



Community Health Workers (CHWs) in HIV Services: Insights from Virginia

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Welcome



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HRSA CHW Project: FY 2016-2019

- Funded through the Secretary's Minority AIDS Initiative Fund (SMAIF)
- Administered by the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB), in the Division of Community HIV/AIDS Programs (DCHAP)

HRSA Project: Goals

1. Increase the utilization of CHWs to strengthen the health care workforce, improve access to healthcare and health outcomes for racial and ethnic minority people living with HIV (PLWH).
2. Assist Ryan White HIV/AIDS Program-funded (RWHAP) medical provider sites with the support needed to integrate CHWs into an HIV multidisciplinary team model.
3. Develop tools, materials and resources to increase the use of CHWs in health care teams.
4. Evaluate the effectiveness of CHWs in linkage to and retention in care for PLWH and assess the CHWs models implemented by RWHAP providers.

Speakers



**Leonard
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HIV Services
Coordinator
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HIV Prevention
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Monitor
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Webinar Goals

- Describe how Virginia Department of Health (VDH) utilizes Community Health Workers (CHWs) in HIV prevention and care
- Identify ways that CHW positions are funded in Virginia
- Describe the scope of work of CHWs in HIV services
- Describe how CHWs are integrated to improve outcomes along the HIV care continuum

Virginia's definition of a CHW

“A Community Health Worker applies his or her unique understanding of the experience, language and culture of the populations he or she serves to promote healthy living and to help people take greater control over their health and their lives.

CHWs are trained to work in a variety of community settings, partnering in the delivery of health and human services to carry out one or more of the following roles: providing culturally appropriate health education and information; linking people to the services they need; providing direct services, including informal counseling & social support; and advocating for individual and community needs, including identification of gaps and existing strengths and actively building individual and community capacity.”

Origins - Special Projects of National Significance (SPNS)

- Four-year Special Projects of National Significance award under the “Systems Linkage and Access to Care for Populations at High Risk of HIV Infection” initiative from HRSA
- Virginia was granted a no-cost one year extension
- \$4 million competitive award
- Goal: Design, develop and implement innovative interventions to improve linkage, retention and viral suppression for persons living with HIV (PLWH)

Origins - Special Projects of National Significance (SPNS)

Four systems linkages interventions developed:

1. Active Referral - Coordination of Care Services Agreement (CCSA)
2. Mental Health
3. Care Coordination
4. Patient Navigation

Origins - Special Projects of National Significance (SPNS)

Patient Navigation

Target Populations: PLWH not fully engaged in care along the HIV care continuum

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 using motivational interviewing techniques.

Origins - Special Projects of National Significance (SPNS)

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

Origins - Special Projects of National Significance (SPNS)

Why Motivational Interviewing (MI)?

- A critical core component of the Patient Navigation project
- Collaborative conversation to strengthen a person's own motivation for and commitment to change
- Addresses/overcomes barriers to care and treatment
- Patient Navigators utilize the relationship groundwork established with clients and rely on their MI skills to help clients understand their challenges and formulate a plan of action based on what the client's own goals and needs are

Origins - Special Projects of National Significance (SPNS)

Patient Navigation - implemented in the Southwest and Central health regions of Virginia

Two original sites (two health systems) and two expansion sites (one health system and one local health district)

Evaluation

- Fidelity monitoring - MI skill adherence and maintenance
- HIV care outcomes

Origins - Special Projects of National Significance (SPNS)

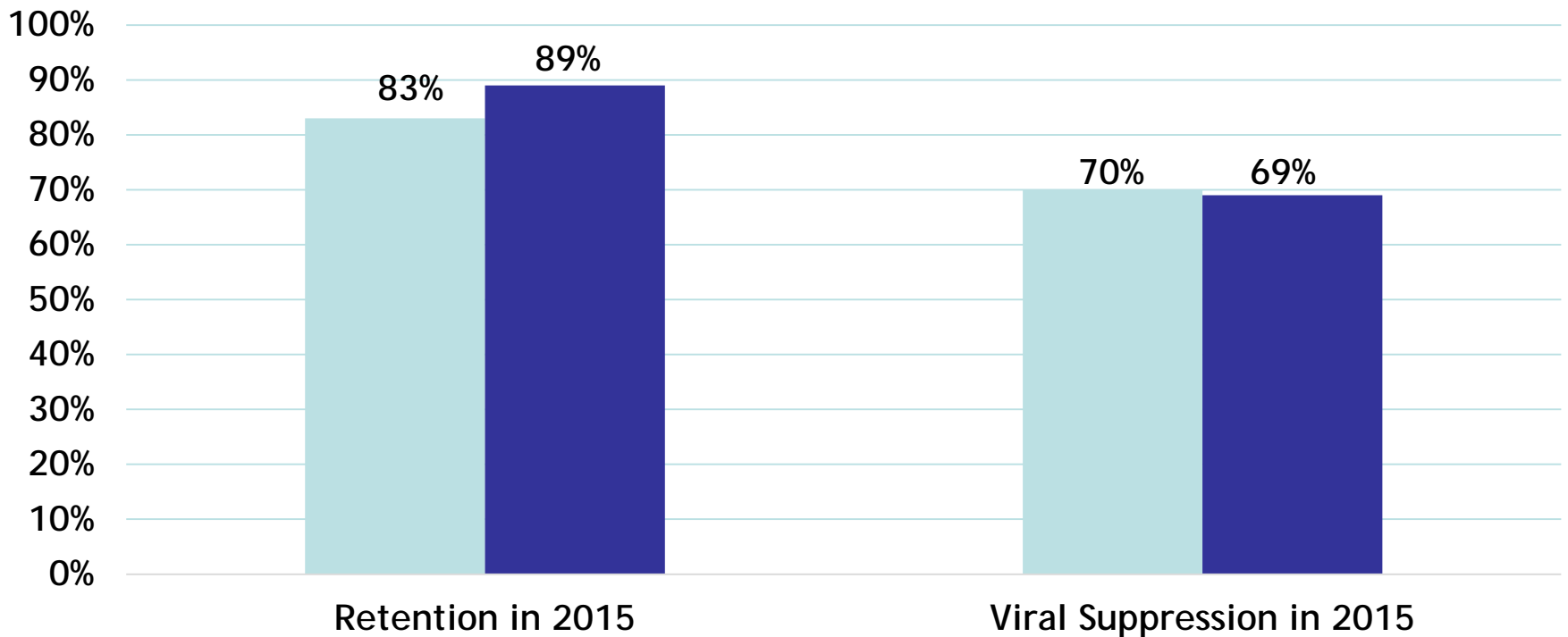
Fidelity Monitoring was introduced to address some implementation challenges:

- VDH implemented an ongoing Fidelity Monitoring program to assess the use of Motivational Interviewing (MI) during client encounters
- Navigators received training in MI through a series of didactic sessions and interactive role-plays
- Patient Navigators 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

HIV Care Outcomes Among SPNS Patient Navigation Clients

■ Patient Navigation Clients (n=380)

■ All Ryan White Clients in Virginia as of 12/31/2015 (n=10,058)



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.



Origins - Care and Prevention in the United States (CAPUS)

- Three-year demonstration project Care and Prevention in the United States (CAPUS)
- Virginia was able to continue for an additional year using carryover funds
- Funded through a collaboration of federal funders, CDC, HRSA, SAMHSA, HHS, and NASTAD as the technical assistance
- The total CAPUS project was \$44.2 million
- Virginia received over \$2 million per year for the entire project

Goals of the project

The overall goal of CAPUS was to provide services to African-Americans and Latinos in four areas:

- Identify new HIV infections
- Link/retain newly and previously-diagnosed individuals with comprehensive HIV-related medical care with the goal of viral suppression
- Use surveillance data to improve HIV prevention and care
- Address social and structural barriers to HIV testing and treatment, such as stigma and housing

Origins - Care and Prevention in the United States (CAPUS)

Virginia's components

- Patient Navigation using Community Health Workers
- Enhancing Surveillance
 - Care markers database
 - Data to Care
- Social and Structural Determinants of Health
 - Media Campaigns
 - Housing
- HIV Testing
 - Increasing community testing sites
 - Pharmacy testing
 - Walgreens

