2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Learning Objectives

At the conclusion of this activity, the participant will be able to:

1. Define different forms of patient navigation using a patient-centered approach, and describe strategies used by Grady IDP to differentiate and communicate different styles of patient navigation within the same clinic.
2. List 3-5 strategies that patient navigators can use to form personal connections with patients and to ensure that they are understanding the patient's needs in a whole-person context.
3. Discuss the structure of interdisciplinary case conferences, including data reporting needs, and how they can be used to promote viral suppression.

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When Job Titles Are The Same and Position Descriptions Vary: Defining Patient Navigation

Tajma Washington, Grady Health System

Alexis Marbach, Abt Associates; Hannah Bryant, AIDS United

Disclosures

Presenter(s) has no financial interest to disclose.

This continuing education activity is managed and accredited by AffinityCE/Professional Education Services Group in cooperation with HRSA and LRG. PESG, HRSA, LRG and all accrediting organization do not support or endorse any product or service mentioned in this activity.

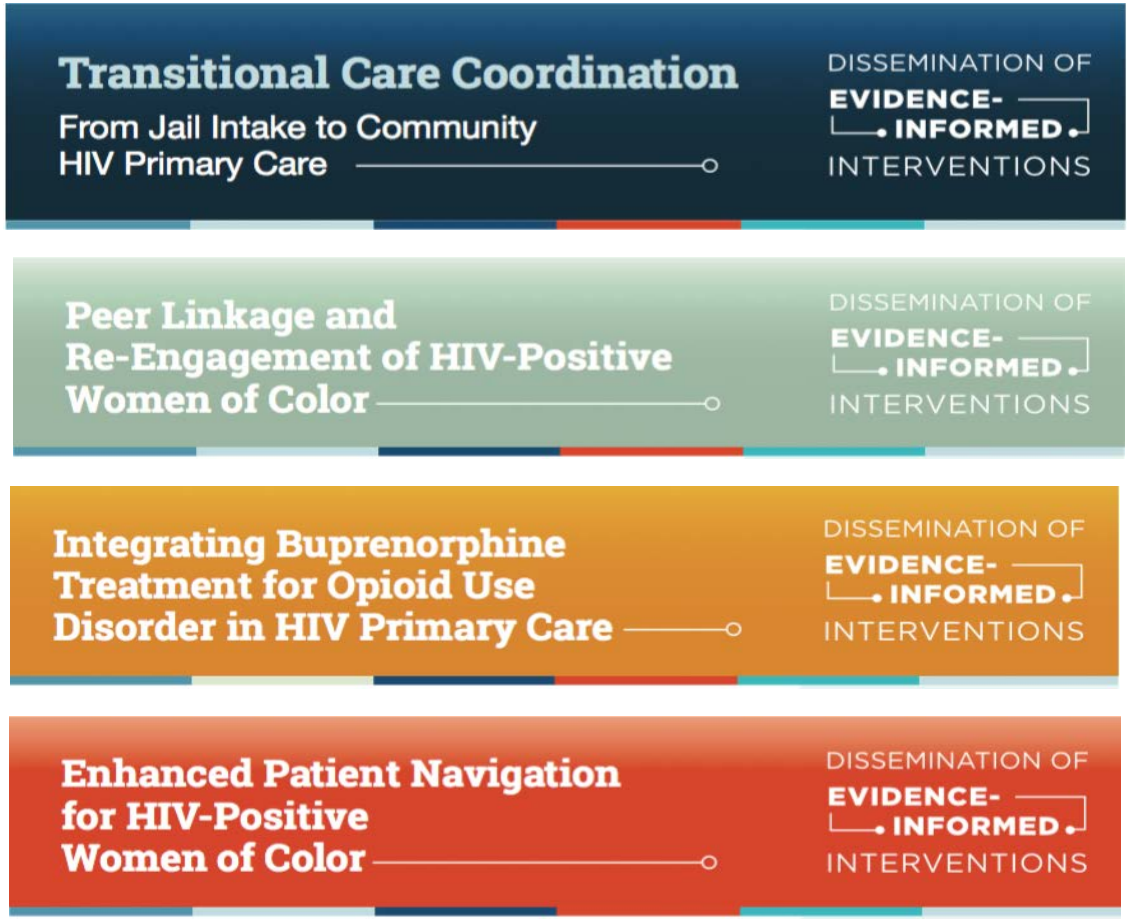
PESG, HRSA, and LRG staff as well as planners and reviewers have no relevant financial or nonfinancial interest to disclose.

Commercial Support was not received for this activity.

