



# Improving Health Outcomes

## Moving Patients Along the HIV Care Continuum

INTERVENTION GUIDE

SPNS Demonstration Model on Patient Navigation Intervention

SEPTEMBER 2018



**HRSA**  
Health Resources & Services Administration

U.S. Department of Health and Human Services  
Health Resources and Services Administration  
HIV/AIDS Bureau

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# Improving Health Outcomes

## Moving Patients Along the HIV Care Continuum

### INTERVENTION OVERVIEW & REPLICATION TIPS

## Patient Navigation Intervention

### Virginia Department of Health

This intervention guide examines an intervention focused on linkage to care and provides information on key components of the intervention and the capacity required by organizations/clinics to conduct this work.

This intervention guide is part of a training series entitled, “Improving Health Outcomes: Moving Patients Along the HIV Care Continuum,” and is published by the Special Projects of National Significance (SPNS), under the HIV/AIDS Bureau (HAB) of the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS). The purpose of this intervention guide and others featured as part of the *Translation of SPNS Findings and Technical Assistance Support to Implement New Models of Care* project is to highlight interventions along the HIV care continuum and support replication of these evidence-informed innovative models of care. The HIV care continuum refers to the fluid nature of HIV health care delivery and client experiences, and research has demonstrated the importance of moving clients along the continuum with the goals of being fully linked, engaged, retained, and virally suppressed. This framework has received attention as research has demonstrated the importance of these activities. Therefore, finding programs that help clients move along the stages of the continuum are particularly important.



**Diagnosing HIV**



**Linkage to Care**



**Retention in Care**



**Prescription of ART & Medication Access**

#### About SPNS

The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, is the primary federal agency for improving health care to people who are geographically isolated, economically, or medically vulnerable. The Special Projects of National Significance (SPNS) Program is a part of the HRSA HIV/AIDS Bureau (HAB). The SPNS Program supports the development of innovative models of HIV care and treatment in order to quickly respond to emerging needs of clients served by HAB. SPNS advances knowledge and skills in the delivery of healthcare and support services to underserved populations living with HIV. Through its demonstration projects, SPNS evaluates the design, implementation, utilization, cost, and health-related outcomes of treatment models while promoting the dissemination and replication of successful interventions.



#### About the System Linkages and Access to Care Initiative

The featured evidence-informed intervention was part of the SPNS “System Linkages and Access to Care Initiative.” For this initiative, SPNS supported six demonstration sites for four years to design, implement, and evaluate innovative strategies to integrate different components of the public health system such as surveillance, counseling and testing, and treatment to create new and effective systems of linkages and retention in care for hard-to-reach populations who have never been in care, have fallen out of care, or are at-risk for falling out of care. Populations of interest were limited to: those persons who are at high risk for and/or infected with HIV but are unaware of their HIV status, are aware of their HIV infection but have never been referred to care, or are aware but have refused referral to care. The demonstration sites also participated in a robust multi-site evaluation and received programmatic technical assistance. To learn more about this initiative, visit: <https://hab.hrsa.gov/about-ryan-white-hiv-aids-program/spns-systems-linkages-and-access>.

# Patient Navigation Intervention

Virginia Department of Health

Diagnosing HIV



Linkage to Care

Retention in Care

Prescription of ART & Medication Access

## Why This Intervention?

The intervention links people living with HIV (PLWH) into care within 30 days of their diagnosis or from an initial referral by an HIV test site to a Patient Navigator. The Patient Navigation intervention also supports retention in HIV care for up to 12 months. These are critical steps in helping PLWH achieve viral suppression, which is directly linked to improved health outcomes and decreased risk of transmitting HIV to others. The intervention resulted in 83 percent retention versus 43 percent retention statewide and 70 percent viral load suppression compared to 42 percent statewide.

## At-a-Glance

The table below provides a general overview of the Virginia Department of Health's (VDH) Patient Navigation intervention.

Model at-a-Glance	
<b>Step 1</b> 	<b>Client Referred to Patient Navigation Services</b> After a positive test result, the client is referred to VDH's Patient Navigation intervention via a Disease Intervention Specialist (DIS) or to another community partner. During this step, the client completes a Coordination of Care and Services Agreement (CCSA), which provides his or her consent to receive Patient Navigation services and share information with designated providers.
<b>Step 2</b> 	<b>Client Intake</b> The Patient Navigator conducts an assessment of the client's barriers to accessing and staying in care. The assessment is not limited to one interaction; a full assessment may take weeks or even months. During this step, the Patient Navigator and client work hand-in-hand to develop a linkage-to-care plan, which addresses the client's barriers to care and strategies to address these barriers.
<b>Step 3</b> 	<b>Routine Client Encounters</b> Once connected to care, the Patient Navigator and client work together on a retention plan, which outlines challenges or barriers that have been resolved and outstanding challenges that require continued attention. During these client encounters, the Patient Navigator may also identify other HIV infected individuals through HIV testing of clients' partners and contacts.
<b>Step 4</b> 	<b>Client Transition</b> The Patient Navigator performs an assessment of the client's readiness for transition out of the Patient Navigation program at least every six months. When the client is determined to be successfully engaged in care, the client is transitioned out of the Patient Navigation intervention into community care—such as case management services—or into self-managed care.
<b>Step 5</b> 	<b>Client Discharged</b> The Patient Navigator documents the client's transition plans when discharging him or her from care and that the transition has occurred. Although the intervention is designed to result in self-management, clients may be re-enrolled based on new or changing needs. Re-enrolled clients would need to go through the same referral and initial assessment process and would be required to sign a new CCSA form.

