Integrating and Sustaining Patient Navigators in a Primary Care Medical Home

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OVERVIEW

• Learning Objectives
• HIV 101
• HIV & Homelessness
• Special Projects of National Significance (SPNS) Background
• Study Design Overview
• Multnomah County Health Services Center & Cascade AIDS Project
• Community Health Worker (Patient Navigator) Model
• Client Vignette (3)
• HHSC Project Outcomes
• Project Sustainability
• Digital Story: Michael & Amy
• Questions
LEARNING OBJECTIVES

• Learn about HIV/AIDS and their relationship to Homelessness

• Identify methods used to create collaborative relationships between primary care clinics and community based social service (housing) organizations

• Learn about strategies and tools to document and evaluate the activities of patient navigators

• Identify strategies to fund and sustain navigation programs within a Patient Centered Medical Home (PCMH)
HIV 101

- **Human Immunodeficiency Virus (HIV)**
  - Virus that causes AIDS
  - About 47 million have been infected worldwide
  - More than 1.2 million people living with HIV in the US
    - Approximately 1 in 8 (13%) are unaware of their status
  - Transmitted via sex, blood, and mother-to-child
    - Not transmitted through casual contact

- **Acquired Immune Deficiency Syndrome (AIDS)**
  - The final and most serious stage of HIV
  - Fifth leading cause of death among persons 25-44 in the US
  - Causes severe damage to the immune system
    - CD4 count under 200 or presence of Opportunistic Infection(s)
HIV 101

- Only way to know your status is to GET TESTED!!!
- Minorities are disproportionately represented
  - Blacks 12% of population, 44% of new infections
  - Hispanics 16% of population, 21% new infections
- Effective treatments available, but no cure for HIV/AIDS
- Highly Active Anti-Retroviral Therapy (HAART)
  - Effective in reducing viral load and increasing CD4
    - Viral Suppression (<200) greatly lowers risk of transmitting the virus
  - Expensive
  - Lots of side effects
  - Resistance problems
    - Barriers: Homelessness, Stigma, A&D issues, MH concerns
HIV & HOMELESSNESS

- HIV and Homelessness are intricately related
  - People coping with homelessness are at greater risk of becoming infected with HIV and people living with HIV/AIDS experience high rates of housing loss and instability.
  - People who are homeless or unstably housed have HIV infection rates as much as 16 times higher than people who have a stable place to live (Kerker et al., 2005)
  - For many people with HIV, problems finding and keeping stable housing are exacerbated by discrimination related to HIV, sexual orientation, race, culture, mental health issues, substance use and/or involvement with the criminal justice system (Greene et al., 2010)
  - At least half of all people living with HIV/AIDS experience homelessness or housing instability (Rourke et al., 2010)
    - Housing is the greatest unmet need of people living with HIV/AIDS
HIV & HOMELESSNESS

• People with HIV/AIDS who are homeless or unstably housed have worse overall physical and mental health. Their CD4 counts are lower and their viral loads are higher. They are less likely to receive and adhere to antiretroviral therapy, and they are more likely to die prematurely (Rourke et al., 2010)

• More likely to use emergency rooms for HIV care or be hospitalized due to HIV related complications (Arno et al., 1996)

• Lower income people with HIV/AIDS who receive housing assistance have better access to health care services, their physical and mental health improves, and they live longer (Wolitski et al., 2010)
  • Savings in health care costs can offset cost of housing interventions
SPNS BACKGROUND

- 50,000 new infections per year
- 100% HIV-Infected
- 86% HIV-Diagnosed
- 80% Linked to HIV Care
- 40% Retained in HIV Care
- 37% Prescribed ART
- 30% Undetectable Viral Load

SPNS BACKGROUND

NATIONAL AIDS STRATEGY

• Set of priorities and strategic action steps tied to measurable outcomes for moving the Nation forward in addressing the domestic HIV epidemic
  • Reduce the number of people becoming infected with HIV
  • Increase access to care and optimize health outcomes for people living with HIV
  • Reduce HIV-related health disparities
SPNS BACKGROUND