Project Background

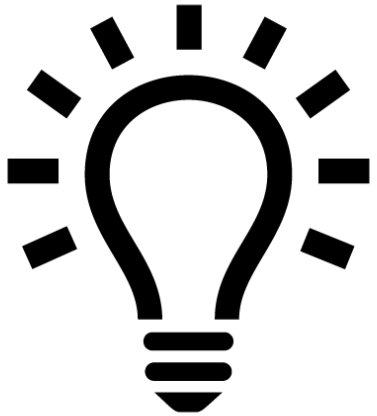
- Four-year Cooperative Agreement with HRSA's Special Projects of National Significance (SPNS)
- Funding amount of $3 million/year for the ITAC, with $2.4 million going to implementing sites
- Replicates four previously-implemented SPNS initiatives

Interventions Being Replicated



AIDS United: Implementation and Technical Assistance Center (ITAC)

Select & Fund 12 Sites

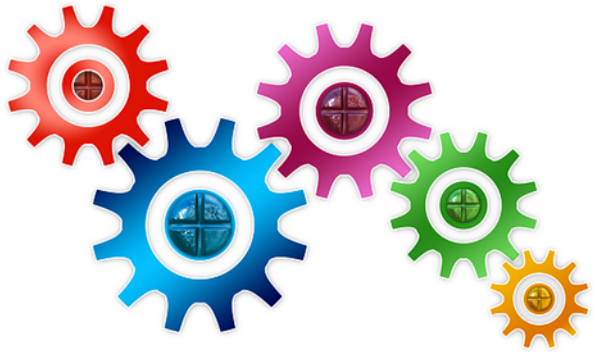


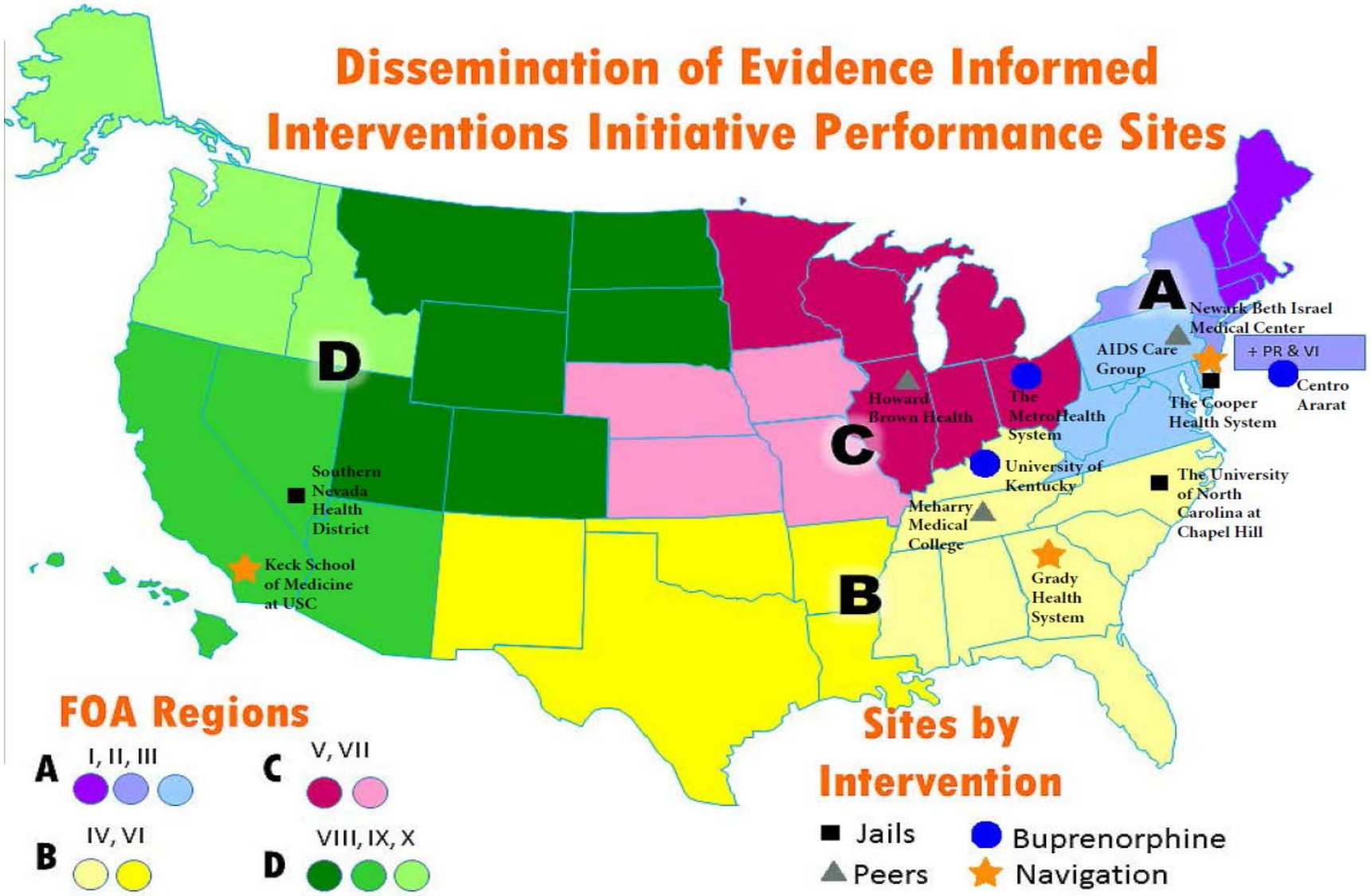
Provide TA

Coordinate Experts

Boston University: Dissemination and Evaluation Center (DEC)