Note: See [Appendix](#) for CCSA, [linkage-to-care plan](#), [retention plan](#), and [client transition assessment samples](#).

Source: Virginia Department of Health. *Active Referral: Implementation Manual*. Virginia Department of Health, *Special Projects of National Significance, System Linkages and Access to Care Initiative*. Final Report. October 2015.



## Resource Assessment Checklist

Prior to implementing the Patient Navigation intervention, organizations should walk through a Resource Assessment (or Readiness) Checklist to assess their ability to conduct this work. If organizations do not have these components in place, they are encouraged to develop their capacity so that they can successfully conduct this intervention. Questions to consider include:

- Does your organization have an existing Patient Navigation or Community Health Worker program? If not, is there capacity to establish one?
- Does your organization provide clinical care services or have a partner agency who does? If not, do you have the ability to develop partnerships with agencies who do?
- Do existing staff have expertise in outreach, counseling, testing, and navigation?
- Does your staff or organization have any experience with Motivational Interviewing? Motivational Interviewing is a goal-oriented, client-centered counseling approach that facilitates change behavior.\* If not, are they able to be trained and certified in this counseling technique?
- Do you have sufficient supervisory and management staff to manage a Patient Navigation Program?
- Does your staff or organization have knowledge of or training in assessing and addressing social determinants of health?
- Has your organization identified a specific HIV-positive target population in need of Patient Navigation services whose needs are not currently being met by other services in the area? If not, do you plan to identify a target population and does your organization have experience working with the target population?
- Has your organization explored the availability of similar services for the target population in your service area (i.e., What already exists and can you complement those services or will your services be duplicative or unnecessary.)?
- Does your organization have strong community relationships and processes for referring (and tracking) clients to resources for HIV prevention, care and support services in the area?

\*To learn more about Motivational Interviewing, visit the Motivational Interviewing Network of Trainers at:

<http://www.motivationalinterviewing.org>

## Setting the Stage

VDH sought to establish a Patient Navigation intervention to promote linkage to and retention in care through the guidance and support of health workers known as Patient Navigators. The aim of the Patient Navigation intervention is to help clients access HIV-related medical care in a timely and effective manner, thus assisting clients to move along the HIV continuum of care.

Special attention was paid to learning from community-based organizations' and local health departments' prior attempts to implement linkage programs so as not to duplicate efforts. It was particularly critical that VDH's Patient Navigation intervention coordinate efforts with a similar program funded by the Centers for Disease Control and Prevention (CDC) known as the Care and Prevention in the United States (CAPUS) demonstration project. To ensure the efficacy of both programs and to reduce confusion among healthcare providers and clients, VDH decided not to launch its Patient Navigation intervention in the same regions that CAPUS placed Community Health Worker programs. In addition, CAPUS staff was actively involved in the VDH's Patient Navigation intervention from the beginning of the project. This allowed both navigation programs to maximize resources and identify and mitigate overlaps and gaps in services.

VDH's Patient Navigation intervention outlined in this intervention guide was funded by SPNS as part of the Systems Linkages and Access to Care for Populations at High Risk of HIV Infection Initiative.

### Patient Navigation Terminology 101

**Collaborative Learning Model:** A process where systems, organizations, and providers implement and measure small-scale interventions and then share their experiences in an effort to accelerate learning and widespread implementation.

**Motivational Interviewing:** A directive, client-centered communication strategy that empowers people to change unhealthy or problematic behaviors.

**Fidelity Monitoring:** A process to ensure that an intervention's protocol is being carried out as it was intended; that is, how well the program is implemented without compromising the program's core components.

## Description of Intervention Model



### CHALLENGE ACCEPTED

**THE CHALLENGE:** To create more timely and effective linkages to and retention in medical care for PLWH through the guidance and support of health workers known as Patient Navigators.

### Intervention Model: Patient Navigation

Patient Navigation is a process of service delivery that helps PLWH obtain timely HIV-related care to optimize his or her health and prevent HIV transmission and acquisition. VDH piloted the Patient Navigation intervention in the Central and Southwest regions of the State at two clinical sites. It then replicated the intervention at a third site in a separate service area in the Southwest region.

