Enhanced Patient Navigation: Adherence, Retention, and Care of African Americans with HIV

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Conflicts:

LaShonda Spencer, MD: Research Support, Advisory Board- Gilead

Shellye Jones, MSW, LCSW: Speaker Board- Merck

OBJECTIVES

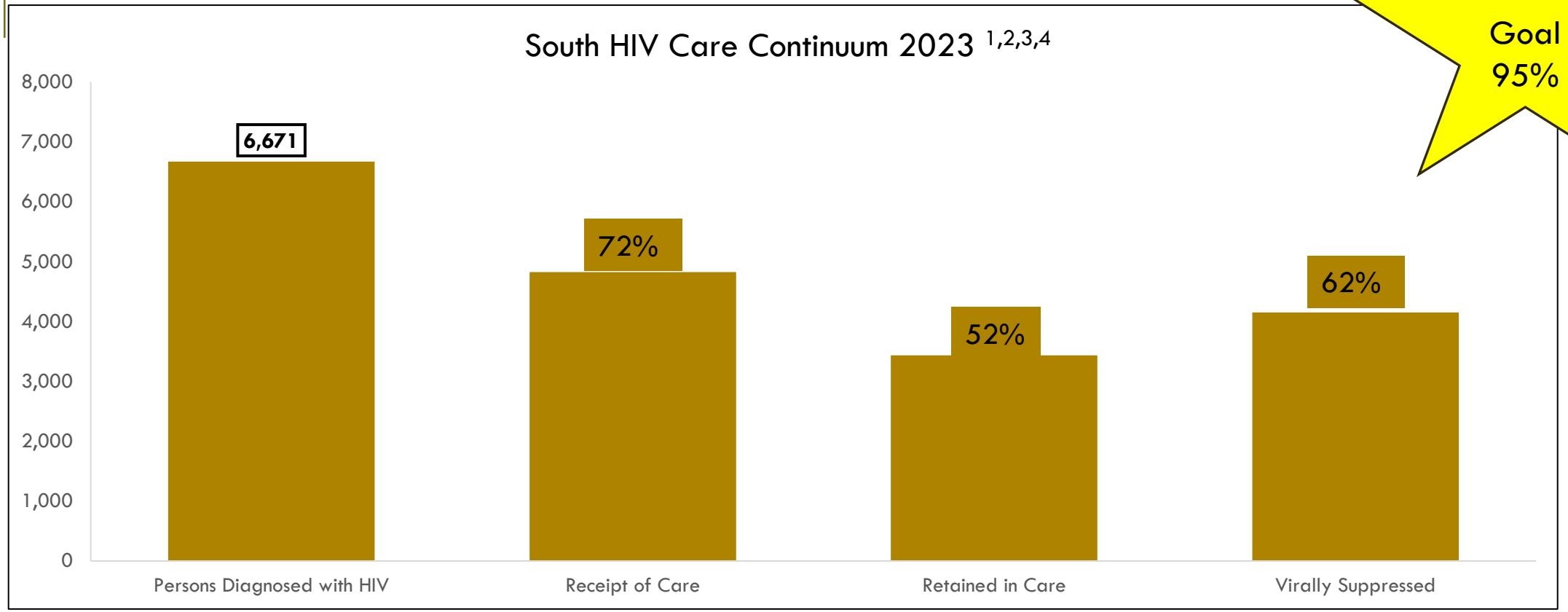
- To understand the HIV epidemiology of South LA and impact on Black clients with HIV.

- To identify key challenges faced by African American clients in navigating HIV care resulting in poor retention in care and viral load suppression.

- To demonstrate an understanding of effective patient navigation to identify and address barriers, and provide client support in order to empower clients to improve their HIV health outcomes.

