DEII Intervention

SPOTLIGHT

Finding People Who Are Not in Care: Collaborations between Early Intervention Specialists and Peer and Patient Navigators in the Health Care Team

THE CHALLENGE

Approximately 1 in 7 people with HIV do not know their status.[1] Women are a particularly vulnerable group, comprising 19% of new infections, with only 51% achieving viral suppression.[2] Factors such as exposure to violence, stigma, and competing needs such as housing, food, child care, and employment may interfere with engaging in HIV care and treatment. Because of these factors, finding effective strategies to locate and engage women who are newly diagnosed or (who have) fallen out of care and helping them obtain necessary services can be time consuming and burdensome for the care team.

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

Enhanced Patient Navigation for Women of Color Living With HIV

Peer Linkage and Re-engagement of Women of Color Living with HIV

WHY THIS SPOTLIGHT?

Employing Peer and Patient Navigators can support patients with HIV link to and engage in HIV care. By collaborating with existing Early Intervention Services teams within their agencies or communities, Peer and Patient Navigators can enhance their outreach efforts and engage more patients in their care.

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[1]Centers for Disease Control Division of HIV/AIDS Prevention National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention. HIV in the United States and Dependent Areas (2019) Available at: https://www.cdc.gov/hiv/statistics/overview/ataglance.html. Accessed December 1, 2019.

[2]Centers for Disease Control Division of HIV/AIDS Prevention National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention. Women and HIV in the United States and Dependent Areas (2019) Available at: https://www.cdc.gov/hiv/group/gender/women/ Accessed December 1, 2019.

THE SOLUTION

Peer and patient navigators within the health care team are potential workforce members who can support women and other people with HIV experiencing challenges to staying in care and sustaining viral suppression. Peer and Patient Navigators often share characteristics with the patient population and are trusted members of the community who, unlike other health care team members, have the time and motivation to educate, support, and outreach to patient populations. Through Health Resources and Service Administration's Dissemination of Evidence-Informed Initiative (DEII), six HIV clinics implemented Peer and Patient Navigation interventions to find and re-engage newly diagnosed or out of care women with HIV. Finding the women was one of the first and most difficult hurdles to overcome. Each clinic first reviewed their out of care list and attempted to contact the women. When initial contacts failed, each site partnered with community actors or re-

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organized their care team to intensify efforts to locate women. Two DEII sites, Meharry Community Wellness Center (MCWC) in Nashville, TN, and Newark Beth Israel Medical Center (NBIMC) in Newark, NJ, partnered with Early Intervention Service (EIS) workers (also known as Linkage Coordinators (LC)) who had additional information and resources to help the clinics find the women.

HOW IT WORKED

At NBIMC, Linkage Coordinators (LC) contacted and helped newly diagnosed and out of care patients make their first HIV medical appointment. Funded through the Centers for Disease Control and Prevention, LC ensured that clients had appropriate documentation confirming their HIV status, obtained necessary insurance information, and identified other barriers and appropriate referrals to enhance successful linkage and retention. Once a client made their first appointment, the LC coordinated with the Patient Navigator, who conducted intensive education sessions and assigned clients to the appropriate Supportive Case Manager (SCM) for guidance and advocacy during the treatment of HIV and all co-morbidities. The PC partnered with a Community Health Worker (CHW) to address other non-medical needs and coordinate home visits as necessary. Working together, LC, PC, CHWs and SCMs can "connect the dots" between the care team and ensure clients have support both in the medical center and the community.

"Working together, the EIS worker and peer were able to locate and reconnect eight clients who had dropped out of care from MCWC."

At MCWC, peers (called Treatment Adherence Counselors) met weekly with health care providers and medical case managers to review the list of patients who were out of care and prepare before contacting the women. Peers would attempt to contact those who were out of care at least three times or for up

to two months. When the peer was unsuccessful in making contact, she would meet with the EIS worker, who worked closely with the city health department, to locate all clients who were newly diagnosed or out of care. If a client was out of care for more than a year, the MCWC EIS worker would alert the TN Health Department Disease Intervention Service workers to deploy additional resources to locate the women. The EIS worker was funded by Ryan White Part B, which supported their role for the clinic and Health Department.

In addition to meeting weekly to review out of care client lists, the EIS worker also conducted outreach in the community with the peer to visit client homes, or other places where clients could be found. The EIS worker also had access to resources such as jail and county health records, to check for clients who may have been incarcerated or passed away.

Working together, the EIS worker and peer were able to locate and reconnect eight clients who had dropped out of care from MCWC. For example, the team located a woman who had been in and out of the Meharry-Nashville General Hospital. The client had a private health care provider so the peer was not successful in reaching out to the client originally. Based on information from the EIS worker they were able to locate the client, who had been living on the street behind a church. They met with the client and were able to build a close relationship, address some of her needs, and reconnect her to medical care.

TAKEAWAYS

Teams of EIS/LC and Peer and Patient Navigators can work effectively to ensure clients engage with and stay connected to the health care system. EIS/LC may have the resources, information, and time to find clients and create outside partnerships with city and county health departments, jails, hospitals, and other community agencies. These workers may be known in the community and can help clinic-based staff like Peer and Patient Navigators spend less of their time locating and contacting clients. In addition, frequent communication and meetings (at least every other week) can help build and reinforce collaboration between these staff members and providers, helping to reduce duplication of efforts in identifying, locating, and contacting hard-to-reach clients. Clients stayed more engaged when they felt their primary care providers supported outreach efforts

FIND OUT MORE

To learn more about the initiative and access additional project resources, visit: *https://targethiv.org/deii/deii-peer-linkage*

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