VDH's Patient Navigation intervention aims to link PLWH to care following diagnosis and support retention for up to 12 months. The target populations for the Patient Navigation intervention are:

- Newly diagnosed PLWH
- PLWH who have fallen out of care for six months or longer
- PLWH who have never received care
- PLWH who are at risk of being lost-to-care

Patient Navigators typically work with clients over a 12-month period to secure full retention in care and self-management. However, depending on the client's needs and the services provided by the Patient Navigator, the intervention may be longer or shorter. In general, Patient Navigation services generally follow this timeline:

- Months one to three: Focus on addressing initial barriers to care and linkage to care.
- Months four to nine: Focus on retention.
- Months 10–12: Focus on transitioning client to self-care.

Client encounters should occur routinely and as needed. Ideally, they are face-to-face, either in the home or elsewhere in the community—but may also be by phone or even by text. Some Patient Navigators and clients are in contact weekly or more, while others only when they are at the clinic for medical appointments. Client encounters usually are most frequent at the beginning of the intervention and taper off as the client is transitioning to self-care. However, just as the length of the intervention is determined by client needs, so too is the frequency of contact.

During client encounters, the Patient Navigator and client work hand-in-hand to develop a linkage-to-care plan, which outlines the client's barriers to care and strategies to address these barriers. This is based on indicated client needs and the client's barriers to engaging and staying retained in care as well as needs

indicated during pre-medical screenings, financial screenings, mental health screenings, and screenings conducted in alignment with Ryan White HIV/AIDS Program directives and performance measures. As the client is empowered and builds skills toward self-management, the Patient Navigator and client then devise a retention-in-care plan, which outlines the client's barriers to staying in care and strategies to address these barriers. The Patient Navigator also facilitates linkages to other services, such as case management, mental health, housing, transportation, and substance use disorder services, as well as education related to HIV and risk reduction.

In addition, the Patient Navigator leverages training in disclosure and stigma and discusses the importance of HIV testing and offers an opportunity for HIV testing services for partners, contacts, and family members at community testing sites. If the client prefers, the Patient Navigator may offer to provide an in-home test for the client to give to a partner or contact. If the client opts for the at-home test, the Patient Navigator may distribute one after demonstrating how to take the test; the Patient Navigator need not be present during the administration of the at-home test. The Patient Navigator provides follow-up resources, including his or her contact information, as well as phone numbers for counseling services, the HIV/STI hotline, and instructions for next steps based on results. The Patient Navigator logs the number of in-home tests distributed monthly.

Documenting each client encounter is critical. During each client encounter, the Patient Navigator should complete a **checklist of all activities** that should occur during a client encounter. The Patient Navigator should also make sure to update client contact information during each client encounter. Following each visit, the Patient Navigator documents relevant data either using an electronic database, such as CAREWare,<sup>1</sup> or on a **Client Encounter Form**. Thanks to another SPNS grant—the Health Information Technology (HIT) Capacity Building for Monitoring and Improving Health Outcomes Along the HIV Care Continuum Initiative—VDH has also launched e2Virginia, which enables full integration of HIV treatment, surveillance, and laboratory data to better monitor and track PLWH along the HIV care continuum and which can draw from and be shared across all Ryan White HIV/AIDS Program (RWHAP) Parts across the State and additionally support patient navigation efforts.<sup>2</sup> (To learn more about VDH's HIT work, visit: <https://hab.hrsa.gov/about-ryan-white-hiv-aids-program/spns-health-information-technology>.)

Clients should be made aware during intake that the Patient Navigation intervention is time-limited and that they will be transitioned out when they have developed the necessary skills to access and stay in care. Clients are assessed for transition from Patient Navigation services at least every six months. Patient Navigation services end when the client is transitioned to self-management of care or to community services, such as case management or substance use disorder services, and the client is discharged. Although the intervention is designed to result in self-management, clients may be re-enrolled based on new or changing needs. If this is necessary, they would go through the same referral and initial assessment process and would be required to sign a new CCSA form.



**Clients are assessed for transition from Patient Navigation services at least every six months.**

<sup>1</sup> CAREWare is a free, electronic health and social support services information system for RWHAP recipients.

<sup>2</sup> e2Virginia is powered by the Electronic Comprehensive Outcomes Measurement Program for Accountability and Success (eCOMPAS), a web-based, client-level data system that can be customized for HIV data reporting.

