The Navigation Program: An Innovative Method for Finding and Re-Engaging Lost HIV Clinic Patients

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LAC TLC+ Framework and PATH TLC+ Projects

- Social Network Testing $^{1,4}$
- Clinical Linkage Specialist $^{1,3}$
- Project Engage $^{1,3,4,5}$
- Medical Care Coordination (MCC) Program

High Risk Persons → HIV Positive → Linked to Care → Re-Engaged Care → Retained in Care → Adherent to ART Medication → Suppressed VL and Reduced Transmission

HIV Negative → Customized Prevention Program → PEP → PrEP $^{1,2,3,4,5}$

Collaborating Sites
- DHSP
- UCLA-Care Clinic
- LAGLC
- APLA
- Drew-OASIS Clinic
Background

- Retention in HIV care is a challenge for many HIV-infected persons
- Failure to engage in care can result in suboptimal ART use, poor disease prognosis and increased forward transmission
- Reasons for poor retention include substance use, mental health challenges, language barriers, housing insecurity, and stigma.
- Novel methods for identifying, engaging and retaining HIV-infected persons in care are needed
CHRP PATH Navigation Program Overview

- **Goal**
  - To re-engage lost HIV clinic patients using both enhanced PHI locator techniques and a tailored intervention approach

- **Identification/Location Methods**
  - Utilize HIV surveillance and other public health databases, clinic medical records and public records to identify and locate out of care patients

- **Re-engagement Methods**
  - Enroll patients into a three-tiered intervention strategy to facilitate re-engagement in care
CHRP PATH Navigation Program Overview

- **Eligibility:**
  - Adult HIV-infected clinic patients identified as out of care

- **Design:**
  - Sample of patients from publicly funded HIV clinics in LAC and local HIV surveillance database

- **Main Objectives:**
  - Describe effective lost patient identification techniques
  - Evaluate effective intervention strategies
  - Evaluate the effectiveness of using Navigators for linkage
  - Determine if program can foster long-term retention
Lessons Learned:
DHSP/APLA SIF Navigation Pilot Program
Screening: 702/1010\(^1\) Identified Lost Clinic Patients

- **28%** In Care Elsewhere
- **11%** No Longer LAC Resident
- **13%** Returned to Clinic Independently
- **14%** Patient is Deceased
- **14%** Patient is not available/Left message
- **5%** Number is Wrong/Disconnected
- **23%** Patient Declined Enrollment
- **4%** Patient Located/Interested in NAV; appt. scheduled

\(^1\)308 lost clinic patients were found ineligible due to VL/last appointment date
Most Effective Sources\(^1\) for Contact Information (n=702)

- HIV Surveillance\(^2\)  \(\text{21\%}\)
- Clinic Medical Record  \(\text{45\%}\)
- Ryan White Client Database  \(\text{29\%}\)
- Lexis-Nexis  \(\text{2\%}\)
- Other\(^3\)  \(\text{3\%}\)

\(^1\) Patient contact data searches were hierarchical starting with clinical medical records, followed by Ryan White Patient database, HIV surveillance, Lexis-Nexis, and Other until patient was successfully contacted.

\(^2\) HIV Surveillance breakdown: iHARS-LAC=1\%, eHARS-CA=8\%

\(^3\) Includes LAC Inmate locator, CA Prison Locator, STD surveillance database.
Baseline Demographics & Care History

Demographics (n=74)
- Race: 18% African American, 72% Latino, 5.5% white, 6% Other
- Gender: 75% male, 21% female, 4% transgender
- Insurance Status: 48% insured, 52% uninsured
- Age: 34% <40, 66% ≥40
- Employment: 33% employed, 43% unemployed, 24% other
- Current housing: 88% stable, 9% temporary, 3% homeless
- Education: 32% <High School, 68%=High School/GED
- Recent (6 month) substance use: 7.5% IDU, 25%, Non-IDU

Care History (n=74)
- Time Since Positive Result: avg 9.5 years (range: 1 month - 30 years)
- Time since last medical apt: avg 12 months (range: 21 days – 3 years)
- Last reported VL: avg 54,774 copies/ml (range: 20 – 1,011,623)
Barriers to Care

- Other Life Priorities (childcare, work): 45%
- Immigration Status: 6%
- No Transportation: 20%
- Stigma: 12%
- Drinking/Using Drugs: 9%
- Didn't think Needed HIV Care: 7%
Intervention

