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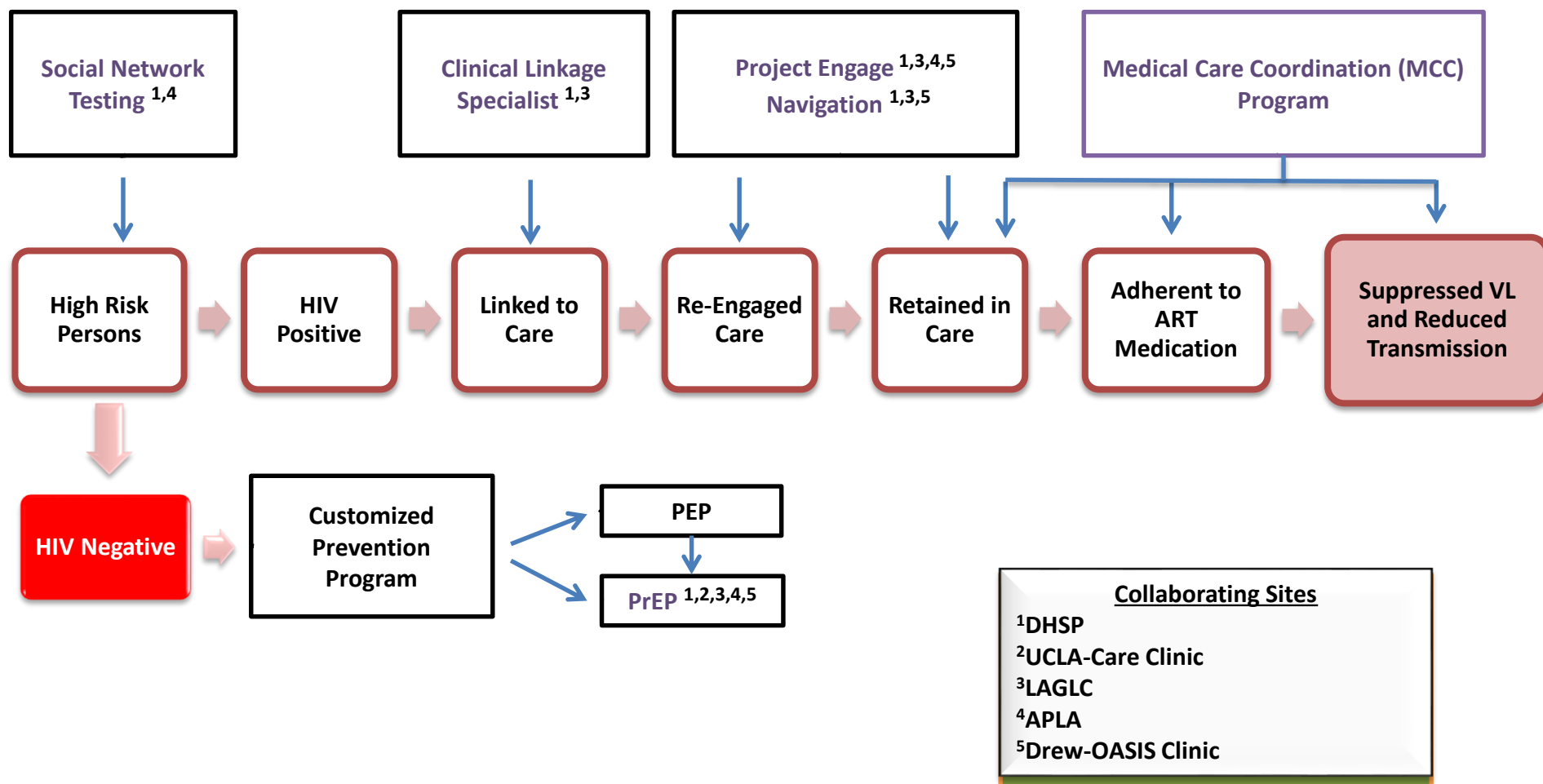# An Innovative Method for Finding and Re-Engaging Lost HIV Clinic Patients