# Virginia Department of Health’s Patient Navigation Intervention

## Motivational Interviewing and Fidelity Monitoring

The Patient Navigators use Motivational Interviewing to empower clients to make positive behavior changes and improve their access to and engagement in care. Motivational Interviewing is an evidence-based intervention to help people identify their readiness, willingness, and ability to change. (To learn more about Motivational Interviewing, visit the Motivational Interviewing Network of Trainers at: <http://www.motivationalinterviewing.org>) Patient Navigators’ Motivational Interviewing techniques were evaluated by a Fidelity Monitoring process that involved audio-recording client encounters to help them improve their skills. Supportive, corrective feedback was then provided by the Patient Navigator Supervisor as needed. Client consent and Institutional Review Board (IRB) approval for Fidelity Monitoring involving client audio-recorded activities were obtained for the entire project period.

VDH staff also developed a program-centered Fidelity Monitoring Tool Kit to help facilitate consistent application of the core components of the intervention. Tools include: a chart review to ensure linkage, retention, assessment, and transition plans are completed; a training checklist to document maintenance of core competencies; client surveys to measure client engagement and service quality; and Patient Navigators self-assessments. The Tool Kit is intended to help programs self-monitor consistent implementation of core components of the intervention, improve service quality, and are anticipated to be used in future Patient Navigation programs funded through VDH.

## Logic Model

Patient Navigation Intervention				
Resources	Activities	Outputs	Outcomes	Impact
<ul style="list-style-type: none"> <li>• Patient Navigators</li> <li>• Clinic staff</li> <li>• Experience/expertise</li> <li>• Funding</li> <li>• Technology (data collection process and database, e.g. CAREWare)</li> <li>• Data manager</li> <li>• Community partners</li> </ul>	<ul style="list-style-type: none"> <li>• Assess PLWH’s barriers to care</li> <li>• Develop linkage-to-care plan</li> <li>• Develop retention-in-care plan</li> <li>• Provide or refer client to support services to overcome barriers</li> <li>• Empower clients to make behavior changes via Motivational Interviewing</li> <li>• Evaluate Motivational Interviewing techniques via Fidelity Monitoring</li> <li>• Transition PLWH to community-care or self-managed care</li> </ul>	<ul style="list-style-type: none"> <li>• Link PLWH to care within 30 days of their diagnosis or date of referral to navigator</li> <li>• Support retention for up to 12 months</li> </ul>	<ul style="list-style-type: none"> <li>• Achieve viral suppression</li> <li>• Better health outcomes</li> <li>• Decreased risk of transmitting HIV to others</li> </ul>	<ul style="list-style-type: none"> <li>• Improve patient engagement in care</li> <li>• Increase the proportion of RWHAP clients who are engaged at each step of the HIV care continuum</li> </ul>



## Staffing Requirements & Considerations



### Staffing Capacity

Based on the VDH's work, here are the types of staff capacity and characteristics necessary to replicate this intervention.

#### Patient Navigators

Key to VDH's Patient Navigation intervention were several Patient Navigators at each site. Ideally, programs seeking to replicate this intervention should have at least one Patient Navigator on staff, but may need more depending on the number of clients needing services. Client caseload per Patient Navigator may vary based on acuity of needs, length of services, and type of client (newly diagnosed, lost to care, etc.). However, programs that do not have a dedicated Patient Navigator on staff may still replicate some or all of the intervention with the support of community health workers, outreach specialists, or other staff who support linkage-to-care efforts.

Patient Navigators must possess specific knowledge and skills. These include an ability to solve various problems creatively and effectively, direct clients to community resources and information, and an ability to build working relationships. As such, initial and ongoing training for persons assuming the role of the Patient Navigator is critical to ensure they have the skills to perform their job well and engage clients into care. All Patient Navigators were thus required to participate in the following Core Competency trainings. Topics included:

- The Role and Practices of the Patient Navigator
- HIV Facts: HIV Disease Basics
- Introduction of Critical Concepts: Motivational Interviewing, Client Provider Relationships, Exploring Barriers to Care
- Field Safety Overview
- Home Testing Kits Protocol, Guidelines, and Guidance
- Motivational Interviewing Intensive
- HIV Prevention Counseling: The Fundamentals and Home Testing Hands-On
- Cultural Competency Overview
- Linkage to Care and Active Referral
- Disclosure and Stigma
- Patient Navigation: Client Perspectives
- Self-Care and Managing Stress Related to the Patient Navigator Role
- Sexually Transmitted Infections (STIs)
- Recognizing Mental Health, Substance Abuse, Psychosocial Issues
- Dealing with Difficult Clients
- Collaborating with Other Organizations

To help support trainings, VDH engaged with local providers and their regional AIDS Education and Training Center (AETC).

#### Patient Navigator Supervisors

Supervision of Patient Navigators is a critical element of the intervention's infrastructure. Patient Navigators are managed by a variety of staff, including administrative staff, nurse managers, and physicians.