**SPNS:** Special Projects of National Significance (SPNS)
- Supports the development of innovative models of HIV treatment
- Advances knowledge and skills in the delivery of health care and support services to underserved HIV populations
- Evaluates the design, implementation, utilization, cost, and health related outcomes of treatment models (promotes dissemination)

**SPNS Initiative:** Building a Medical Home for Multiply Diagnosed HIV Positive Homeless Populations

**Funding:** Awarded by the Health Resources Services Administration (HRSA) Special Projects of National Significance (Ryan White Part F)
SPNS BACKGROUND

Overview: Five year (2012-2017) demonstration project that serves homeless persons living with HIV who are diagnosed with a severe mental illness and/or substance abuse

Objective: To engage homeless/unstably housed persons living with HIV/AIDS who have persistent mental illness and/or substance use disorders in HIV primary care and behavioral health care and to assist in obtaining housing

Partnership: Innovative collaboration between Multnomah County Health Services Center (HSC) and Cascade AIDS Project (CAP) utilizing patient navigators (community health workers)
STUDY DESIGN OVERVIEW

• Nine demonstration sites
  • Multnomah County HHSC in Partnership with Cascade AIDS Project

• Methodology
  • Longitudinal study with data collection at baseline, and follow-up points at 3, 6, 12, 18, and 24 months

• Data collection instruments
  • Client interviews (qualitative and quantitative)
  • Medical chart reviews
  • Intervention encounter forms
STUDY DESIGN OVERVIEW

HRSA/SPNS Initiative: Building a Medical Home for HIV Homeless Populations
STUDY DESIGN OVERVIEW

EVALUATION MEASURES

• Outcome measures
  • Clinical: CD4/VL, HIV primary care visits, BH visits, quality of care, housing and HIV CM visits
  • Client level: perceived stigma, health related quality of life, housing status, HIV treatment adherence, substance use, mental health, etc.

• Process measures
  • Number and duration of encounters with intervention staff
  • Building a medical home: patient quality of care measures (for homeless), self-management and end-of-life plan
    • Qualitative supplement: provider and staff in-depth interviews
MULTNOMAH COUNTY HIV HEALTH SERVICE CENTER (HSC)

• Patient-centered primary and HIV care (PCMH) since 1990

• Part of Multnomah County’s network of 8 Community Based Health Centers and 14 School Based Health Centers

• HSC is the largest provider of primary care to Oregon’s uninsured and low-income persons living with HIV/AIDS

• In 2015, we served almost 1300 PLWH—this is 1 in 3 PLWH/A in the greater Portland area AND 1 in 4 PLWH/A statewide

• Although the majority of our patients live in the Portland metro area, we serve clients from all over the state
MULTNOMAH COUNTY HIV HEALTH SERVICE CENTER (HSC)
MULTNOMAH COUNTY HIV HEALTH SERVICE CENTER (HSC)

- 86% of clients are male, 13% female and 1% transgender
- 51% of clients are over 50 years old
- Primary HIV transmission categories are: MSM (74%) and IDU (18%)
- 30% of clients are persons of color—16% limited English speakers
- 20% incarcerated at least once in the past 2 years (high recidivism)
- High rates of substance abuse (29%) and mental illness (56%)
- Our population is overwhelmingly low income (71% ≤ 138 FPL)
- 1 in 5 patients are homeless or unstably housed
- Co-morbidities: diabetes, hypertension, and depression
CHARACTERISTICS OF OUR CHRONICALLY HOMELESS

- History of mental illness, domestic violence and substance abuse
- Frequent visits to ER
- History of incarceration
- Weak employment history
- Not adherent to HIV meds
- Comorbidities (Hep C, diabetes, hypertension, depression, etc.)
MULTNOMAH COUNTY HIV HEALTH SERVICE CENTER (HSC)

PRIMARY CARE MEDICAL HOME
• Multi-disciplinary teams
• Engage our clients in all aspects of their medical care
• Remove barriers to care
• Improve clinical outcomes
• Improve the patient experience of care
• Decrease or sustain the cost of care
• Increase staff satisfaction and involvement
• Certified by the State of Oregon and Joint Commission
MULTNOMAH COUNTY HIV HEALTH SERVICE CENTER (HSC)