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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] Navigation [1,3,5] | 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
[1]DHSP
[2]UCLA-Care Clinic
[3]LAGLC
[4]APLA
[5]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**
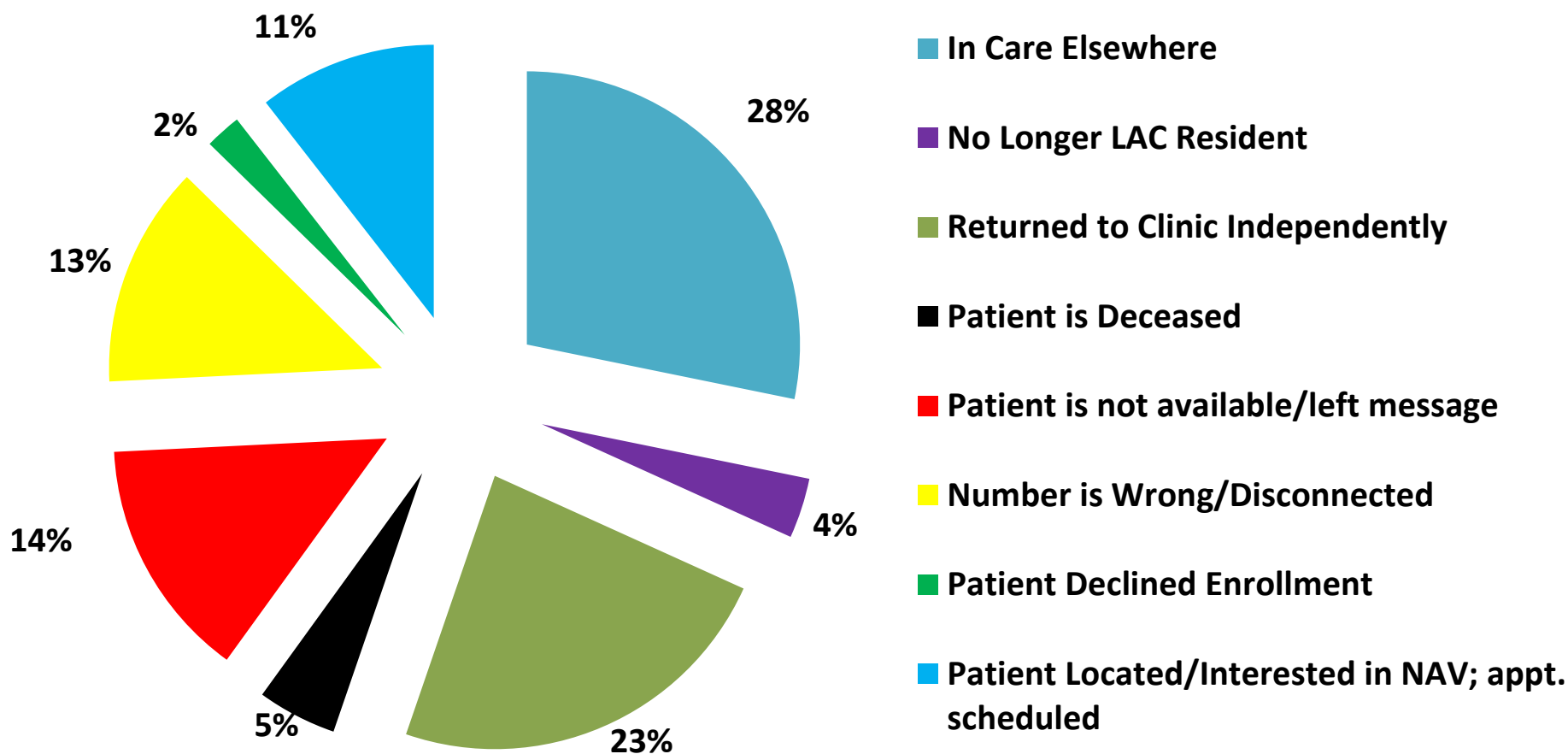
- **Main Objectives:**