### Staff Characteristics

- Familiar with client-centered approaches to service delivery
- Proficient in networking with HIV service providers, the community, and high-risk populations
- Strong interviewing and oral communication skills
- Ability to provide culturally competent and sensitive health and risk reduction educational messages
- Ability to work in a team setting
- Strong time management skills
- Knowledge of community resources and ability to develop new linkages in the community
- Familiarity of health care delivery/services in particular service areas

Source: Virginia Department of Health. *Systems Linkages and Access to Care Initiative*. Special Projects of National Significance. [Final Report.] October 2015.

# Replication Tips for Intervention Procedures and Client Engagement

This section provides tips for readers interested in replicating the intervention and, where applicable, includes grantee examples for further context.

Recommendations for getting started:

- *Conduct a needs assessment* to determine what services are already available in your community. Know where they overlap with similar services. Ask members representative of the target population what their most pressing needs and concerns are and tap local consumer advisory boards and/or planning council to solicit input as well.
- *Build partnerships* at the local, state, and regional levels. These partnerships are integral to project design and execution.
- *Maintain partnerships*. Building rapport and stewarding relationships is not a one-time activity. They must be nourished and maintained over time.
- *Upfront planning is key* to the intervention's success over the long-term. Key steps of VDH's planning process included:
  - ▶ *Reviewing HIV/AIDS data* in the service areas.
  - ▶ *Building upon existing planning processes and community groups*.
  - ▶ *Augmenting current processes*. Prior attempts, with various levels of success, had been made to establish a Patient Navigation model. VDH built upon this to create a sustainable model that could be replicated throughout the State.
  - ▶ *Coordinating related activities*, specifically with the CDC's CAPUS demonstration project.
- *Be inclusive at planning*. VDH engaged various stakeholders from the earliest stages of the intervention.
  - ▶ *A Project Planning Group*, comprised of representatives from all related care continuum activities, guided the overall strategy and design of the intervention.
  - ▶ *Community Advisory Committee*, which includes a large representation of PLWH, gathered community feedback on the intervention.
  - ▶ *Strategy Groups*, which includes Patient Navigators and Navigator Supervisors from the sites implementing the intervention, provided input on the process and the development of the intervention's protocol.
  - ▶ *Regional Groups*, which included representation from the regions in which the intervention was piloted. The goal of these groups is to create a discussion forum about the intersection of the various linkage strategies being developed and implemented through the SPNS Systems Linkages Initiative.

- *Develop a protocol* for all members of the Patient Navigation intervention to follow.
  - ▶ *Ensure clarity about job procedures*, particularly the importance of Fidelity Monitoring, as needed.
- *Define job responsibilities*. DIS and Patient Navigators share common goals and therefore, roles must be coordinated locally.
- *Allow for flexibility* in training to take into account Patient Navigators' real-world experience. Keep in mind that Patient Navigation programs may have varying challenges and successes at different sites throughout the State.
- *Make supervision a critical part of the intervention's infrastructure* with the goal of ensuring that Patient Navigators are supported in doing the best possible job and that they avoid burn-out.

## Securing Buy-In

The Patient Navigator Strategy Group determined during the planning process that it was critical to introduce the Patient Navigation intervention to community partners prior to the intervention's launch. As such, the VDH made it a priority to:

- Build relationships between testing agencies, DIS at Local Health Departments, and Patient Navigators
- Receive support from agency leadership and stakeholders
- Have access to resources for initial and ongoing training and curriculum components
- Guarantee buy-in and support through community and stakeholder education
- Ensure new processes are useful for all parties

Securing buy-in with Patient Navigators themselves was equally important. VDH made it a priority to engage Patient Navigators in the development of the protocol from the very beginning of its inception, as part of planning groups. VDH also held a kick-off meeting to discuss the intervention and how it benefits clients and community health prior to the launch of the Patient Navigation intervention in an attempt to bolster buy-in and address questions up-front.

Still, some Patient Navigators were reluctant to following the protocol put forth by the Patient Navigation intervention, particularly those who had already served as a Patient Navigator or in a similar role when hired. As such, VDH also made it a priority to encourage Navigators to participate in Strategy Groups, Planning Groups, and Learning Sessions, which were held on a routinely

**VDH made it a priority to engage Patient Navigators in the development of the protocol from the very beginning of its inception, as part of planning groups.**

scheduled basis—for example, monthly calls, a twice yearly face-to-face meeting—and were continually updated on the intervention’s milestones. VDH also provided the opportunity for Patient Navigators to highlight their work on statewide forums and contractor meetings as a way to foster buy-in and celebrate collaborative successes.