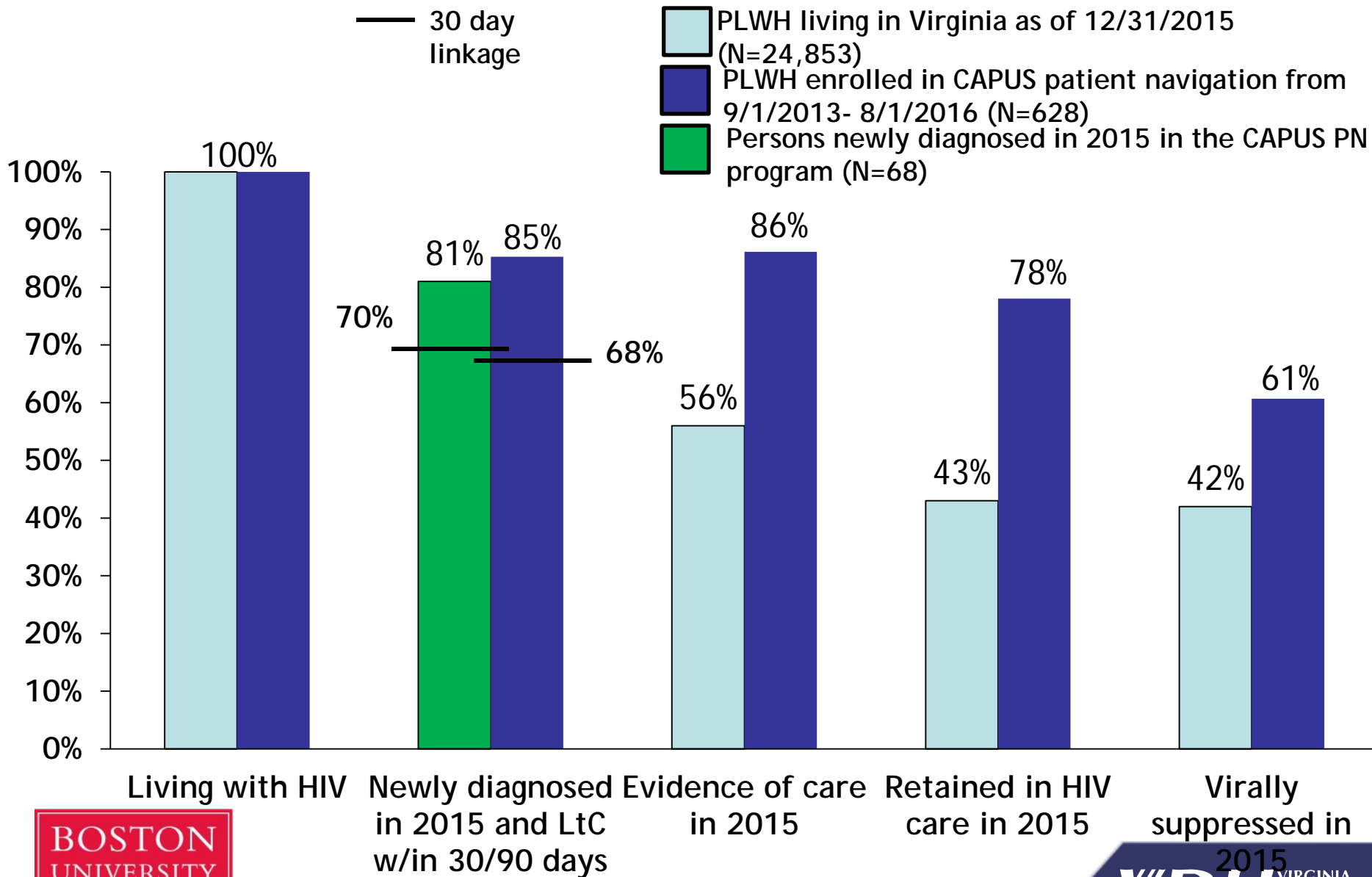
Trainings- CHW

Initial 40 hour Core Competency trainings with an emphasis on HIV

Quarterly in person trainings including many topics

- Barriers to Care
- Field Safety
- Cultural Competency
- Linkage to Care and Active Referral (CCSA Form)
- Disclosure and Stigma
- Self-care and Managing Stress
- Sexually Transmitted Diseases
- Dealing with Difficult Clients
- Recognizing Mental Health, Substance Abuse, and Psychosocial Issues
- Motivational Interviewing

CAPUS Patient Navigation HIV Continuum of Care, 2015



Data is considered preliminary and may be incomplete due to reporting delays. Note that persons enrolled in 2016 will have preliminary data as there has not been 12 months from initial enrollment in the program to fully assess health outcomes.

Implementation

Ryan White HIV/AIDS Program Service Categories

- Outreach Services
- Health Education/Risk Reduction
- Medical Transportation
- Referral for Health Care and Support Services
- Non-Medical Case Management Services

HIV Integrated Planning

- VDH Prevention, Care, Disease Intervention Specialists, Surveillance
- Coordination Care and Services Agreement
- Stakeholders - Collaborative Learning Model
- HIV Community Planning Group

Illustrative Interventions

Data to Care

- Included as a contractual requirement provided by CHWs at local health departments, community based organizations (CBOs) and health systems

HIV Testing - Linkage to a HIV Prevention Navigator at the same organization or nearby and or to a Disease Intervention Specialist (CCSA)

Ryan White HIV/AIDS Program Part B/MAI Patient Navigator

- Currently six subrecipients (one CBO, two local health districts, and three health systems)

Continued Interventions

Comprehensive Prevention for People Living with HIV

- Community Health Workers and Navigators

Comprehensive HIV/AIDS Linkages for Inmates (CHARLI) and Housing Navigators

HIV Prevention Navigation services for Negatives

- Empowering Communities for Life
 - Eight contractors- all provide service navigation with an emphasis in serving African-American and Latinos
- Prep Navigators
 - Project PRIDE 15-1506
 - Bridges 757 Collaborative 15-1509
- An emphasis to serve African-American and Latino men
 - Four CBOs and four local health departments

Future of Virginia's Patient Navigation

- RFP - Linkage and Retention in Care Request for Proposals - Care and Prevention Joint Project
- CBOs, Health Systems, Local Health Departments
- CHARLI and Housing Navigators
- CHWs are also funded through other non HIV state and local agencies; such as hospitals, federal and community health centers, mental and substance related agencies,
- Credentialed CHWs - Working toward billable services/sustainability

Legislation in Virginia

- A proposal to designate the Virginia Community Health Worker (CHW) Advisory Group as the official entity within Virginia to explore and standardize training and certification guidelines for CHWs, and explore financing and other sustainability options was sent to the Virginia legislature

To Learn More

A case study on the Patient Navigation intervention will be published soon. It will describe how grantees can replicate the intervention in their organizations.

If you would like to be notified when it is published, subscribe to the SPNS Integrating HIV Innovative Practices (IHIP) listserv at the URL below.

<https://www.careacttarget.org/ihip>

Questions?

Presenter Contact Information

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