  - **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**
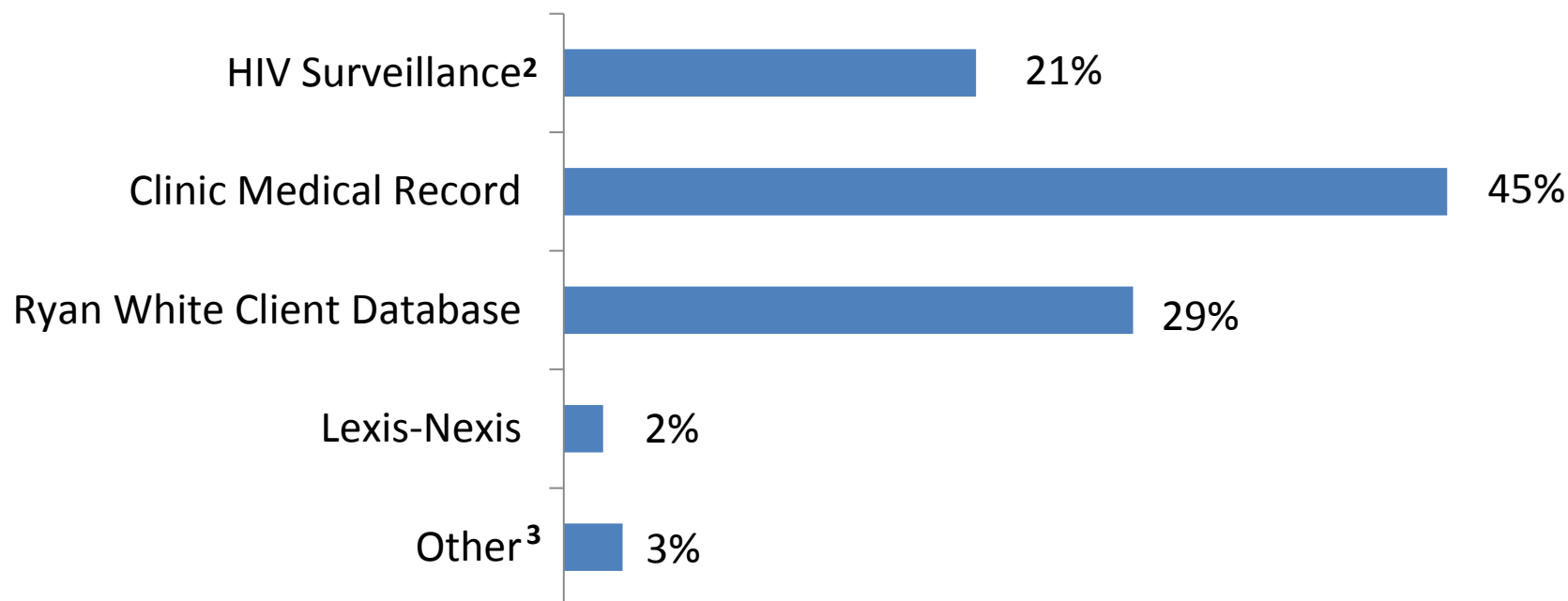
Lessons Learned:
DHSP/APLA SIF Navigation Pilot Program

Screening: 702/1010[1] Identified Lost Clinic Patients

Legend:
- **In Care Elsewhere** — 28%
- **No Longer LAC Resident** — 4%
- **Returned to Clinic Independently** — 23%
- **Patient is Deceased** — 5%
- **Patient is not available/left message** — 14%
- **Number is Wrong/Disconnected** — 13%
- **Patient Declined Enrollment** — 2%
- **Patient Located/Interested in NAV; appt. scheduled** — 11%

[1]308 lost clinic patients were found ineligible due to VL/last appointment date

Most Effective Sources[1] for Contact Information (n=702)