- Adapt and design 4 intervention models for replication.
- Design and implement multi-site evaluation
- Studying both patient outcomes (including retention in care and viral suppression) and implementation findings (what works in practice and what facilitates/hinders implementation)
- Publish and disseminate final adapted interventions and study findings




Dissemination of Evidence Informed Interventions Initiative Performance Sites
A
B
C
D
Newark Beth Israel Medical Center
AIDS Care Group
+ PR & VI
Centro Ararat
The Cooper Health System
Howard Brown Health
The MetroHealth System
University of Kentucky
Meharry Medical College
The University of North Carolina at Chapel Hill
Grady Health System
Southern Nevada Health District
Keck School of Medicine at USC
FOA Regions
A I, II, III
B IV, VI
C V, VII
D VIII, IX, X
Sites by Intervention
Jails
Peers
Buprenorphine
Navigation

Enhanced Patient Navigation for Retention of Women of Color in HIV Care

Utilizes patient navigators to retain women of color living with HIV who are experiencing at least on of the following:

- they have fallen out of care for 6 months or more,
- are loosely engaged in care (have cancelled or missed appointments),
- are not virally suppressed,
- and/or have multiple co-morbidities

With the goal of increasing retention in care and achieving viral suppression.

Time frame of the intervention: Patient navigators will work with patients for a minimum of 6 months and a suggested maximum of 12 months. After 6 months, patients will be reassessed every 3 months using an acuity based system to determine if they still need the support of the navigator.

DEII Intervention Patient Navigator Core Activities

- Identify potential clients
- Conduct screening, assessment, and goal planning
- Deliver 6 structured client educational sessions
- Support client in making healthcare appointments, attend healthcare visits with clients, provide ancillary support
- Participation in multi-disciplinary team meetings
- Transition clients to standard of care case management

Patient Navigation: Literature Review

There is no one, universally accepted definition of patient navigation, the tasks of a patient navigator, or the credentials/training necessary to become a patient navigator.

Patient navigation was more likely to be positively associated with linkage to care, retention in care, and viral suppression than with antiretroviral (ART) uptake or ART adherence.

- Based on systematic literature review, “Is HIV patient navigation associated with HIV care continuum outcomes”, conducted by Mizuno, Higa, Leighton, Roland, Deluca, and Koenig (2018).

Patient Navigation: Clarifying roles and responsibilities

Patient navigation is a model of care coordination that shares characteristics with advocacy, health education, case management, and social work (Bradford JD, Coleman S, Cunningham W. HIV system navigation: An emerging model to improve HIV care access. AIDS Patient Care and STDs 2007; 21(Suppl 1): S49-S58.)

Patient navigation activities include (but are not limited to):

- Accompanying clients to appointments
- Coordinating appointments
- Providing non-clinical, ancillary support services (food, clothing, transportation, housing assistance)
- Providing HIV education and information
- Providing referrals for HIV care and additional medical services
- Relationship building

Patient Navigation: Clarifying roles and responsibilities

Backgrounds, training, and credentials:

- Some patient navigators have been “peers” to their clients, some have nursing or clinical social work degrees
- Staff vs. volunteer status

Boundaries:

- Boundaries between PNs and CMs vary; some PNs provide case management services, and some PNs work along side case managers to provide support in separate lanes

Structure:

- Structured intervention (e.g. with education sessions and specific goals) vs. plans based on the individual and their particular immediate needs and goals
- Transitioning to the standard of care vs. being the standard of care
- Based in the office vs. out in the community (or a combination of the two)

Grady Team

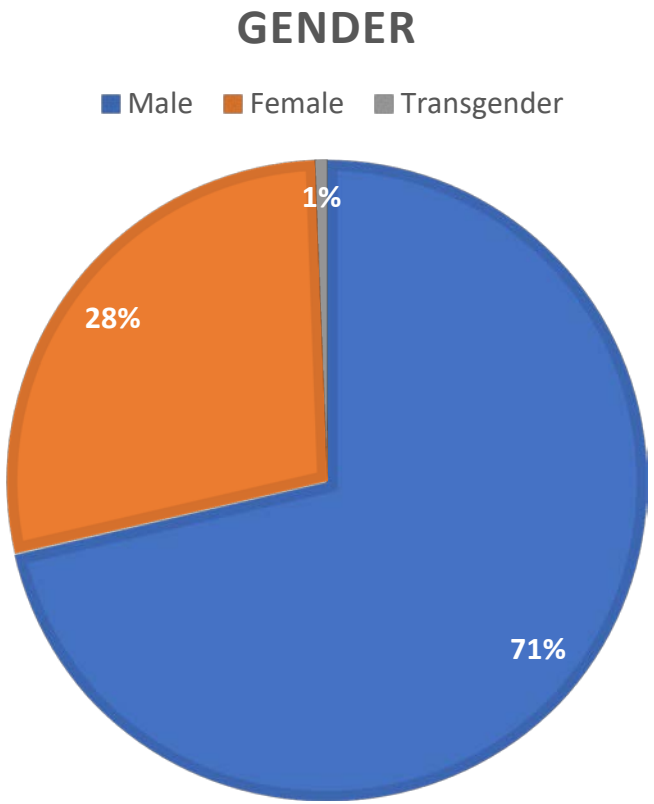
Pictured above left to right: Larisa Niles-Carnes, Tajma Washington, Lucy Smith, Gina Bailey-Herring

