



Each One, Teach One: Impact of Peer Navigation at the Ryan White Wellness Center

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Hey Y'all!

- 3 Counties surrounding Charleston, SC
- Rural, coastal South Carolina
- Serve 700 750 patients annually
- HIV & Primary Care
- Mental Health
- Medical Case Management
- Hope Housing
- Peer Navigation
- Contracted specialty and supplemental services







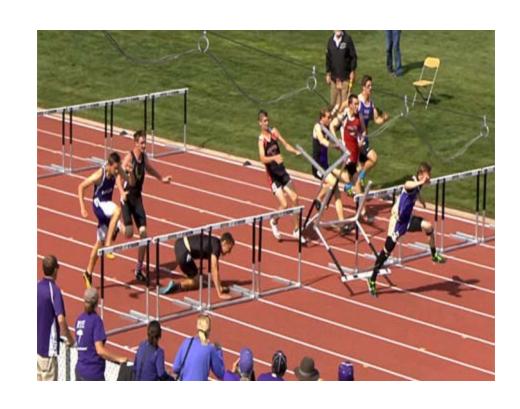
Program Highlights & Hurdles

High Quality

- 95% Optimally Retained
- 87% Virally Suppressed
- 100% newly enrolled have been fully engaged in care for first year
- 40 PrEP patients since Jan 1

Limited resources for peer support

- Young African American men most likely to be poorly retained and unsuppressed
- Stigma/fear of group settings
- Rural area, poor public transportation
- No PLWHA on staff







Goals of Peer Navigation Program

- Reduce the number of clients lost to care by 50% by training program staff and peer counselors in motivational interviewing to help retain clients in care and master skills to address specific barriers to African American PLWHA in a 12-month period
- Re-engage 50% of those lost to care and reduce the number of clients lost to care by 50% by establishing a peer mentoring program to provide peer-level counseling and advocacy in a 12-month period







Policy Development

Policies and procedures were developed in a collaborative process including case managers, peers, and program administration.

- Primary Functions
- Expectations/Requirements
- Documentation
- Supervision
- Termination of peer services









Facility: Roper Hospital

Division: Medical Affairs

Policy & Procedure

Policy #: Ryan White Wellness Center, 04.06

Origination Date: February 2015

Latest Review/Revision: March 2015

Administrative Approval: Steve Shapiro, MD
(Type name)

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Administrative Title: VP, Medical Affairs

Originator: RWWC Administrative Staff

SUBJECT: PEER NAVIGATORS

PURPOSE:

To provide Ryan White staff, peer navigators, and enrolled clients a clear understanding of the roles and responsibilities of the peer navigators, and the purpose of the peer navigator program.

POLICY:

Peer Navigators are intended to provide a bridge between providers and clients that facilitates the medical & psychosocial care of the client.

Peer Navigators are intended to foster trust and understanding in a capacity that is distinct from the provider or case manager role.

Peer Navigators are to serve as a role model, providing reliable information and emotional and/or practical support to enrolled clients.

Peer Navigators are to encourage clients to remain in care and adhere to medications. Success of these interventions will be measured using In +Care Campaign measures.

GUIDELINES:

Primary Functions

- Disseminate information on community resources, including services available via the Ryan White Wellness Center
- Empower clients to be active in their own healthcare, making use of skills such as motivational interviewing
- Provide outreach services limited to phone calls and letters
- Provide psychosocial support that is distinct from mental health counseling
- Advocate for clients' needs
- Identify and address barriers to care and supportive services

Other Expectations/Requirements

- Attend ongoing training and educational opportunities provided by the Ryan White Wellness Center. Peer Navigators are encouraged to attend as many as they are able to
- Wear appropriate clothing business casual, while on site during clinic hours
- Display professional conduct while representing the program
- Peer Navigators are to work/be available only during normal working hours. Please turn off cell phones at 5pm
- Peer Navigators must abide by all professional and ethical standards outlined RSFH contractor agreement and the RSFH standards of behavior

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- Although the majority of client contact should occur at the Ryan White Wellness Center, Peer Navigators may meet clients at mutually agreed locations such as coffee shops and libraries.
 Peer and client safety should remain the top priority
- Peer Navigators should not borrow, lend, or exchange money, services, or goods with clients
- Peer Navigators should not transport clients in their personal vehicles

Referral Process

- All clients must be referred to the Peer Navigation program by their case manager
- Clients will be matched to the most appropriate Peer Navigator if available

Documentation

- Peer Navigators must document encounters in a timely manner using CAREWare (within 72 hours of the encounter)
- Case Managers have access to Peer Navigator notes and services for continuity of care
- Peer Navigators have 'as needed' access to medical information or service histories of their clients