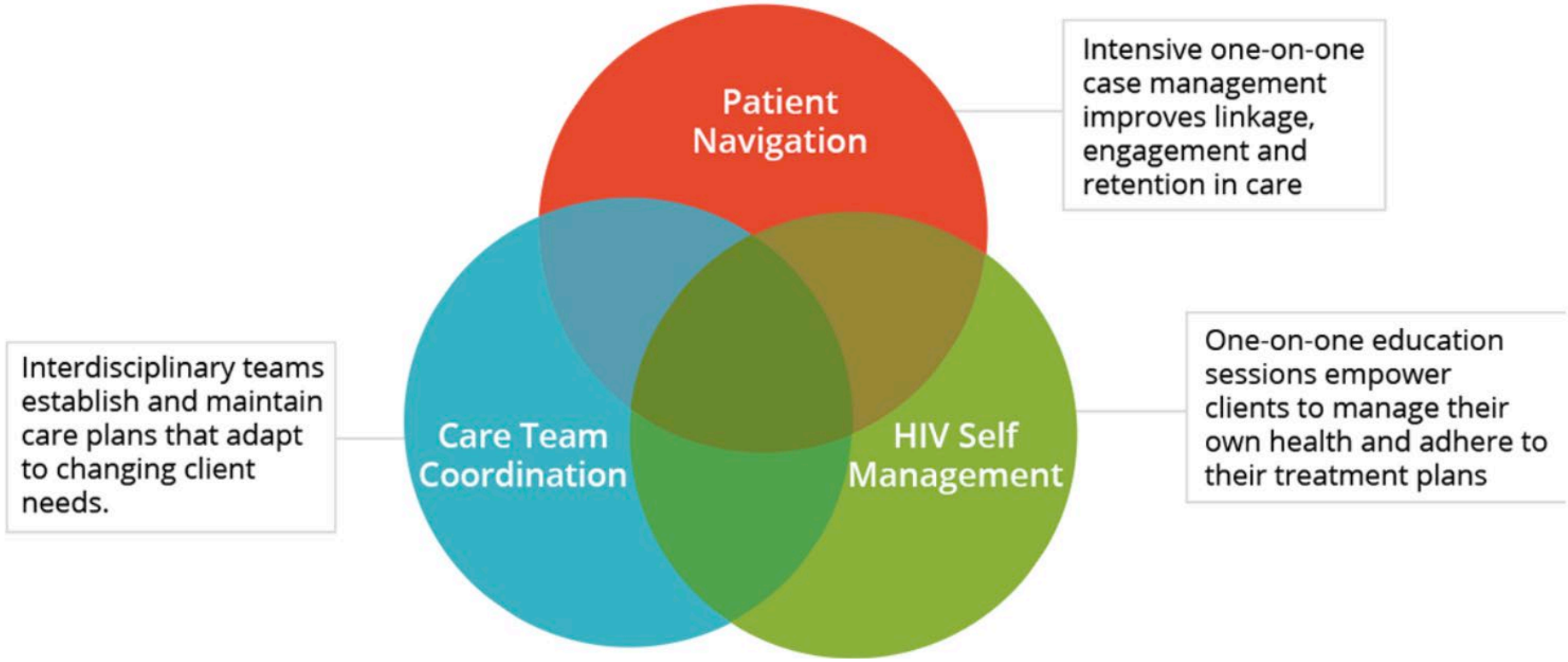
HIV Care Continuum

but, It's complicated…..



1. Persons living with diagnosed HIV (PLWDH) include those diagnosed with an HIV infection through the previous calendar year and living in LAC at calendar year-end, based on most recent residence. To allow for 12 months of surveillance, PLWDH excludes new HIV diagnoses in the calendar year.
2. Receipt of care is defined as the percentage of PLWDH who reported (or had) 1 or more CD4, Viral Load, and/or HIV genotype tests in the calendar year.
3. Retention in care is defined as the percentage of PLWDH who reported 2 or more DC4, Viral Load, and or HIV genotype tests at least three months apart in the calendar year
4. Viral suppression is defined as the percentage of PLWDH who reported one or more VL tests with HIV-1 RNA < 200 viral copies per milliliter of blood plasma in the calendar year.

Evidence-Informed Strategies to Improve Health Outcomes in PWH



What is Enhanced Patient Navigation?

- Enhanced Case Management services by nonmedical, ***culturally aware staff*** for patients at high risk for poor health outcomes.

  - Strength-based and patient centered
  - Includes guiding clients through health care systems to support their full engagement in care.
  - Increases client linkage to, and retention in medical care.
  - Addresses social and structural drivers of health disparities (Stigma, housing, and education).
  - Provides services and interventions to mitigate barriers to care including but not limited to*:
    - *Substance use*
    - *IPV/trauma*
    - *Stigma*
    - *Mental Health*
    - *housing and food insecurities*

**in addition to the clinic's existing case management standard of care*

What is CDU/OASIS Enhanced Patient Navigation?