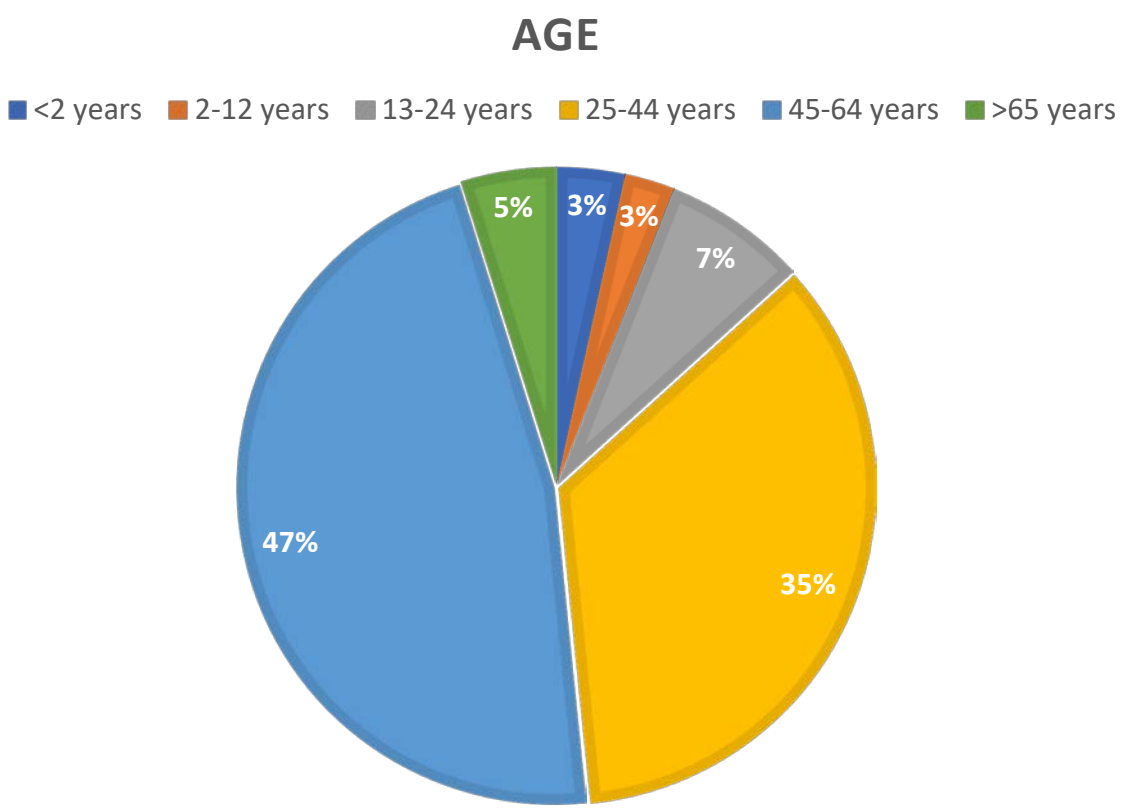
Grady Demographics

One-stop-shop model: Grady provides mental health, dental, optometry, nutrition, case management and social work, health educators, nurses, and research