## Overcoming Implementation Challenges

No intervention is implemented without challenges, and the VDH’s Patient Navigation intervention is no exception. These included:

- *When to Discharge.* In general, most clients receive services for approximately one year, with discharge assessments performed every six months. Because there is no hard-and-fast rule for when client discharge must happen, there was a tendency to keep clients engaged in the intervention longer than necessary and a hesitancy, at times, among the Patient Navigators to discharge clients. Even when clients were discharged after one year of services, some Patient Navigators continued to provide a stepped-down version of the navigation service. It was necessary to remind Patient Navigators, either directly or during monthly and quarterly meetings, that the intervention is a demonstration project to test and measure the effect of Patient Navigation services and that successful transition of clients from the intervention was critical to the initiative.
- *Inconsistent Application of the Intervention.* Project Evaluators and Patient Navigator Supervisors sometimes had concerns about how the intervention’s strategy was applied. For example, in contrast to Patient Navigators who did not transition their clients in a timely matter, others simply gave clients a quick referral and then discharged them. Neither is how the intervention is intended. Some navigators needed to build skills in these areas more than others; ongoing training and fidelity monitoring is key.
- *Resistance to Fidelity Monitoring.* Patient Navigators initially resisted the process of fidelity monitoring, feeling that it was to monitor their job performance rather than to improve service quality. Once evaluators explained that the fidelity monitoring process was an opportunity to provide supportive feedback and ensure consistent application of the intervention, most Patient Navigators began to embrace it. However, getting their buy-in was a process and did not happen immediately.

## Promoting Sustainability

Some or all components of the Patient Navigation intervention can be incorporated into existing linkage-to-care services. For example, if funds do not exist to hire a Patient Navigator, it may be possible to incorporate tenants of it into other services. Community health workers and case managers, for example, already often provide some level of navigation services. It may be possible to incorporate tenants of patient navigation into other services. Community health workers and case managers, for example, often provide some level of navigation services. It may be possible for them to embrace aspects of the VDH’s Patient Navigation intervention, for example, developing linkage-to-care or retention-in-care plans specific to HIV-infected clients, when serving patients.

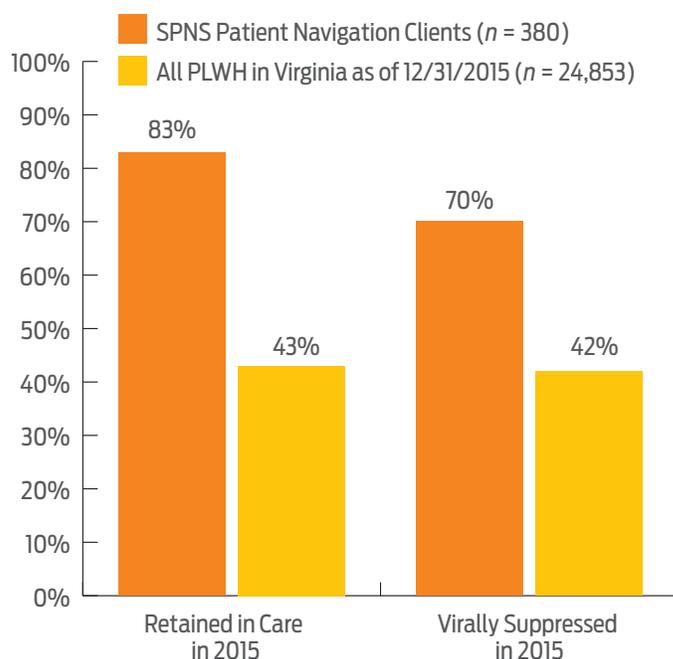
Given that the VDH’s Patient Navigation intervention no longer receives dedicated funding, VDH has transitioned Patient Navigation services to other funding streams. For example, Patient Navigation services are permissible under Ryan White Part B funding. Other strategies to secure funding include rolling Patient Navigation services into services categories. For example, services that support Patient Navigation are “Medical Transportation Services,” which support access to medical appointments, and “Case Management, Non-Medical,” which supports time intensive activities such as linking clients with social or community services. Ongoing evaluation of data is being utilized for a future Request for Proposal for a statewide Patient Navigation program.

## Conclusion

Patient Navigation is a strategy that can be used to help PLWH access and stay in medical care. Among the 380 PLWH served by the three SPNS Patient Navigation programs in Virginia from September 1, 2013–August 31, 2015, 83 percent were retained in care and 70 percent were virally-suppressed in Calendar Year (CY) 2015. Compared with the overall population living with HIV in Virginia, SPNS Patient Navigation clients had better rates of retention and viral suppression in CY 2015, indicating the importance of client-centered Patient Navigation programs that focus on addressing client barriers to linkage or retention in care. (See Figure 1.) Linkage, retention in care, and viral suppression not only contribute to an individual’s improved health, but also reduces the transmission of the disease to others. Patient Navigation is thus a promising intervention that can be replicated in part or in full at sites nationwide.

Retention in care for 2015 was defined as having at least two or more HIV care markers (evidence of antiretroviral treatment, HIV medical visit, or a viral load test or CD4 count measurement) in CY 2015 at least three months apart. A client was considered virally suppressed in CY 2015 if the last viral load taken in CY 2015 was <200 copies/mL.

