



Patient Navigation Intervention

Highlights from the Special Projects of National Significance (SPNS) Program



This fact sheet contains highlights from the Virginia Department of Health's *Patient Navigation* Intervention, focused on using patient navigation in linking newly diagnosed persons to care within 30 days of diagnosis. This intervention also targets those who have fallen out of care, who have never received care, or are at risk of being lost-to-care.

Setting: Central and Southwest Regions of Virginia

Target Population: Newly diagnosed PLWH; PLWH who have fallen out of care, have never received care, or are at risk of being lost to care

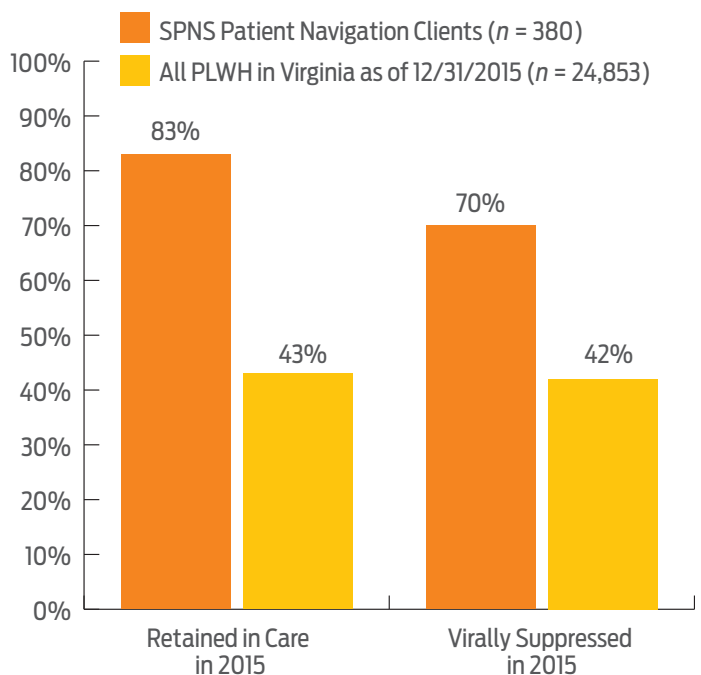
Theoretical Basis: Collaborative Learning Model

and cultural barriers that impede their linkage to and engagement in care.⁴ As such, addressing these key areas by increasing social support services; integrating one-stop-shop care delivery; removing structural barriers; providing financial support services; and using peer navigators or care coordinators, can help improve linkage to care for PLWH.

Background

Following a diagnosis of HIV, linking people living with HIV (PLWH) to HIV services is the next step on the HIV care continuum. Early initiation of HIV treatment is associated with improved outcomes along the HIV care continuum. Lower CD4 T cell counts at the time of treatment initiation is associated with shorter life expectancy and a lower likelihood of full rebound of CD4 counts.^{1,2} Thus, linkage to care soon after diagnosis can be an important strategy for supporting PLWH. HHS guidelines indicate that all PLWH should be initiated in treatment, and as early as possible. Patient navigation support for PLWH has been demonstrated to improve efficiency and effectiveness of linkage to care interventions.³ The Virginia Department of Health sought to promote timely linkage to and retention in care through the guidance and support of health workers known as Patient Navigators.

HIV Care Outcomes Among VDH SPNS Patient Navigation Clients Served 9/1/2013–8/31/2015



Unmet Needs

Underserved populations, including many racial, ethnic, and sexual minorities, face numerous structural, financial,





✓ Intervention Objectives

The objectives of the *Patient Navigation* Intervention were to create more timely and effective linkages to and retention in medical care for PLWH through the guidance and support of Patient Navigators.

➔ Key Considerations for Replication

- Engage potential partners and stakeholders early in the planning process, and include diverse planning partners (e.g., service providers, community members, PLWH)
- Research the availability of similar interventions in the local area to avoid duplication or confusion and identify opportunities for partnerships and coordination
- Develop a clear and comprehensive protocol for Patient Navigators to follow
- Client encounters should take place routinely (more frequently at the start of navigation), be face-to-face whenever possible, and documented by the Patient Navigator
- PLWH may enter the intervention at varying stages of the HIV care continuum, and may need to re-engage with the intervention at some point
- Navigators and PLWH work collaboratively to develop a linkage-to-care plan; clients should be informed during intake that the transitioning out (once appropriate) will take place
- Linkage to non-HIV-related services (e.g., mental health, housing, transportation, education) can be facilitated by the Patient Navigator

👤+ Intervention Staff Requirements

To replicate the Virginia Department of Health's Patient Navigation intervention, the following positions and capacity are necessary.

- **Patient Navigators**—must possess specific knowledge and skills including being able to solve problems creatively and effectively; direct clients to community

RESOURCES

This fact sheet is part of the *Improving Health Outcomes: Moving Patients Along the HIV Care Continuum and Beyond* resources from the Integrating HIV Innovative Practices (IHIP) project.

- **SPNS Initiative: Systems Linkages and Access to Care, 2011–2016:** <https://hab.hrsa.gov/about-ryan-white-hiv-aids-program/spns-systems-linkages-and-access>
- **VDH Active Referral Intervention Case Study:** <http://careacttarget.org/ihip>

resources/information; and build working relationships. **Programs may be able to rely on community health workers or other staff dedicated to linkage-to-care efforts if a patient navigator is not available.*

- **Patient Navigator Supervisors**—A variety of staff serve to manage/supervise Patient Navigators including administrative staff, nurse managers, and physicians.

Notes

¹ Althoff KN, Gange SJ, Klein MB, et al. Late presentation for human immunodeficiency virus care in the United States and Canada. *Clin Infect Dis.* Jun 1 2010;50(11):1512–1520. <http://www.ncbi.nlm.nih.gov/pubmed/20415573>.

² Moore RD, Keruly JC. CD4+ cell count 6 years after commencement of highly active antiretroviral therapy in persons with sustained virologic suppression. *Clin Infect Dis.* 2007;44(3):441–446. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=17205456.

³ Okeke NL, Ostermann J, Thielman NM. Enhancing linkage and retention in HIV care: a review of interventions for highly resourced and resource-poor settings. *Curr HIV/AIDS Rep.* 2014;11(4):376–392. <https://www.ncbi.nlm.nih.gov/pubmed/25323298>

⁴ CDC. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas, 2014. *HIV Surveillance Supplemental Report* 2016;21(No.4), Table 5a. www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-21-4.pdf Accessed September 16, 2016.