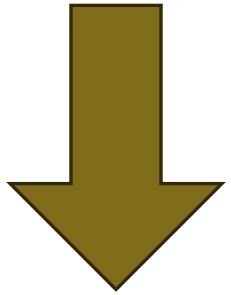
- Culturally tailored, time-limited support through patient navigators (PN) to increase health literacy and address barriers related to social determinants of health for viral load suppression.

- Focuses on reconnecting lost-to-care and high viral load patients by addressing care barriers, essential to reducing disparities and improving health outcomes.

*Initial intervention project funded by CDPH Project Empowerment Grant

Why is Patient Navigation Important?

Empowers clients to take control of their HIV and manage their overall health.



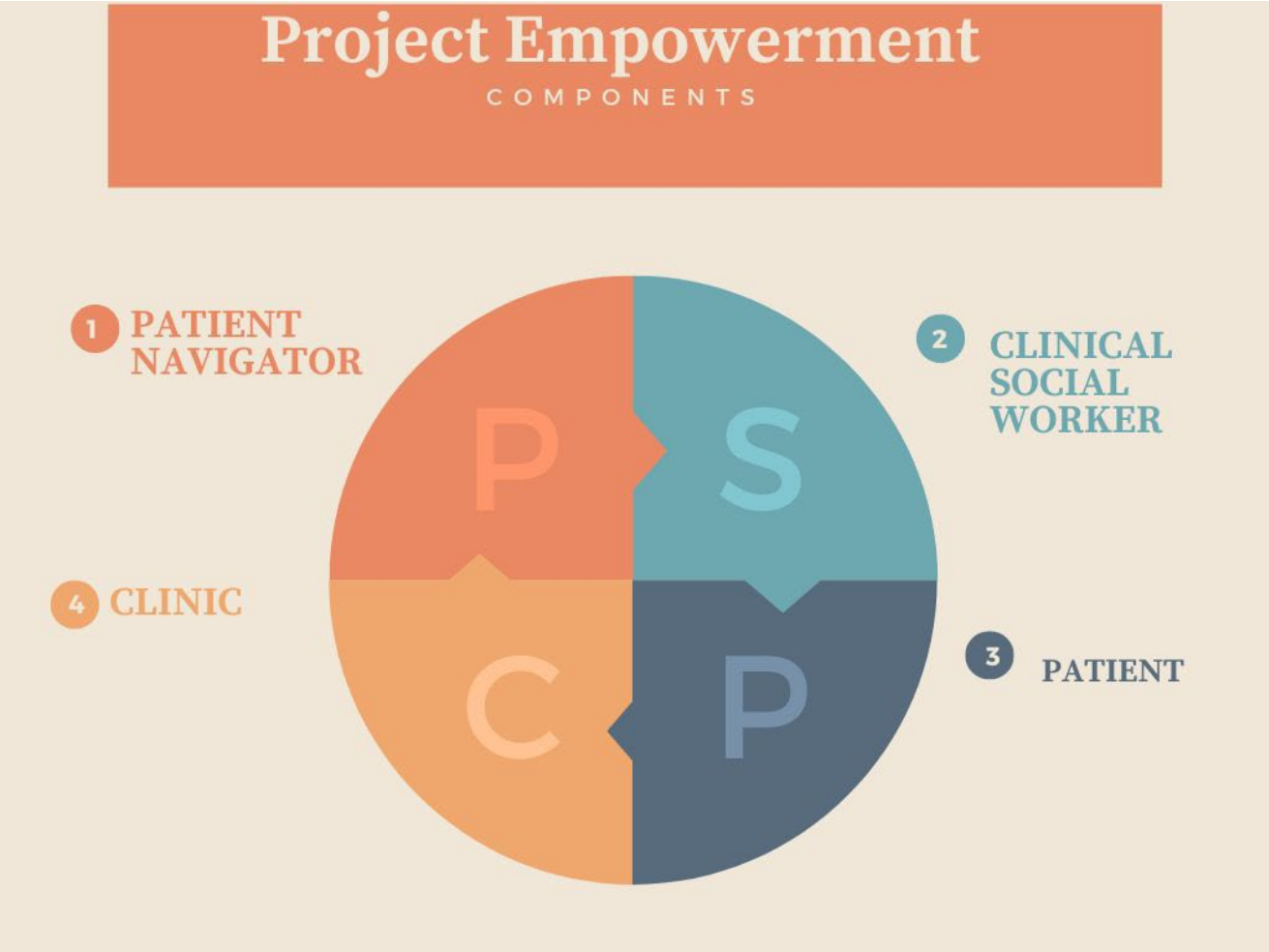
Ultimate Goal

To help patients transition to self-management and full engagement in care

To improve their overall health

Source: Thompson MA, Mugavero MJ, Amico KR, et al. *Ann Intern Med*. 2012;156(11):817-294.

