Special Project of National Significance System Linkages: Developing and Implementing a Successful Patient Navigation Model

Mari Ruetten, MPA

Wisconsin Division of Public Health, AIDS/HIV Program

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Presentation Outline

- Background
- Original model
- Evolution of the model
- Final implemented model
- Challenges and successes
- Recommendations

Special Project of National Significance

- Competitive four-year (2011 – 2015) demonstration grant
- Charged to develop an "innovative," "replicable," and "sustainable" model to:
  - Identify HIV-positive individuals not in medical care
  - Link HIV-positive individuals to medical care
  - Retain HIV-positive individuals in medical care
- Required to use the Institute for Healthcare Improvement's Collaborative Learning Model

Special Project of National Significance

- Wisconsin was one of six states chosen to participate
  - Louisiana, Massachusetts, New York, North Carolina, and Virginia were also selected
- The University of California-San Francisco served as the evaluation and technical assistance center
  - Coordinated the evaluation
  - Provided quality coaches

The Wisconsin Model: Original

- Developed Linkage to Care Specialists (LTCS)
  - Five sites in southern Wisconsin identified to employ LTCS
  - Specialized medical case managers
  - Preferably without previous case management experience
- Distinguishing LTCS from medical case managers
  - Assigned to work with one specific client type
  - Case loads capped at 10 clients
  - More intensive with weekly, if not daily, client contact
  - Serve as sole-point of contact
  - Enrollment limited at 12 to 18 months

The Wisconsin Model: Original

- Four client types
  - Newly diagnosed: diagnosed during previous 90 days
  - New to care: diagnosed more than 90 days earlier, but not linked to medical care
  - Out of care: have not attended a medical visit during the previous six months
  - Post-incarcerated: previously diagnosed and referred by and released from the Wisconsin Department of Corrections

The Wisconsin Model: Original

- Service expectations
  - Identify barriers to participation in medical care
  - Attend medical appointments with the client
  - Provide transportation to medical appointments
  - Coordinate all services for the client
  - Educate clients about living successfully with HIV
  - Arrange for the client to transition to self-management or traditional medical case management

The Wisconsin Model: Modified

- Client types
  - Able to work with all client types
- Enrollment time
  - Reduce client enrollment to a maximum of 9 months
- Service expectations
  - Coordinate delivery of care with medical case managers
  - Identify reliable transportation for medical appointments
  - Optional attendance at medical appointments
  - Make clients more self-reliant

The Wisconsin Model: Final

- Service sites
  - Seven sites in southern Wisconsin now employ LTCS
- Client types
  - Work with all client types and added a new “at risk” population
- Enrollment time
  - Maximum of 9 months and attendance at 3 medical appointments
  - Clients may transition out before the 9 months

The Wisconsin Model: Final

- Expectations
  - Primary LTCS function is to identify and address client barriers to medical care
  - Coordinate with medical case managers on needs not directly resulting in a barrier to medical care
- Client transition
  - Self-management or medical case management is identified in the service plan
  - Work with medical case manager on discharge plan
  - Post discharge, follow up at 3 and 6 months to verify retention in care

Challenges and Successes

- Provider relationships
  - Medical providers initially unsure about role of LTCS
  - Learning sessions, newsletters, and site visits helped medical providers learn about LTCS
  - Medical providers now want the initiative to expand
- Coordination with medical case managers
  - Initial role confusion
  - Medical case manager role now being redefined to incorporate lessons learned from the LTCS experience

Challenges and Successes

- Service expectations
  - Transportation assistance was initially used as a motivator to encourage client participation
  - LTCS were being asked to help clients with an incredibly broad spectrum of services which led to an inability to enroll new clients
  - Shifted focus to establishing ongoing participation in medical care and viral suppression
  - LTCS are now able to serve more clients

Challenges and Successes

- Communications
  - Housing instability, poverty, and emerging modes of communication can make it difficult to maintain communication with a client
  - LTCS rely on texting and social media platforms to communicate with clients
- Client transitions
  - LTCS and clients develop a bond that makes transition to medical case management difficult
  - Exploring ways to allow medical case managers to have a more proactive relationship with clients

Recommendations

- Involve front-line staff in planning and development of the initiative
- Carefully consider discharge criteria and length of enrollment
- Monitor case loads and required time to ensure the maximum number of clients can participate
- Incorporate current modes of communication
- Strong supervision required to help LTCS balance case load and avoid burnout

Recommendations

- Education is key
  - Inform and involve key partners, providers, and stakeholders
  - Provide regular trainings for LTCS
  - Make program requirements, expectations, and enrollment time clear to the client from the beginning
- Do not be afraid of change
  - Listen to feedback and modify program as appropriate
  - Evaluate program to ensure that positive health outcomes are achieved

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Mari Ruetten

mari.ruetten@wisconsin.gov

608-261-6397