Source	Percentage
HIV Surveillance[2]	21%
Clinic Medical Record	45%
Ryan White Client Database	29%
Lexis-Nexis	2%
Other[3]	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
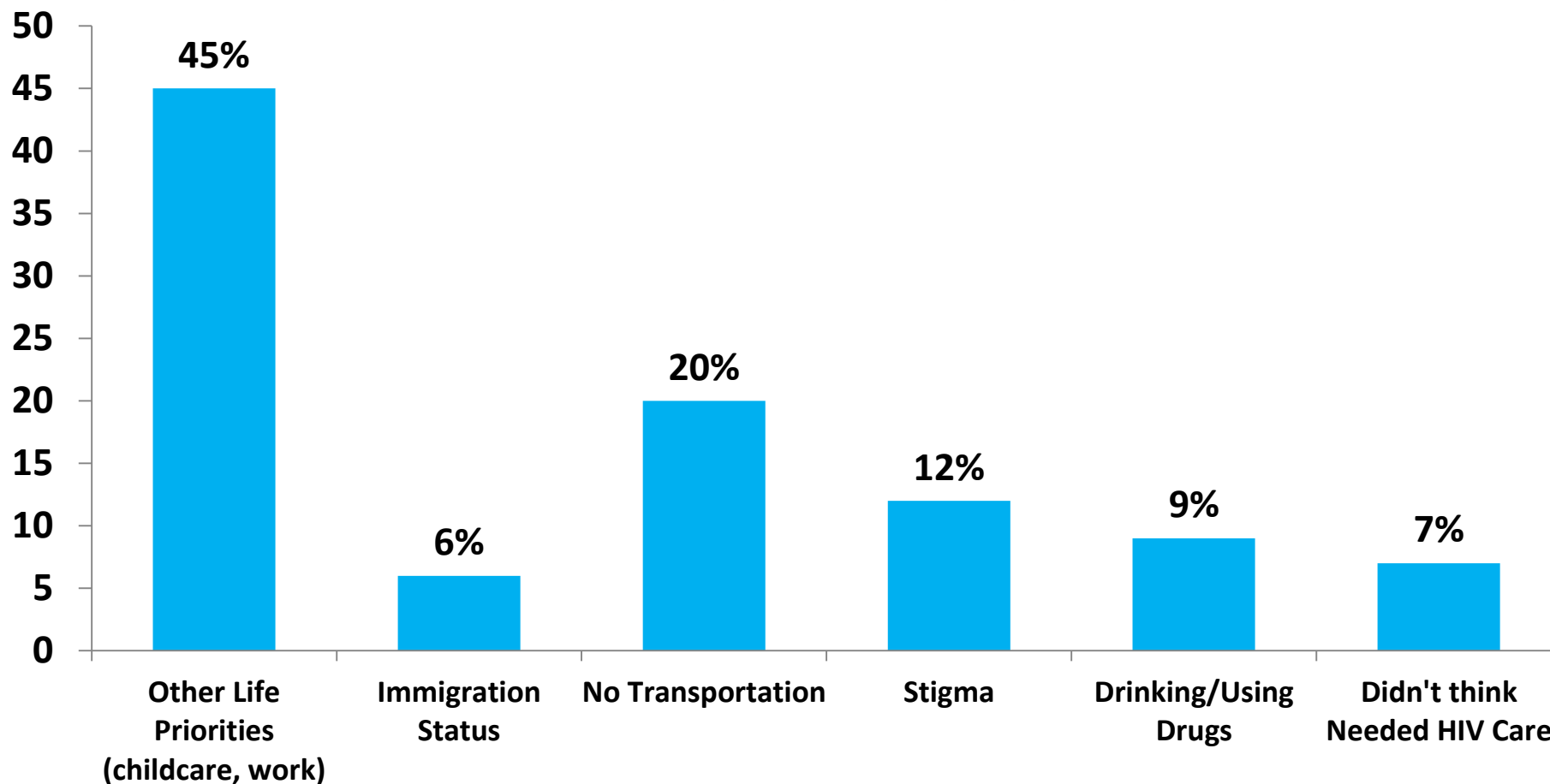
Intervention

