ***Institutional silos.*** To overcome institutional silos and work in a collaborative care model, co-located community and clinical staff must establish strong relationships that clearly define work schedules (particularly now that many employees work from home several days a week) and physical workspaces. These approaches are key to developing strong working relationships and collaboration to benefit clients.

Promoting Sustainability

Alliance has grown this program through the innovative use of diverse funding mechanisms, notably by using RWHAP Part A funds and Medicaid dollars generated through the Health Home Care Management initiative. Revenue is additionally generated through case management facilitated by the Health Home Care Management Team. Alliance and Ryan Health offset other costs by taking on aspects of the program "in-kind." Alliance has since leveraged this approach in expanding their co-location model in working with other clinical locations.

BY THE NUMBERS

The intervention has sustained an enrollment of **50–60 clients each year**, most of whom are:

- >65 years old
- Disabled with multiple chronic conditions
- Spanish-speaking
- Residents of Upper Manhattan or the Bronx

In 2020:

98% had at least 2 primary care appointments in the past 12 months.

100% were engaged with the Health Home Care Management team monthly.

Conclusion

The Co-locating Care Management Staff and Peers in Medical Clinics intervention represents an innovative approach to ensuring people with HIV with two or more chronic conditions who have missed appointments, are re-engaged in care. Rather than working in silos, the intervention brings community care into the clinical setting. Community organizations can access lists of clients needing intensive navigation support, while clinical settings benefit from information about clients' lived circumstances gleaned through peer navigation encounters, often not shared during clinical appointments. The approach facilitates tailored linkage to care, treatment, and support for clients dealing with chronic conditions and life circumstances, such as unstable housing and lack of transportation, that can create significant barriers to care. A community-clinic partnership can ensure patients are more quickly re-engaged in care tailored to their needs, resulting in faster alignment with medical care.

OTHER AVAILABLE RESOURCES

Co-locating Care Management Staff and Peers in Medical Clinics Intervention Resources

Co-locating Care Management Staff and Peers in Medical Clinics Intervention:
https://targethiv.org/intervention/co-locating-care-management-staff-and-peers-medical-clinics

Alliance/Ryan Health Pilot Project: Care Management & Peer Navigation Presentation from the 2020 National Ryan White Conference on HIV Care and Treatment:
https://targethiv.org/sites/default/files/RWNC2020/16080_Duke.pdf

Additional Replication Resources

Integrating HIV Innovative Practices (IHIP):
https://targethiv.org/ihip

Best Practices Compilation:
https://targethiv.org/bestpractices/search

HIV Care Innovations:
https://targethiv.org/library/hiv-care-innovations-replication-resources

Need Help Getting Started?

If you are interested in learning more about this intervention or other interventions featured through the Integrating HIV Innovative Practices project or want to request technical assistance, please email: **ihiphelpdesk@mayatech.com**

Subscribe to our Listserv

To receive notifications of when other evidence-informed and evidence-based intervention materials, trainings, webinars, and TA are available through the Integrating HIV Innovative Practices project, subscribe to our listserv at: **https://targethiv.org/ihip**

Tell Us Your Replication Story!

Are you planning to implement this intervention? Have you already started or know someone who has? We want to hear from you. Please reach out to **SPNS@hrsa.gov** and let us know about your replication story.

Endnotes

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