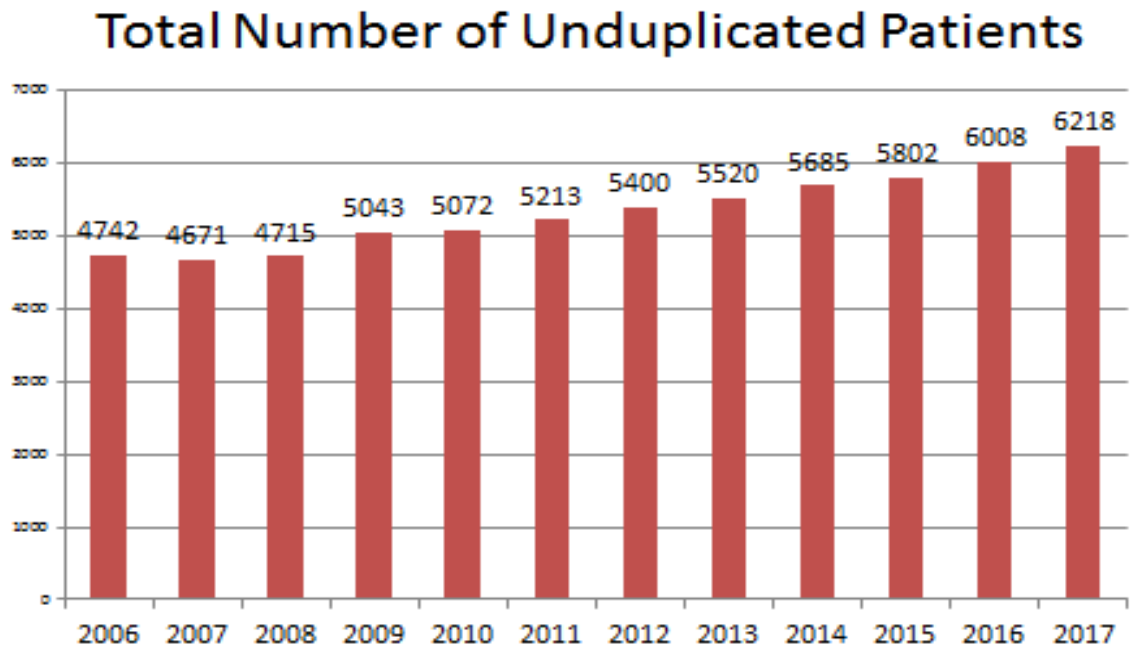
- 71% Male, 28% Female, <1% Transgender
- 84% Black/African American, 9% White, 5% Latino
- 14% <= 24, 35% 25-44, 51% >=45 years of age
- 32% < FPL, 60% < 2X FPL
- 42% uninsured, 26% Medicaid, 21% Medicare
- 64% Stage 3 (AIDS)

Grady Demographics





Grady Demographics



Patient Navigation vs CRC

Similarities

- Some Overlap
- Assist with Housing
- Addressing Adherence Barriers
- Reducing Food Insecurity
- Transportation
- Phone calls
- Eligibility criteria

Patient Navigation vs CRC

Differences

Care Resource Coordinator

- Assist with housing
- Addressing adherence barriers
- Reducing food insecurity
- Transportation
- One monthly call
- Assist with substance use placement

Patient Navigator

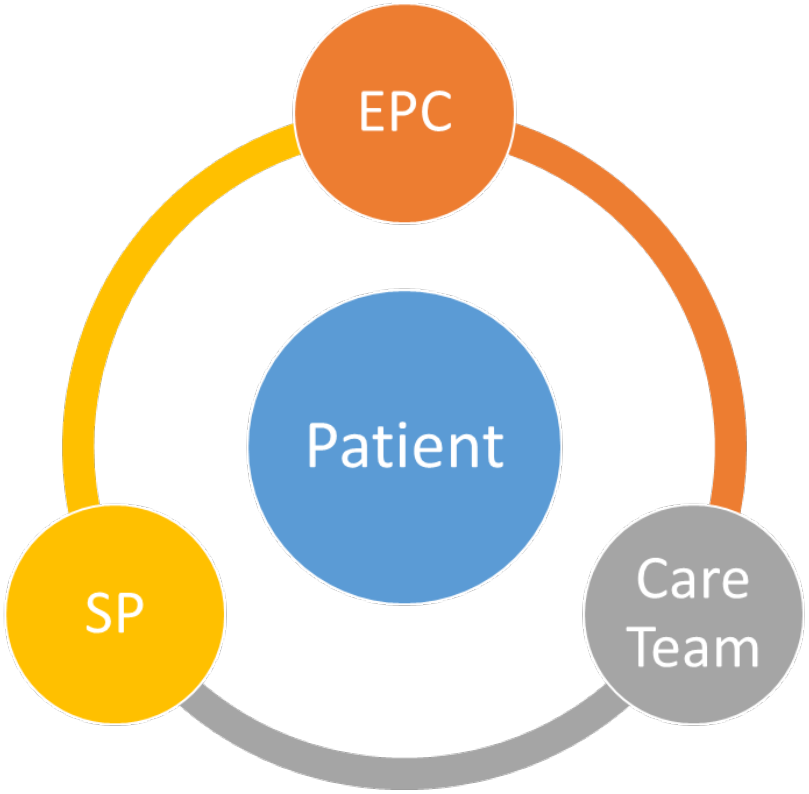
- Education sessions and weekly calls
- Navigating patient within and outside of the health care system
- Addressing adherence barriers
- Monitor Ryan White and ADAP status
- First point of contact and liaison between provider and patient