- Based on ARTAS Model
  - Modified for non-treatment naïve
  - 4 phased-10 session intervention
  - All patients enrolled at baseline
Outcomes

- **Intervention (n=55):**
  - Avg # of NAV visits = 7 (range 3-10)
  - Avg # of hours spent with NAV = 15 (range 2-44)

- **Linkage and Retention outcomes:**
  - 98% linked to care\(^1\)
  - 48% retained in care after 6 months (n=34)\(^2\)

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\(^1\) Attended at least one medical visit
\(^2\) Based on n=34 who have been linked and enrolled in care for at least 6 months; linkage efforts ongoing
Lessons Learned and Next Steps

- **Lessons Learned**
  - Supplementing clinic locator information with that of surveillance data is most effective method for obtaining useful contact information
  - A one size fits all intervention strategy is inefficient and not client-centered
  - Expanded retention efforts may assist these clients

- **Next Steps**
  - Take these key lessons and integrate them into CHRP-PATH Navigation Program and county-based LTC program
CHRP-PATH Navigation Program
Navigation Program Flow Chart

Clinic/Surveillance list of out of care individuals

Confirm eligibility with clinic staff

Referral to navigator (NAV)

Initial attempt to contact using clinic contact info

Located?

Yes

Contacted! Patient Agreed

No

1) Utilize HARS/Casewatch to gather contact info/status
2) Coordinate with MCC & prioritize
3) Utilize MMP/PHI investigative methods to locate

NAV contacts patient to schedule initial appointment and enroll in Navigation

In consistent care
(Intervention Ends)

Linked to care (medical, case management)

- NAV follow-up for 6 months after linkage
- additional NAV visits as needed

IN CONSISTENT CARE
(Intervention Ends)

Unable to find, case closed

Case closed

In care elsewhere, case closed

Clinic staff updated info in Casewatch

Low (Resources)

Initial appointment with NAV:
- consent
- survey
- intervention intensity assignment (Low, Mod, ARTAS)

Not Linked

Moderate (MI)

Not Linked

ARTAS

Transitional Retention

1) Utilize HARS/Casewatch to gather contact info/status
2) Coordinate with MCC & prioritize
3) Utilize MMP/PHI investigative methods to locate

Case closed

In care elsewhere, case closed

Clinic staff updated info in Casewatch

IN CONSISTENT CARE
(Intervention Ends)
Intervention Strategy

- **Three-Tiered Intervention Strategy**
  - **Tier 1: Direct Linkage to Care (no-intervention)**
    - For clients ready to link soon after enrollment
  - **Tier 2: One session Motivational Interviewing (MI) intervention**
    - For clients who have some ambivalence/minor challenges
  - **Tier 3: Modified ARTAS**
    - For clients with numerous barriers/challenges to overcome
Determining Intervention Intensity

- Based on Trans-theoretical model
- Baseline screener will assess:
  - Time since last HIV Care visit
  - How important it is to client to be in HIV Care
  - Client readiness to re-engage in HIV Care
- NAV judgment:
  - Based on the assessment of barriers from the baseline interview
  - Based on professional judgment about appropriate intervention
- Stepwise increase in intervention intensity as needed:
  - Flexibility to step-up intervention intensity for clients who do not link
Screening to Date: 1052/1423\(^1\) Identified Lost Patients

- In Care Elsewhere: 37%
- Returned to Clinic: 21%
- Patient is Deceased: 19%
- Not LA County Resident: 16%
- Ineligible based on Study Criteria: 6%
- Out of Care: 1%

\(^1\) 164 lost clinic patients were found ineligible due to VL/last appointment date
Outcomes

- **Number of potential participants with contact attempts:** 137
  - Phone calls made: 132
  - Text messages sent: 5
  - Emails sent: 7

- **Number of potential participants contacted:** 42
Navigation Program Enrollment

- Patient contacts began 5/2014 and were prioritized by:
  - Viral Loads (highest to lowest)
  - Length of time out of care
- 10 participants enrolled
  - Direct Linkage: 3
  - Motivational Interview: 5
  - ARTAS: 2
- 1 Linked to care
Next Steps

- Continue Enrollment
- Expand recruitment to include:
  - second HIV clinic in LAC
  - Out of care patients identified from surveillance
- Integrate best practices into a coordinated county-based Linkage to Care Program
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