Supervision, Complaints and Grievances

- The primary point of contact for Peer Navigators is the case manager of the client they are working with
- The case manager, case management supervisor, or the program manager may escalate complaints as appropriate
- A Peer Navigator or a client may request to be switched or discontinue peer navigation services at any time

Termination of Peer Navigator Services

 A client may 'graduate' from peer navigation services if the client no longer requires, or is no longer benefitting from peer services. A joint decision will be made by the Peer Navigator and the Case Manager, with input from the client



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Primary Peer Navigator Duties







1 Year Program Outcomes (N=75)

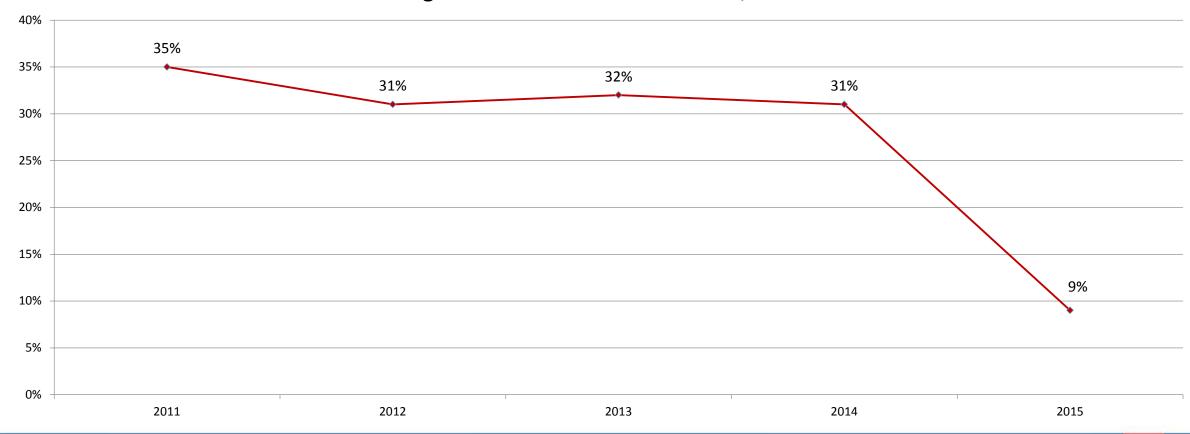
Year	Viral Suppression	Optimally Retained	Gap in Care
2015	50%	74%	17%
2016	68%	85%	4%





ACA Enrollment Goals

Percentage of Uninsured RWWC Patients, 2011 – 2015







Peer Program Successes

- Divulging information to peers
- Disclosure issues
- Isolation
- Peer Successes
 - "I'm suppressed for the first time"
 - "This job means so much to me, you have no idea."







STEPS to Care







STEPS to Care Process and Procedures

STEP 1: Assign patients

Patients that meet the following criteria should be enrolled in STEPS –

- Newly diagnosed
- Non-compliant
- Previously connected with Peer
- High acuity level (as assessed by case manger)

STEP 2: Introduce the program

Case managers should contact their prospective patients to explain the purpose and process of the program. Case managers will also work with the patient to outline goals and needed support. This STEPS plan will be reviewed and updated during the patient's routine case management visits, and shared with the assigned Peer.

STEP 3: Peer contact

After reviewing the patient's case management notes and STEPS plan, the Peer should contact the patient and arrange an initial visit. Try to make this visit convenient for the patient (i.e. next case management or medical appointment, home visit, cafe). Discuss barriers noted on STEPS plan and provide support in reaching goals. Peer and patient should communicate at least once every 2 weeks for 12 weeks (6 contacts).

STEP 4: Assess compliance, adherence and stability

At 12 weeks, patient's care team (medical provider, case manager, Peer) should meet to discuss and reassess patient's compliance and stability. If deemed compliant and stable, Peer should reduce contact frequency to monthly for 3 months.

At 3 months, patient's care team should reconvene. If deemed compliant and stable, Peer should reduce contact frequency to quarterly. Continue reduction of communication for one year.

STEP 5: STEPS Graduation

At one year, patient's care team (medical provider, case manager, Peer) should meet to discuss and reassess patient's compliance and stability. If deemed compliant and stable, Peer will graduate from STEPS program.

Patients that can not be reached should be re-directed to the case manager for additional support and communication.

Patients can be reengaged in STEPS if compliance, adherence, stability or aculty issues re-emerge.





Lessons Learned

- Peer Recruitment
- Don't expect an instant peer program
- Referrals? What referrals?
- Go Team!
- Mental Health Services
- Start Low, Go Slow





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