Who is the Enhanced Patient Navigation Team?



Who makes an effective Patient Navigator?

- People with lived experience
- Peers
- Outreach workers
- People with experience working in the field of HIV
- Community Advocates
- Case Managers/ Community Health Workers

Who is eligible for Enhanced Patient Navigation?

- Identify as Black or African American
- Receive their care at MLK Outpatient Center
- Fallen out of care for 6 months or more
- Loosely engaged in care (missed or canceled >2 appointments in last 6 months)
- Unsuppressed viral load (>200 copies/ml)

Where do Patient Navigators find patients?

- Clinic Referrals
- Outreach
- Patient homes
- Medical Clinics
- Service organizations
- Pharmacy
- Public Health
- Word of mouth
- Other locations

How Patient Navigators support clients.

Build rapport and connect with the patients through trusting relationships
Work with, and as part of, the treatment team
Quickly identify barriers and assess needs
Link patients to medical and non-medical appointments and provide reminders
Help patients navigate systems and prepare for appointments
Provide structured health education
Assist with paperwork and transportation
Offer resources, make referrals, and empower patients
Think outside of the box
Celebrate milestones and successes

Methods

Enrollment

- 100 self-identified Black/ African Americans with HIV

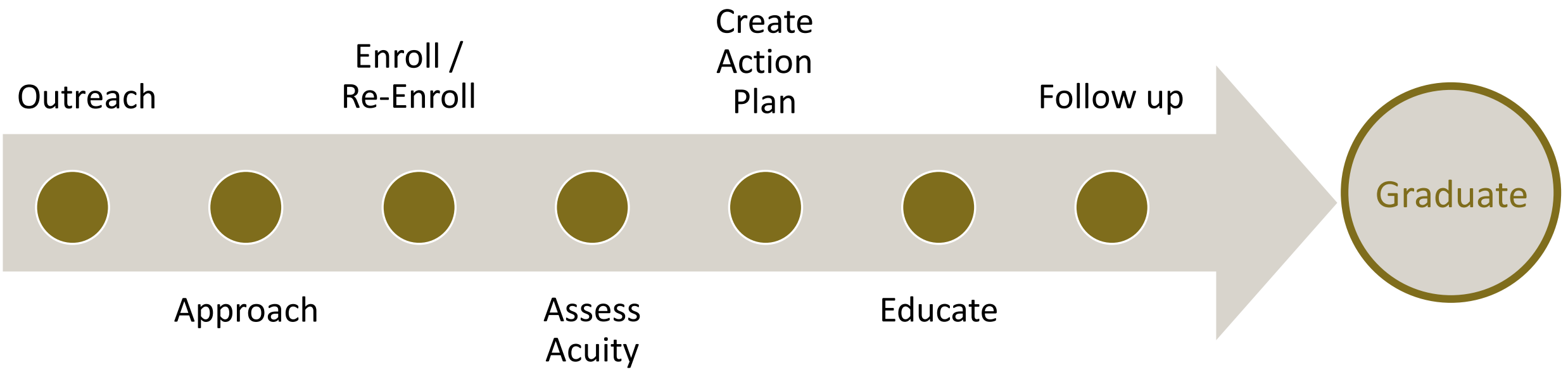
Data collection and assessment

- Baseline surveys
- 3-, 6-, and 12-month follow-up surveys
- Incentives for survey/assessments
- Surveys and forms are entered into RedCap

Inclusion Criteria

- 18+ years old
- Receive their primary care at MLK Outpatient Center
- Fallen out of care
- Not virally suppressed (HIV RNA > 200 copies/mL)

Empowerment Pathway: Client Progression Through EPN



Client Demographics

Total	105 PWH	
Ethnicity	Black	97%
Gender	Male Female Transwomen	68% 29% 1.9%
Sexual Orientation	Heterosexual Bisexual Gay/lesbian/same gender loving	67% 17% 16%
Barries Identified		
	Unstable Housing	36%
	Financial Insecurity	67%
	Transportation	41%
	Mental Health	
	Alcohol misuse	41%
	Cocaine Use	15%
	Stimulant Use (amphetamine/meth)	15%
	Opiate Use (heroin, oxy, etc)	5%
Baseline Viral Suppression		52%