Patient Navigators at Grady Ponce

Task	Location			
	Family & Youth Clinic [1] 1 FTE	Women's Clinic [2] 2 FTEs	Main Clinic [3] 2 FTEs	Youth, Women's, & Main Clinic [4] 2 FTEs
Support of patient around the clinic				
Greeting new patients as they enter the building	●			
Escorting patients to the clinic and ensuring that they are checked in for their appointment	●		●	●
Accompanying/directing patients to the pharmacy, lab, psychologist, social worker or other areas as needed or directed by their provider	●	●	●	●
Ensuring patients have and know about their follow up appointment before they leave	●	●	●	●
Ensuring patients have and know about any referral appointments before they leave	●	●	●	●
Reminding patients to keep up to date with their insurance and ADAP information	●	●	●	●
Communicating and working with social work and care teams to support patients needs to stay in care				
Contacting patients to remind them of their upcoming appointments (medical, dental, mental health, financial, etc.)	●			●
Calling or attempting to make contact with patients who miss their medical appointments per protocol	●	●	●	●
Assist other clinic staff with contacting patients with whom the Patient Navigator has already been working if there is an urgent need to return to clinic and attempts by other staff have been unsuccessful	●	●	●	●
Assisting patients experiencing barriers to accessing care by strategizing with the care team on ways to address and overcome challenges	●	●	●	●
Empowering patients to take ownership of their health including				
Providing health education to patients		●		
Linking patients to appropriate services to address the patient's needs including information on support groups at the IDP	●	●	●	●
Accompanying patients to their IDP appointments to enhance communication between the patient and care team	●	●	●	●
Navigating healthcare in Grady Health System	●	●	●	●

[1] State-funded
[1] Funded by AIDS United, have additional grant requirements regarding patient eligibility for navigation services, ex. Not virally-suppressed
[1] State Legislature funded
[1] Ryan White Part A MAI

Patient Navigators at Grady Ponce



Looking Ahead: Care & Treatment Interventions

- Continue monitoring implementation at sites and multi-site outcomes evaluation.
- Analyze and summarize interim findings
- Update adapted interventions
- Release final interventions as CATIs

Resources Currently Available

Intervention materials are available for download on the TARGET Center site

- https://nextlevel.targethiv.org/

Training Manuals Coming Soon

- Anticipated release, Fall of 2018
- Will also be posted on TARGET Center site

Questions?

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Patient-Centered Approaches to Viral Load Suppression

Finn Schubert, Migdalia Vientos, Dana Evans, Jeanne Carey

Family Health Centers at NYU Langone

Interdisciplinary Case Conferences

- Bimonthly meetings to bring together providers, patient navigators, case managers, and others who may interact with patients.
- Patients who are not virally suppressed or who have other challenges in care are discussed, so that the team can plan how to create better health outcomes for these patients.

Data reporting for case conferences

- Patients with unsuppressed VL regardless of visit activity – provide current as well as second most recent result value
- Patients whose last HIV visit was >5 months ago
- Patients whose last VL test was >5 months ago
- Current year new dx and new patients – provide number of days since last visit to assess retention in care

Integrated linkage to care for new patients

- #HIV Navigation email system allows care management, clinical, and data/quality staff to communicate quickly regarding patients newly identified as positive
- Care management reviews charts of identified patients and communicates with medical providers to create a patient-centered care management plan
- Data analyst records data for inclusion in monitoring and reporting

VLS: Demographic Drill Down

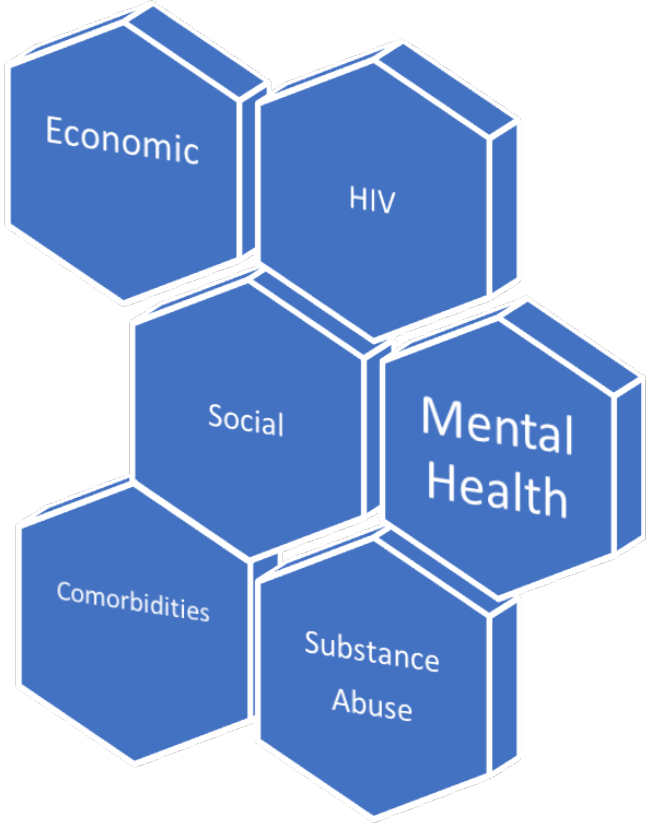
- Drilling down by multiple demographic categories highlighted disparities that were masked when examining one demographic category at a time
  - Heterosexual females ages 40-59 were less likely to be virally suppressed than heterosexual male or MSM of the same age category
  - Hispanic heterosexual males had a VLS rate of 100%, while non-Hispanic white heterosexual males had a VLS rate of 67%.
- Differences may be due to different experiences of stigma or different child/elder care responsibilities, and can inform programming

How do we address the gender and age disparity for heterosexual females ages 40-59?

