Patient Navigation for HIV-Positive Individuals in Virginia
SPNS Systems Linkages and Access to Care Initiative

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Disclaimer

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Overview

• Virginia Department of Health (VDH) received a four-year Special Projects of National Significance (SPNS) award under the “Systems Linkage and Access to Care for Populations at High Risk of HIV Infection” Initiative from HRSA in September 2011.

• Goal: Design, develop, and implement innovative interventions to improve linkage, retention and viral suppression for persons living with HIV (PLWH).

• Evaluate impact of interventions and disseminate findings for replication.

Source: [www.hiv.gov](http://www.hiv.gov)
Project Methodology:

- Utilized the Collaborative Learning Model and Plan Do Study Act (PDSA) cycles to develop, test, and implement small tests of change and then replicate on a larger scale.

- Involved stakeholders from all sites and geographic regions:
  - DIS and local health department representatives
  - Patient navigators and community health workers
  - Mental health counselors
  - Community HIV testing sites
  - Department of Corrections
  - Medical providers and case managers
  - Persons living with HIV
Virginia implemented four systems linkages interventions to address these project goals:

- **Active Referral** – aimed to accelerate linkage to HIV care for newly diagnosed individuals by Disease Intervention Specialists.

- **Mental Health** – aimed to address mental health barriers that prevent clients from linking or retaining in HIV care through a standardized screening and referral process.

- **Care Coordination** – aimed to facilitate immediate access to medications and medical care for PLWH being released from a prison or jail.

- **Patient Navigation** – aimed to increase linkage, retention and viral suppression among PLWH by working with clients to address barriers and ensure access to needed resources.
Patient Navigation Objectives:

- Link newly diagnosed clients to care within 30 days of diagnosis
- Re-engage at-risk and out of care clients
- Address barriers to staying in care
- Link clients to needed support services
- Use Motivational Interviewing to provide client-centered counseling
- Transition clients to community services and self-management
- Facilitate referrals to HIV testing and distribute at-home HIV test kits.
Target Populations: Newly diagnosed, sporadically in care/at-risk to dropping out of care, lost to care, previously diagnosed/never engaged in care.

Services Duration and Scope:

• 90 days of navigation services focused on addressing client barriers to linking and engaging in HIV care.

• 6-9 months of navigation services focused on addressing ongoing barriers to retaining in care through client-centered counseling.
## Intervention At-A-Glance

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Referral</strong></td>
<td>Clients are referred to PN services by DIS, testing sites, or medical sites. Client signs “Coordination of Care and Services Agreement.”</td>
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<tr>
<td><strong>Intake</strong></td>
<td>PN conducts intake assessment of barriers (ongoing) and develops “Linkage to Care Plan” with the client.</td>
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<td><strong>Ongoing Encounters</strong></td>
<td>PN works with client to stay engaged in care using Motivational Interviewing to continuously address barriers. Uses “Retention in Care Plan.”</td>
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<td><strong>Transition</strong></td>
<td>Client is assessed for transition from PN services every 6 months. May be transitioned to self-care, case management or other community services.</td>
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<tr>
<td><strong>Discharge</strong></td>
<td>Client and PN document “Transition Plan” together and client is discharged to other services or self-management.</td>
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Implementation Sites
Capacity and Resource Needs I

• Identify target population to be served by Patient Navigation.

• Assess availability of other resources in your services area (to coordinate with and/or avoid duplication).

• Develop partnerships with key stakeholders and referral sites: testing sites, community based organizations, local health departments, medical providers, case managers.

• Identify Patient Navigation model to be used and all tools, resources, and forms that will be used (existing or new model).
• Identify, hire, and train Patient Navigators.

• Ensure adequate supervision from appropriate staff at your agency (may vary by organization type- medical vs. non-medical settings)

• Identify data to be collected from program and data system that will be used. Hire data coordinator or analyst if possible to assess program impact and outcomes.

• Identify a way to measure implementation fidelity to ensure consistent application of the protocol.
Implementation Challenges:

- When to discharge clients from PN services
- Inconsistent supervision of PNs
- Data collection issues
- Inconsistent use of the intervention protocol
Fidelity Monitoring was introduced to address some implementation challenges:

- VDH implemented an ongoing Fidelity Monitoring program to assess the use of Motivational Interviewing (MI) during client encounters.
- Contracted with a local evaluator/trainer to train PNs in MI-didactic sessions and interactive role-plays.
- PNs submitted audio-recordings of selected client sessions (with client consent and IRB approval) and were provided one-on-one supportive feedback and refresher trainings on an ongoing basis.
VDH also developed a Fidelity Monitoring Program Toolkit designed to allow programs to assess implementation of the model including:

- Patient Navigator Surveys
- Patient Surveys
- Process and Outcome Measures Tool
- Training Plan and Checklist Tool
- Client Record/Chart Review Tool

These tools are then used to assign a “Fidelity Level” to the site: low, medium, high.

Perfect implementation is not necessary or realistic, but tools can help prompt ongoing quality improvement efforts.
Implementation II

- Addressing other implementation challenges:
  - Agency specific **refresher trainings and technical assistance** sessions on the protocol and data collection methods.
  - Creation of a formal **“Transition Plan”** and discharge process for clients.
  - Consistent updates on **program outcomes** including quarterly presentations at sites showing preliminary linkage, retention, and viral suppression data to keep sites focused on long-term outcomes.
Sustainability

- Patient Navigation programs can be incorporated into many existing medical and non-medical settings.

- Ensure adequate funding and resources: Many components of Patient Navigation (medical transportation, outreach, health education/risk reduction, etc.) can be built into Ryan White programs.

- Ensure adequate staffing and address staff turnover to ensure continuous service provision.

- Provide ongoing training and certification programs.
Patient Navigation Clients Served
9/1/2013 - 8/31/2015 (n=380)

Transmission Risk Percent of PN Clients
- Heterosexual Contact 21%
- Injection Drug Use 6%
- MSM 53%
- MSM/IDU 4%
- No Risk Factor Identified or Reported 13%
- Perinatal Exposure 3%

Gender Distribution
- Female 24%
- Male 76%

Race Distribution
- White, Non-Hispanic 21%
- Black Non-Hispanic 74%
- Hispanic 3%
- Asian 1%
- Multi-Racial/Unknown 1%

Age Distribution
- <18
- 18-24
- 25-34
- 35-44
- 45-44
- 55-64
- 65+
- Unknown
HIV Care Outcomes Among SPNS Patient Navigation Clients vs. All PLWH in Virginia

Retained in CY 2015: 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 Calendar Year (CY) 2015 at least 3 months apart.

Virally Suppressed in CY 2015: A client was considered virally suppressed in CY 2015 if the last Viral Load taken in CY 2015 was <200 copies/mL.
Lessons Learned and Key Takeaways

• Assess need for Patient Navigation services and identify target population and referral sources.

• Build partnerships and garner buy-in early from key stakeholders; continuously maintain stakeholder engagement.

• Develop written protocols and policies and develop a plan to monitor implementation (Fidelity Monitoring) to ensure consistent application of the model but allow for adaptation.

• Continuously review program outcomes and plan quality improvement efforts accordingly.
Resources and Contact Information

Virginia SPNS Systems Linkages Intervention Manuals, Protocols and Forms:

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