Patient Centered Medical Home

- Home
- Community Mental Health & Addictions
- Community Service Providers (e.g. Outreach Workers, CHW's, Case Managers)
- Long Term Care / Home Health
- Hospitals - Emergency Departments
- Hospitals - In-Patient
- Community-Based Non-Medical Services
- Dental
MULTNOMAH COUNTY HIV HEALTH SERVICE CENTER (HSC)

SERVICES PROVIDED

- Patient centered, team based primary care and HIV specialty care with a focus on trauma informed care
- Medical case management
- Patient navigation services
- Home based nursing visits
- On site, integrated behavioral health services
- Hepatitis C and Anal Dysplasia Screening and Treatment
- Referrals to Nutrition and Dental Services
MULTNOMAH COUNTY HIV HEALTH SERVICE CENTER (HSC)

SERVICES PROVIDED

• Client Advisory Board (CAB)
• AIDS Education and Training Center (AETC)
• Health education
• Crisis intervention
• HIV prevention and risk reduction support
• Onsite clinical pharmacist
• Drug assistance program
• Adherence counseling
CASCADE AIDS PROJECT (CAP)

• Founded in 1983, CAP is the oldest and largest community-based provider of HIV services, housing, education and advocacy in Oregon and Southwest Washington

• In 2013, $1,177,808 went directly to 804 individual households for rent, utilities, and emergency assistance

• 2,292 people received some type of support services, including housing, employment counseling, referrals, and continuing education

• 115 people received employment counseling and assistance through Working Choices, 37 of whom got jobs
CASCADE AIDS PROJECT (CAP)

NAVIGATION PROGRAMS

• Provide one-on-one individualized support to PLWH/A:
  • Connecting to medical care
  • Adhering to HIV medications
  • Connection to mental health and/or substance abuse treatment services
  • Help secure stable housing
  • Develop life skills
  • Build and sustain positive relationships
  • Work towards self-sufficiency
CASCADE AIDS PROJECT (CAP)

CAP SUPPORTIVE HOUSING PROGRAM

• Short Term Rent Assistance (up to 6 months)
• Long Term Rent Assistance
• Application Fees & Deposits
• Eviction Prevention
• Landlord Advocacy
• Tenant Education
• Furniture & Household Items Delivery and Referral
COMMUNITY HEALTH WORKER (PATIENT NAVIGATOR) MODEL

• Collaborative partnership between HSC and CAP utilizing patient (network) navigators

• HSC Network Navigation (SPNS) Program approach is based in part on the Health Department’s Community Health Worker empowerment model.

• This model helps complex clients engage in care by:
  • Taking control of their health care decisions
  • Forming a bond with their medical team and clinic
  • Accessing needed services
  • Learning how to navigate community programs and paperwork
  • Interacting effectively with their medical teams and community partners
COMMUNITY HEALTH WORKER (PATIENT NAVIGATOR) MODEL

GOALS OF THE MODEL

• Improve timely entry, engagement and retention in HIV care and supportive services

• Build and maintain sustainable linkages to mental health, substance use treatment, housing, and HIV primary care

• Increase access to and receipt of stable housing

• Integration of HIV primary medical care with behavioral health services
COMMUNITY HEALTH WORKER (PATIENT NAVIGATOR) MODEL

INTEGRATION OF PATIENT NAVIGATORS

• Attend medical team huddles and semi-monthly case consult meetings with the provider team staff

• Three Navigators primarily sited at HSC

• Document all activities in Epic (Electronic Health Record) and CAP Service Point

• Develop and maintain collaborative relationships with agencies that serve PLWH/A as well as agencies that provide housing, mental health, substance abuse and psychosocial support services

• Work collaboratively with medical case managers, CAP housing case managers, and other service providers to develop individual client goal plans and provide intensive support to clients in carrying out their goal plan
COMMUNITY HEALTH WORKER (PATIENT NAVIGATOR) MODEL