OUTREACH AND ENCOUNTERS

Ave number of encounters attempted/ person

Ave number of successful encounters/person

- Education Sessions
- Home/Outreach visits
- Action Plan/SMART Goals

Results: Needs and Assistance Received

Baseline Need	Receive (Yes)	Receive (No)	p-value
Housing Assistance	37.5%	62.5%	0.115
Transport Assistance	70.0%	30%	0.001
Medication Assistance	73.3%	26.7%	0.0001
Medical care	81.3%	18.7%	0.001
Substance Use Treatment	90.0%	10.0%	0.001

Results: Viral Load Suppression

Viral Load Outcomes		
Baseline Suppression (%)	3- Month Suppression (%)	12- month Suppression (%)
52	82	82

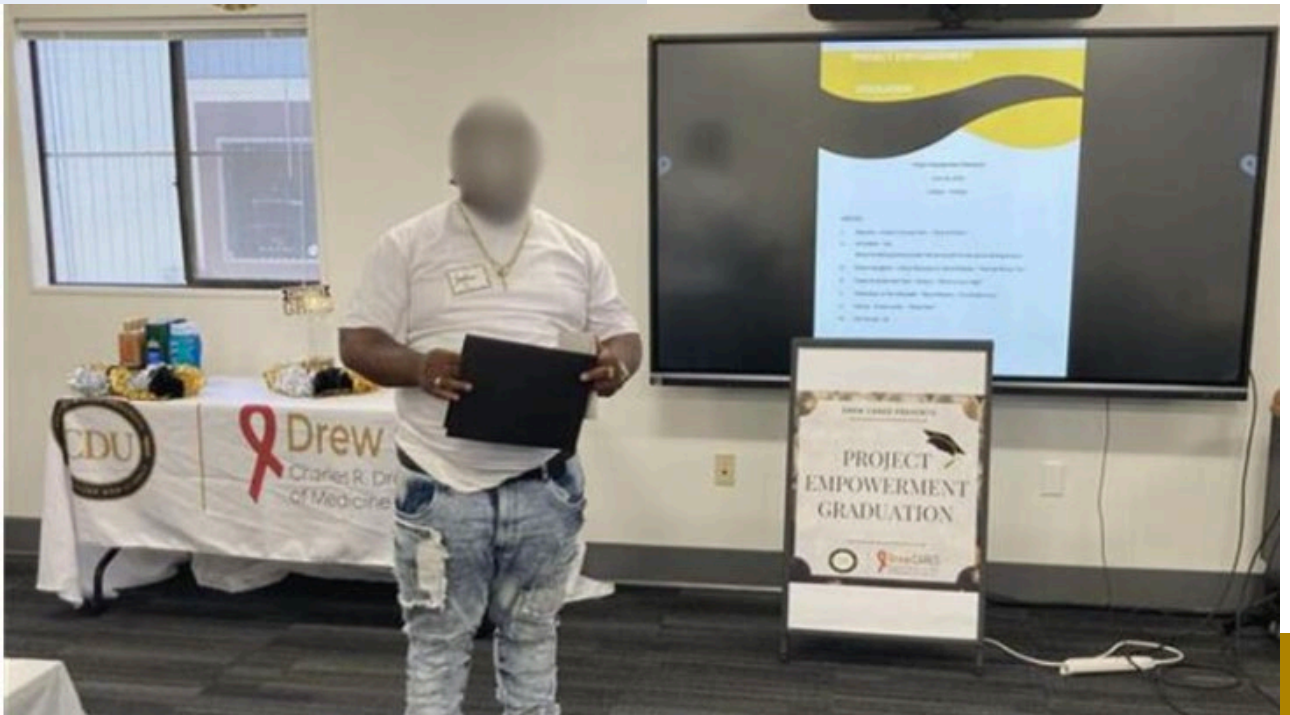
Patient perspectives on the impact of Navigation

"Working with the Navigators helped me to learn how to utilize the resources that I didn't even realize were available to me. At first, I needed a lot of help, and reminders, but now, I am not only able to manage my own healthcare, prescription refills, and other appointments, but I am also about able to help others, who do not have a Patient Navigator.

"Patient Navigation was critical for me when I first moved to Los Angeles. The Navigators provide resources for not only me, but my family, especially therapy, because we really needed it! They were with me at the beginning of my journey when I needed help the most.