- **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]**

[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**
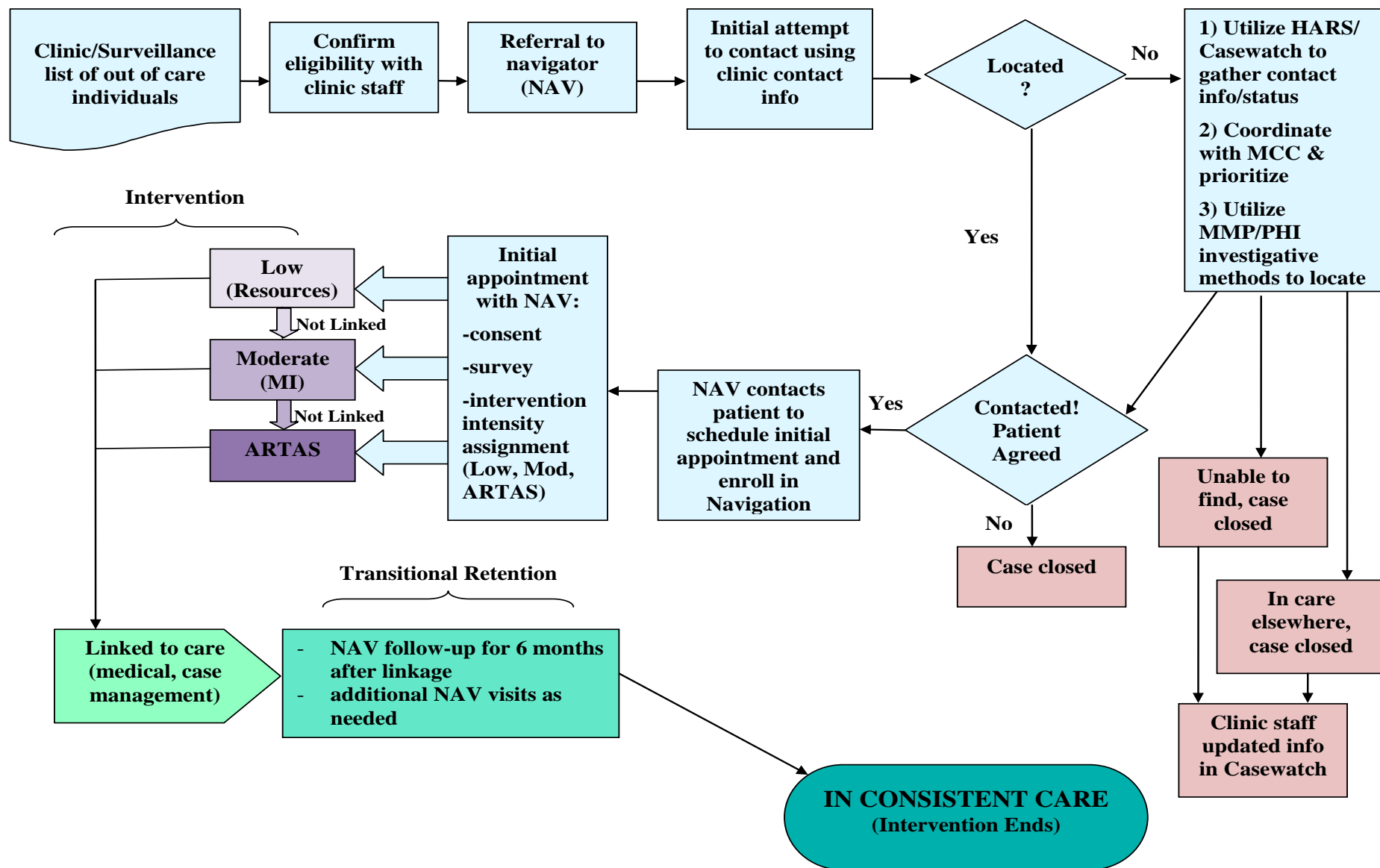
- ## Next Steps

  - **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 ?**

Located ? — No → **1) Utilize HARS/Casewatch to gather contact info/status 2) Coordinate with MCC & prioritize 3) Utilize MMP/PHI investigative methods to locate**

Located ? — Yes → **Contacted! Patient Agreed**

Intervention

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

Not Linked

Moderate (MI)

Not Linked

ARTAS

NAV contacts patient to schedule initial appointment and enroll in Navigation ← Yes — **Contacted! Patient Agreed**

Contacted! Patient Agreed — No → **Case closed**

Unable to find, case closed

In care elsewhere, case closed

Transitional Retention

Linked to care (medical, case management) → - **NAV follow-up for 6 months after linkage** - **additional NAV visits as needed** → **IN CONSISTENT CARE (Intervention Ends)**