ROLE OF NAVIGATOR IN ENGAGING AND RETAINING PATIENTS IN CARE

• Establish rapport with clients
• Facilitate relationship building between the patient and their medical team
• Help the client to identify barriers to care
• Guide the client to develop a series of brief interventions/action plans to address barriers to care and other issues
• Be the initial point person for crisis intervention
• Serve as a liaison between client and medical team until client has established rapport with clinic staff and is engaged in care
COMMUNITY HEALTH WORKER (PATIENT NAVIGATOR) MODEL

EFFECTIVE APPROACHES

• Goal plan & subsequent work guided by client
• Consistent relationship and rapport building
• Easy access to Navigators and consistent follow-up
• Work-dedicated cell phones—navigators available by call/text during work hours
• Inter- and intra-agency advocate
• Support around health literacy
• Small caseload (10-15 clients)
• Flexibility to work with clients in a variety of locations
COMMUNITY HEALTH WORKER (PATIENT NAVIGATOR) MODEL

METHODOLOGIES USED

• Motivational Interviewing
  • Open-ended questions

• Strength-based Counseling
  • Identifying and building on client strengths

• Popular Education
  • Empowerment

• Harm Reduction
  • Meeting the client “where they’re at”

• Trauma Informed Care
  • What happened to you? vs. What’s wrong with you?
COMMUNITY HEALTH WORKER (PATIENT NAVIGATOR) MODEL

TRAUMA INFORMED CARE

• High percentage of clients have experienced trauma/stigma

• HSC/CAP staff participate in training on trauma-informed care

• Principles of Trauma-Informed Care within project
  
  • Voice and choice: the organization aims to strengthen the staff, clients, and family members experience of choice and recognizes that every single person’s experience is unique and requires an individualized approach.

  • Collaboration and mutuality: there is true partnering and leveling of power differences between staff and clients and among organizational staff from direct care staff to administrators; there is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making.
COMMUNITY HEALTH WORKER (PATIENT NAVIGATOR) MODEL

TRAUMA INFORMED CARE

• Principles of Trauma-Informed Care within project (continued)

  • Empowerment: throughout the organization and among the clients served, individuals strengths are recognized, built on, and validated and new skills developed as necessary.

  • Change process: is conscious, intentional and ongoing; the organization strives to become a learning community, constantly responding to new knowledge and developments.
THEODORE

- 31 Year Old, African-American Male, MSM
- AIDS, KS, Clinical Depression
- Homeless
- Lost custody of daughter
- History of Poly-substance Abuse
- No Income, Medicaid
- Off ARVs and MH meds [October 2013]
  - CD4: 372 (19.3%)
  - VL: 79,325
THEODORE

• Enrolled in SPNS September 2013
• Connected with City Team
  • Teaching classes
  • Sponsor
• Stably housed in subsidized unit
• Celebrating two years of recovery
• Regained full custody of his daughter
• Still Struggling with Adherence [May 2016]
  • KS returned
  • CD4:  204 (17.3%)
  • VL: 21,806
DELANEY

- 25 Year Old, White, Transgender (MTF)
- Newly Diagnosed
- HIV+, Syphilis, Acute Renal Failure, Schizophrenia
- Homeless
- No Income, Medicaid
- History of Methamphetamine Abuse
  - Poor Adherence to ARVs [May 2014]
  - CD4: 276 (22%)
  - VL: 57,100
DELANEY

• Enrolled in SPNS in June 2014 (re-engaged July 2015)
• Connected with LifeWorks for MH Care
• Started on Hormones (Transitioning)
• Stably Housed in subsidized unit
• Working with attorney to obtain SSI disability
• Volunteers at Free Geek (computer)

Current Labs [May 2016]
• CD4: 424 (23.1%)
• VL: 32 virally suppressed
ALICIA

• 50 Year Old, African-American Female
• AIDS, Syphilis, Anorexia, Bipolar Disorder, PTSD, DV
• History of Poly-substance Abuse, Probation
• Chronic Homelessness
• Engagement in Care Limited to Crisis Situations
• SSI, Medicaid
• Poor Adherence to ARVs [February 2013]
  • CD4: 98 (7%)
  • VL: 632
ALICIA