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



## Tested and Proven HIV Strategies

The Integrating HIV Innovative Practices (IHIP) project is an outgrowth of SPNS. HAB created IHIP to share knowledge gained from SPNS interventions, and to promote their replication. IHIP takes tested innovations and turns them into practice. IHIP is where training meets implementation, with the intended results being more informed providers, better care delivery and, ultimately, healthier clients and communities.

This intervention guide is part of a larger series of resources and capacity building assistance activities including webinars about the interventions, a dedicated IHIP listserv, and a help desk.

## 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](mailto:SPNS@hrsa.gov) and let us know about your replication story.

## Other Resources

- 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>

## Appendix: SWOT Analysis

SWOT is an acronym for Strengths, Weaknesses, Opportunities, and Threats. A SWOT analysis is a structured planning method that can be used to assess the viability of a project or intervention. By conducting a SWOT analysis in advance of an intervention, organizations can proactively identify challenges before they occur and think through how best to leverage their organizational strengths and opportunities to improve future performance.

VDH Patient Navigation Intervention	
 <b>Internal</b>	<b>Strengths:</b> linkage to care services in place, inclusive planning, evidenced-based approach (e.g. motivational interviewing, fidelity monitoring) with strong data component, clearly defined intervention protocol
	<b>Weaknesses:</b> securing buy-in of staff, challenges in delineating staff roles and responsibilities, program not always implemented as intended
 <b>External</b>	<b>Opportunities:</b> involvement of CAPUS staff, strong community partnerships/ potential for additional collaborations, potential for funding from new RFPs
	<b>Threats:</b> challenges in securing buy-in of community partners, lack of funding

# Appendix: Client Encounter Form/Checklist

## Patient Navigation

### SPNS Patient Navigation Encounter/Visit Checklist

Client ID: \_\_\_\_\_ Date: \_\_\_\_\_ Assigned staff member: \_\_\_\_\_

Intake visit start: \_\_\_\_\_ am/pm Intake visit end \_\_\_\_\_ am/pm

Conduct activities in the order listed on this page at the client's intake visit. Check the appropriate box, as completed:

- Update Client Contact Information Form
- Facilitate or confirm next client medical appointment. Date of appointment \_\_\_\_\_
- Review client accomplishments and ongoing barriers and complete the Retention In Care Plan (RCP) form
- Make a copy of the RCP for the client to take home that *does not have Client ID on it*
  - Client refused copy of RCP
- Make referrals to support services to address barriers in RCP if applicable.
- Offer client Partner Testing Services ( if applicable in encounter setting)
- Provide tailored client education (list components covered)  
\_\_\_\_\_
- Complete the Client Encounter form (or ensure data is recorded electronically)

Please use the space below to document any notes or additional information that may not be captured above:

# Appendix: Coordination of Care and Services Agreement (CCSA) Form Patient Navigation

## Coordination of Care and Services Agreement Form Instructions

### Purpose of Form:

The purpose of this form is to allow the client and the agency that provides the services to identify and select available community resources. The goals are to help coordinate services, assist with closing the referral loop, and allow for easier linkages to care.

Each agency that initiates this form becomes the owner of this form and their agency name should be placed at the top of the page. Each agency should decide if this form will replace or supplement their current consent for services and or release of information form(s). Each agency will also need to decide how and where they want to store and maintain this form.

The client will then have the opportunity to agree to services. It is presumed that when an agency is checked by a client on this form to request services, the agency will initiate the first contact with the client ***unless specified in writing that the client will make the first contact.***

The instruction on this page will help with the completion of the Coordination of Care and Services Agreement Form.

Please remember, if the form is not complete and accurate, this may cause a delay in obtaining additional services for the client.

### Instructions for the CCSA Form Page 1

1. The agency representative will print the client's full name, address, and date of birth on the top portion of the form.
- 2a. Check the appropriate box to indicate the client's medical diagnosis (HIV/AIDS and/or Hepatitis C) and write the corresponding date for each diagnosis.
- 2b. Check the appropriate box for *current gender* of the client.
- 2c. Check the appropriate box to indicate the *client's race*.
- 2d. Check the appropriate box indicating the *client's ethnicity*.

## Patient Navigation

- 3a. Check the appropriate confidential information that the client wishes to exchange, writing in any additional information not listed.
- 3b. Check the appropriate box indicating that the information listed in 3a can be released to help assist with the listed care arrangements and/or providers *as specified on page 2 of this form*. This form is not intended to be a blanket consent form and information should only be exchanged with the agencies listed on page 2 of this form.
4. The client will need to advise the agency representative the best contact method(s) and if it is appropriate to leave a message on the phone or at work.
5. The agency representative will write in the authorization effective date and advise the client that the authorization date is valid for 24 months from the signature date. If revoked, the **client must sign and date**. The client is responsible for contacting the agencies to withdrawal from their services.
6. The client will sign and date the form acknowledging the purpose of the form.
7. The agency representative will complete his or her name, address and phone number.