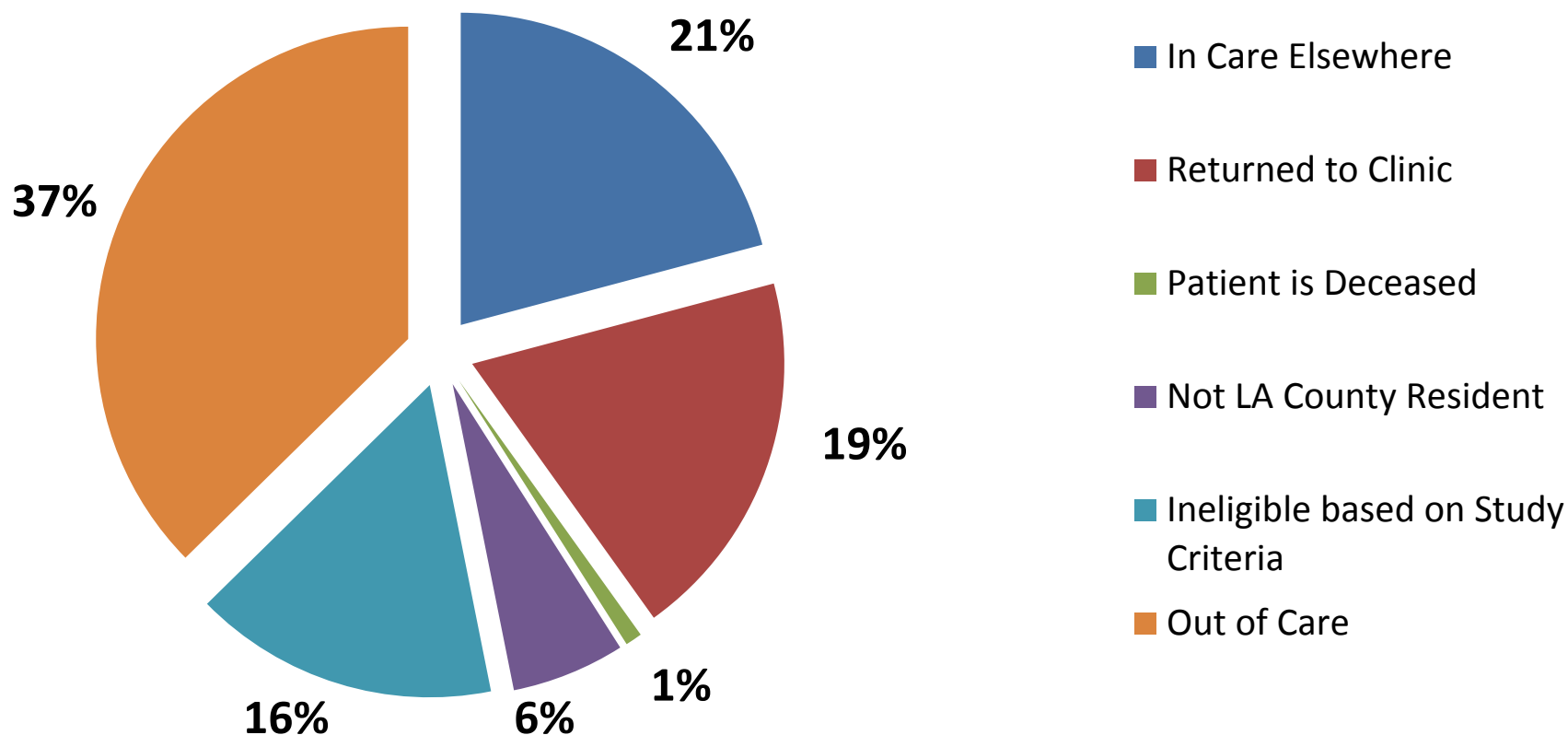**Clinic staff updated info in Casewatch**

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

Legend:
- In Care Elsewhere
- Returned to Clinic
- Patient is Deceased
- Not LA County Resident
- Ineligible based on Study Criteria
- Out of Care

Pie chart values: 21%, 19%, 1%, 6%, 16%, 37%

[1] 164 lost clinic patients were found ineligible due to VL/last appointment date

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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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