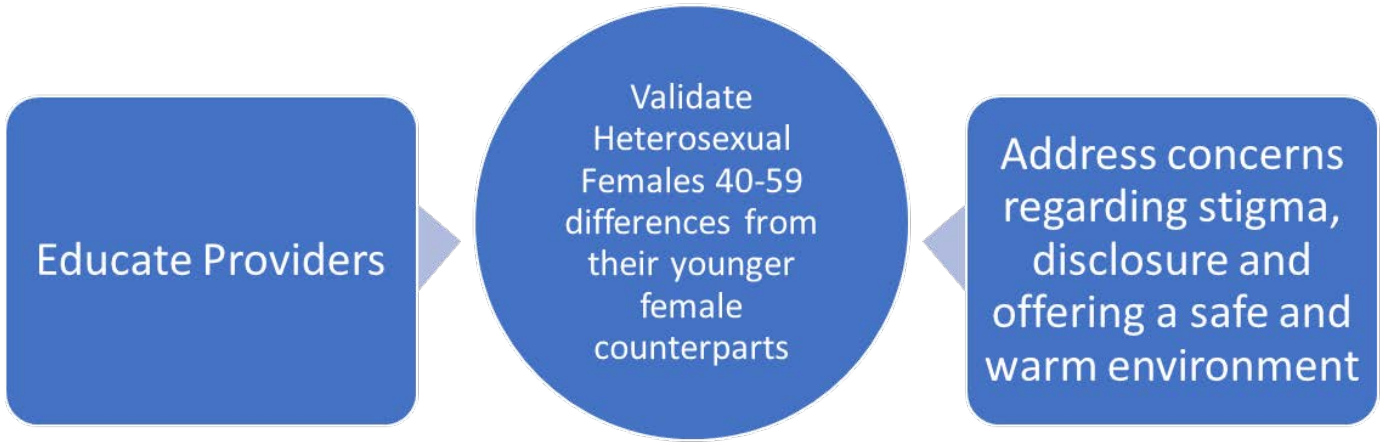
- To improve this situation in which heterosexual females ages 40-59 are less likely to be virally suppressed we must first look at some of the causes for these disparities
- Some Causes might be the fact that females ages 40-59 are embarrassed to disclose their diagnosis to family and friends due to stereotypes
- More women have greater difficulty getting away from work and family responsibilities to make their regular HIV visits
- There are also other major contributors of gender and age disparity as depression, comorbidities in females ages 40-59

Misconceptions About HIV/AIDS Among Heterosexual Females ages 40-59

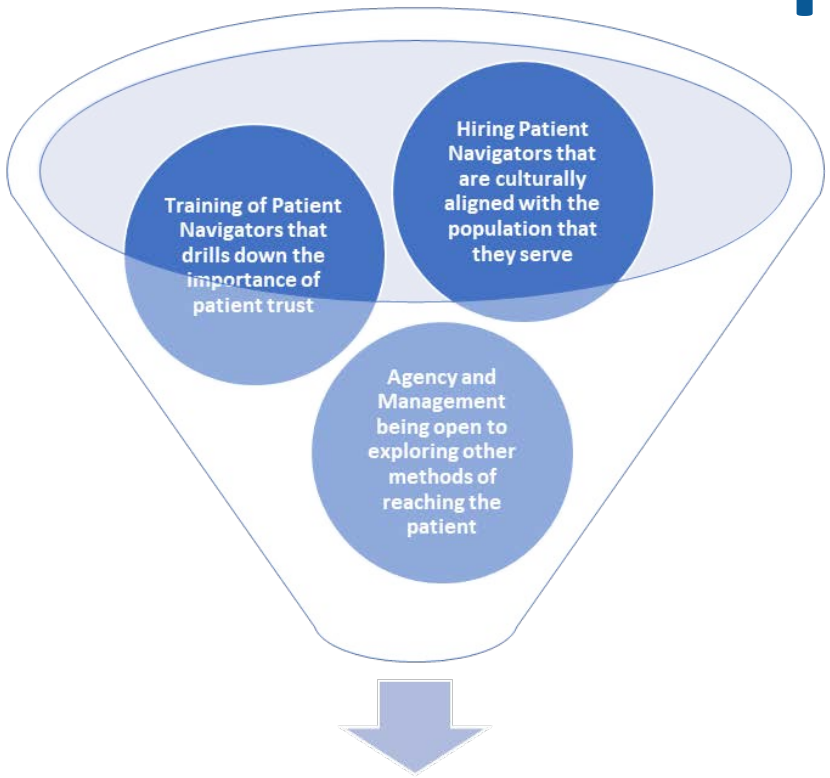
HIV/AIDS in Heterosexual Females ages 40-59 - Medical Complexity