• Enrolled in SPNS in January 2013 (re-engaged 2014)
• Probation Ended
• Transitional Housing (Royal Palm) to Stable Housing
• 8 Months of Sobriety
• MH meds and ARV adherence
• Companion Animal
• Engaged in Quest (WOW)
• Current Labs [May 2016]
  • CD4: 218 (15.1%)
  • VL: <20 virally suppressed (undetectable)
HHSC PROJECT OUTCOMES

• 126 People Served (HHSC)

• Race & Ethnicity
  • 100 White (79%)
  • 22 Black (18%)
  • 4 Other (3%)
    • 2 Multiple Races, 1 Native American, 1 Refused
  • 12 Hispanic (9.5%)

• Sex
  • 102 Men (81%)
  • 19 Female (15%)
  • Transgender (4%)
HHSC PROJECT OUTCOMES

• Project Attrition (N=28)
  • 12 Lost to Care
  • 3 Deceased
  • 3 Incarcerated
  • 1 Dismissed from Clinic
  • 9 Transferred Care/Moved

• Housing (N=98)
  • 71 Housed & 6 Vouchers = 77 (78%)
  • 62 Retained in Housing (80%)

• Antiretroviral Therapy (N=126)
  • 94 people on ARVs (75%)
  • 73 people virally suppressed-viral load <200 (78%)
Prior to participation in the SPNS demonstration project HSC did not use patient navigators.

Concerns about losing an incredibly valuable, rich resource (patient navigators) at the end of the grant period.

Solution - bill insurance for navigation services.

Oregon Health Authority (OHA) manages the State Medicaid Program (the Oregon Health Plan) and approves five Traditional Health Worker Medicaid provider types:

- **Community Health Worker (CHW)*** - Advocates for patient & community health.
- **Personal Health Navigator (PHN)*** - Assists individual & groups with positive health outcomes.
- **Peer Support Specialist** - Focus on recovery from addiction/mental health issues.
- **Peer Wellness Specialist** - Focus on recovery from addictions/mental health/physical health conditions.
- **Doula** - Assists with women’s pre-natal health care.
EFFORTS TO SUSTAIN NAVIGATION SERVICES

• Became acquainted with State’s rules and regulations for community health workers and personal health navigators and the potential to bill for services

• Formed relationship with State and local Coordinating Care Organization to stay abreast of opportunities for Medicaid support (contracted or billable services)

• Researched training and certification requirements for navigators to become Medicaid certified
  • In Oregon certification requires 96 hours of training (2 months), Certification is good for 3 years, 20 hours of continuing education is required for renewal.
PROJECT SUSTAINABILITY

EFFORTS TO SUSTAIN NAVIGATION SERVICES

• Assisted navigators to complete required training in order to become a Certified Medicaid Traditional Health Worker

• Identified documentation requirements and train navigators how to document their work in patient EHR

• Realigned other client support resources to build on the navigation model (Part D)

• Integration of navigators as clinic employees
  • Can be more easily sustained through various funding streams: third party billing, Bureau of Primary Health Care and Ryan White Grants, and one-time only CCO monies. Direct hires save on administrative costs associated with contracted services
PROJECT SUSTAINABILITY

CURRENT SITUATION

• Navigators transitioning to county employees
• Developing MOU with CAP to ensure continued support, integration and coordination
• Not yet able to bill Medicaid
• Utilize a combination or data reports and chart reviews to track patient outcomes
• Health Department received funds from CareOregon to integrate community health workers (patient navigators)
• In October 2015, HSC was able to hire an additional navigator
  • Serves SPNS clients and other clients (refugees)
  • Records “touches” in Epic to support funding
DIGITAL STORY

Healing Through Patient Navigation & Art Therapy

Michael & Amy
QUESTIONS???
REFERENCES

• AIDS Info https://aidsinfo.nih.gov/education-materials/fact-sheets

• Kerker, B., Bainbridge, J., Li, W., et al. (2005). The health of homeless adults in New York City: A report from the New York City Departments of Health


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RESOURCES

Multnomah County Health Department HIV Health Services Center
https://multco.us/health/hiv-health-services-center

Cascade AIDS Project (CAP)
https://www.cascadeaids.org/

Med-HEART (The Medical Home Evaluation and Resource Team)
http://medheart.cahpp.org/