"Working with the Navigators have helped me to get out of my shell and interact more with people. I am learning to trust people and expand my network. I have learned the importance of taking my medication every day and now instead of them calling me to remind me, I check in to let them know I have taken my medication. Without the assistance of the Navigators, I would not have gone to the eye Dr., Dentist, or be registered at the food bank."

"Patient Navigation has impacted my life by providing support and education to me, along with transportation assistance, teaching me how to communicate with my provider and health care team, learning more about my diagnosis, and the importance of building turst with others."



GRADUATION

"I was so proud to attend and participate in the PE graduation.

They invited me back, even after I completed the program, along with some of the other participants and gave me a certificate. I have never been celebrated for taking care of my health."

Study Conclusion

- EPN was effective in mitigating transportation barriers
- EPN addressed substance use disorders significantly
- EPN resulted in an improvement in viral suppression outcomes
- Housing insecurity remains one of the hardest barriers to overcome in Los Angeles and requires more support and effort to address.

Implications for Practice

- ***Culturally responsive*** EPN can be utilized in a case management setting to help increase the attendance rate of clients to medical appointments

- EPN-supported AA clients improve engagement in medical care and viral load suppression, the main goal of HIV treatment and a key factor in prevention.

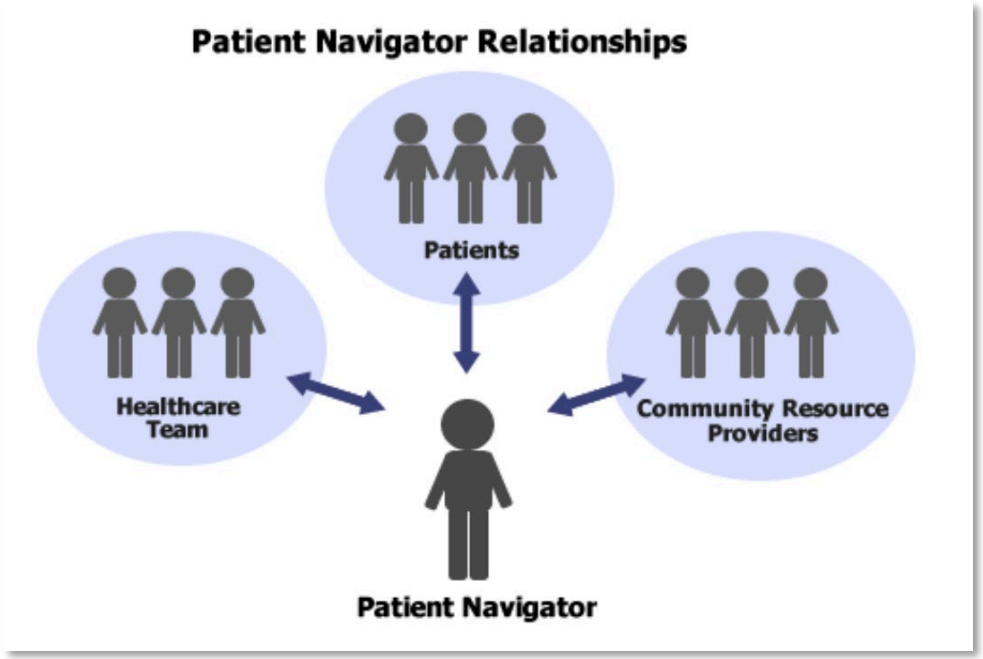
- The effectiveness of EPN on viral load outcomes should encourage clinics to consider integrating *a* ***structured, culturally and patient-centered***, navigation model to increase retention of African American clients living with HIV to ultimately improve health outcomes

Summary

Enhanced Patient Navigation is a strengths-based intervention that empowers clients to recognize and use their internal abilities to solve problems, and help clients navigate complex systems of care.

Through patient navigation, clients have better outcomes in terms of:

- receiving antiretroviral therapy
- achieving virologic suppression
- improving survival
- Improved Quality of Life



Acknowledgments

1. Our amazing OASIS EPN participants
2. CDU Navigation Team
3. Charles R. Drew University of Medicine and Science
4. Research reported was supported by the National Institute of Minority Health and Health Disparities under award number U54MD007598

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Data Analysis

- All analyses were performed with STATA (STATA Corporation, College Station, TX: 2015)
- Descriptive statistics were used to present overall demographic characteristics of the study participants
- Bivariate analyses were performed by using chi-square analysis.