Care Considerations to Address the Disparities for Heterosexual Females 40-59



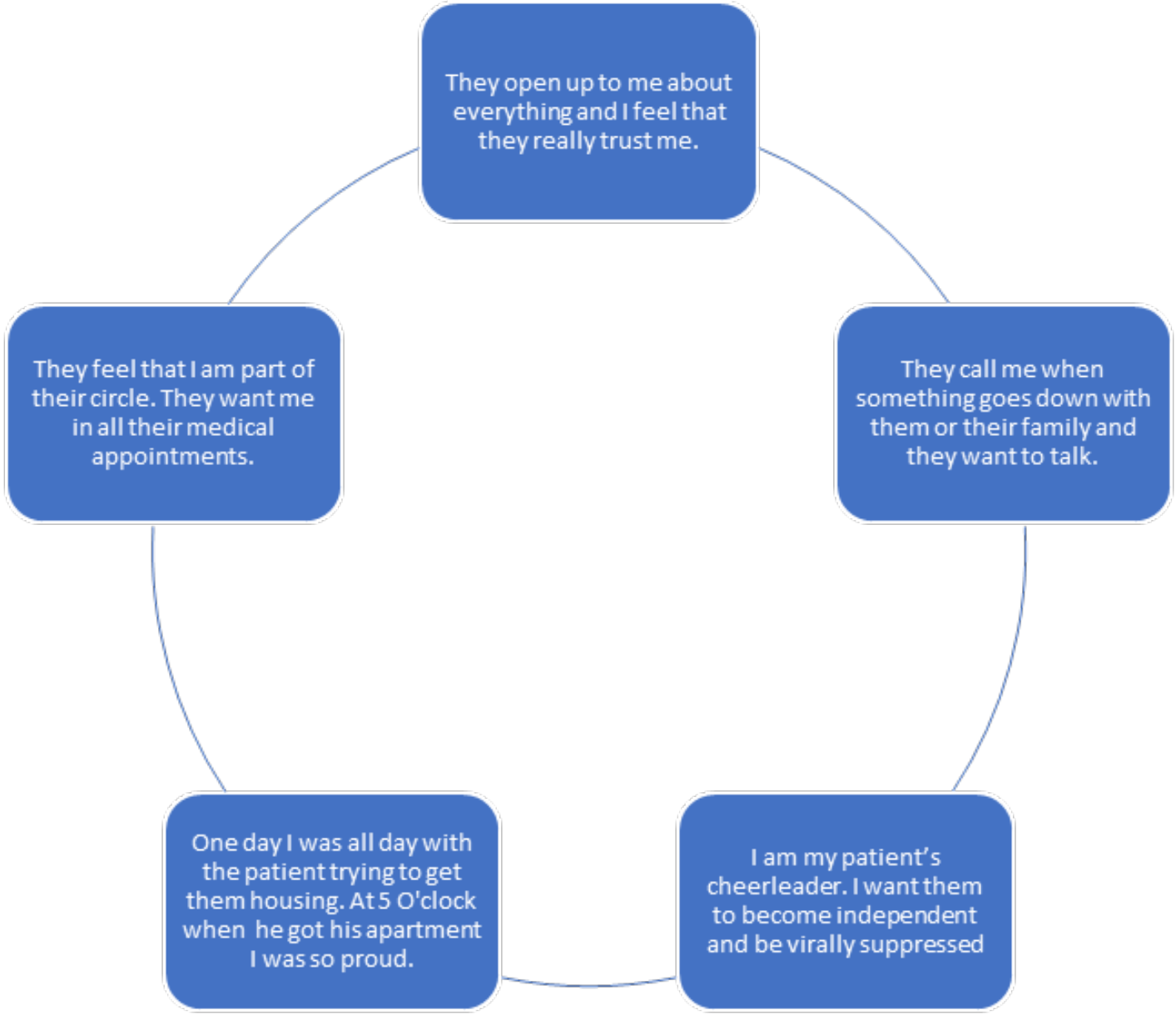
How do we create a patient centered approach to viral load suppression?



Common Activities Used to Address Patient Barriers

- Addressing Patients Attitudes and Beliefs
- Accompaniment to medical appointments and assist with health literacy support
- Practical Assistance with Transportation and Coordination of Dependent Care
- Arrangement of financial help, housing, insurance benefits

Patient Navigators describe how trust and personal connection is established through their relationship with their patients



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Questions?

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THANK YOU

Obtaining CME/CE Credit

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http://ryanwhite.cds.pesgce.com