### Instructions for the CCSA Form Page 2

**Section A:** This section should be filled out by the agency representative who originated the form.

- 1a. Print the client's full name.
- 1b. Print the client's date of birth.
- 1c. List the name of the organization(s) that the client is being referred to for medical care or other services.
- 1d. The agency representative who originated the form should print their own name, secure fax line, and phone number.

**Section B:** This section should be filled out by the agency representative who received this form and who will be coordinating care for the client.

2. The Patient Navigator or other Linkage Personnel will write their name, agency, phone number, and secure fax line.
3. The Patient Navigator or other Linkage Personnel using this form will complete information related to the referral for the medical care including the name of the agency or provider that the client is being linked to, the date of the referral, and the date of the medical appointment.
4. Once attendance to the **medical appointment is confirmed**, the Patient Navigator or Linkage Personnel at the provider site will confirm that date of attendance and circle how the original agency was notified of attended appointment. If sending confirmation by fax, **please be sure to use a fax cover sheet**.
5. Referrals to other services can be recorded in the subsequent lines provided on page 2 of the form.

# Appendix: Linkage-to-Care Plan

## Patient Navigation

### Linkage to Care Service Plan: Assessing and Addressing Barriers (Page 1 of 1)

(to be assessed at each intake visit/encounter)

Client ID: \_\_\_\_\_ Date: \_\_\_\_\_

#### Client's Goal:

Identify *up to* three barriers to achieving client's goal, and potential solutions to those barriers:

#### Barrier #1

Solution/plan to overcome Barrier #1

Target Date:

#### Barrier #2

Solution/plan to overcome Barrier #2

Target Date:

#### Barrier #3

Solution/plan to overcome Barrier #3

Target Date:

# Appendix: Retention-in-Care Plan

## Patient Navigation

### Retention in Care Service Plan: Overcoming Barriers (page 1 of 2)

(to be assessed at each subsequent client visit/encounter)

Client ID: \_\_\_\_\_ Date: \_\_\_\_\_

#### Accomplishments and Resolutions:

Use the space below to document resolution of barriers from previous appointment and client accomplishments.

#### Ongoing Barriers:

Use the space below to document any ongoing or persistent barriers that may not have been resolved since the previous appointment.

## Patient Navigation

### Retention in Care Service Plan: Overcoming Barriers (page 2 of 2) (to be assessed at each subsequent client visit/encounter)

Client ID: \_\_\_\_\_ Date: \_\_\_\_\_

#### Client's Goal:

Identify *up to* three barriers to achieving client's goal, and potential solutions to those barriers:

#### Barrier #1

Solution/plan to overcome Barrier #1

Target Date:

#### Barrier #2

Solution/plan to overcome Barrier #2

Target Date:

#### Barrier #3

Solution/plan to overcome Barrier #3

Target Date:

# Appendix: Client Transition Assessment Plan

## Patient Navigation

### Patient Navigation Client Assessment

#### 1. Client Information

Date:	Client/ID:	Patient Navigator Name
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#### 2. It has been *or* it will be difficult for me to attend my HIV medical appointments because (Please check all that apply.)

<input type="checkbox"/>	I need a more reliable source of transportation	<input type="checkbox"/>	I feel healthy
<input type="checkbox"/>	I am uninsured	<input type="checkbox"/>	Going to appointments reminds me that I have HIV
<input type="checkbox"/>	I have limited or no income	<input type="checkbox"/>	I am afraid other people will know I have HIV
<input type="checkbox"/>	I have to work during clinic hours	<input type="checkbox"/>	HIV treatment won't work for me
<input type="checkbox"/>	My living situation is unstable	<input type="checkbox"/>	I want to see a different medical provider
<input type="checkbox"/>	Childcare is not available and/or affordable for me	<input type="checkbox"/>	I forgot about my appointment
<input type="checkbox"/>	I feel depressed, anxious or have other mental health concerns	<input type="checkbox"/>	Other:
<input type="checkbox"/>	I am using drugs and/or alcohol	<input type="checkbox"/>	Other:
<input type="checkbox"/>	I am confused about how to schedule appointments	<input type="checkbox"/>	Other:
<input type="checkbox"/>	I am too busy to go to my appointments	<input type="checkbox"/>	Other:

Other Comments:
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<b>3. For Patient Navigator to use during client discharge/ transition assessment</b>	Date of Most Recent HIV Medical Visit:	Date of Most Recent HIV Medication Pick-Up:
<b>4. For Patient Navigator to use during client discharge/ transition assessment</b>	Transition/Discharge Recommended YES      NO	Reason:

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