ACCESS NY PATIENT NAVIGATION PROGRAM

Evidence-Based Structural Intervention
Evidence-Based Engagement in HIV Care
Evidence-Based Re-engagement in HIV Care

INTERVENTION DESCRIPTION

Goal of Intervention
- Increase retention in HIV care
- Reduce time to engagement or re-engagement in HIV care

Intended Population
- People with HIV enrolled in the Amida Care health plan who were never in care or lost to care

Brief Description

ACCESS NY Patient Navigation Program is an initiative of Amida Care (AC), a New York City Medicaid HIV health plan. The intervention is designed to reduce the time to first HIV primary care visit and improve retention in HIV care for people with HIV who were recently enrolled in the health plan and were unconnected to care, or re-engage long-time members who had dropped out of care. Community health outreach workers (CHOWs) and health navigators (HNs) are hired and trained as patient navigators. CHOWs and HNs assist members with maintaining scheduled appointments, understanding the nature of HIV, and managing their care. HNs also conduct needs assessments and assist in developing and implementing care plans. Once patient navigators are assigned to a member, up to five attempts are made to contact the member, using a combination of an introductory letter, phone calls, and a home visit. After a successful contact is made, patient navigators meet with their assigned member at least weekly, and facilitate making the initial appointments. accompany clients to their first medical appointment, and support clients in making further appointments. Patient navigators also arrange transportation to and from appointments, assist with filling medication prescriptions, make connections to case management, help patients receive lab work, and follow up with service providers to ensure individual patient needs are being met. Case assignments remained open for a maximum of three months.

Theoretical Basis
- Strengths-Based Perspective in Social Work
- Motivational Interviewing
- Transtheoretical Stages of Change

Intervention Duration
- Case assignments remained opened for a maximum of 3 months

Intervention Settings
- Letter
- Phone calls
- Home visit

Deliverers
- Patient navigators, who included:
  - Community Health Outreach Workers (CHOWs), who were peers with HIV
  - Health Navigators (HNs), who had bachelors' degrees in human services and experience working with people with HIV

Delivery Methods
- Case management
- Peer-based
- Patient navigation

Structural Component
- Access
  - Increased access to HIV care through services provided by patient navigators
- Capacity Building – Hired staff
  - Employed patient navigators with both peer and professional qualifications (i.e., CHOWs and HNs)
- Capacity Building – Provider/supervisor training
  - Trained CHOWs and HNs on motivational interviewing, enhanced outreach strategies, and cultural diversity, as well as writing progress notes, field safety, and de-escalation skills building
- Policy/Procedure – Institutional policy/procedure
  - Developed and implemented patient navigation program
- Social Determinants of Health – Survival
  - Facilitated transportation to and from HIV primary care appointments

INTERVENTION PACKAGE INFORMATION

An intervention package is not available at this time. Please contact **Maiko Yomogida,** Mailman School of Public Health, Department of Sociomedical Sciences, Columbia University, 722 West 168th Street, Room 549B, New York, NY 10027-6902, USA.

Email: **pam9@columbia.edu** for details on intervention materials.

EVALUATION STUDY AND RESULTS

Study Location Information
The original evaluation study was conducted in New York City, NY between July 1, 2010 and April 15, 2013.

Key Intervention Effects
- Increased engagement and re-engagement in HIV care (measured as decreased time to first HIV primary care visit)

Recruitment Settings
ACCESS NY membership files

Eligibility Criteria
People with HIV were eligible if they were Amida Care (AC) members (i.e., HIV positive, Medicaid eligible, and resided in one of the five New York City boroughs), and had either dropped out of care (i.e., were a long-time AC member whose most recent claim for an HIV primary care visit was 180 days or longer at time of ACCESS NY enrollment) and were unconnected to care (i.e., were newly enrolled in AC [within the past 179 days] and had not designated an existing HIV medical care specialist at time of AC enrollment).

Study Sample
The ACCESS NY participants (n = 856) are characterized by the following:
- *38% Black or African American, 17% Hispanic, Latino, or Latina, 5% White, 40% other/unknown*
- *70% male; 30% female*
- *Mean age of 42 years*
- *53% completed high school, 26% completed more than high school, 21% completed less than high school*
- *Mean months since initial HIV diagnosis at AC enrollment: 149 months*
- *HIV care status at AC enrollment: Unconnected to care (n = 331); Dropped out of care (n = 525)*

Assignment Method
AC staff generated a monthly list of ACCESS NY clients with no claims for HIV primary care visits during the past 6 months. AC staff assigned ACCESS NY clients to navigators by going down the list to fill all available navigator slots using a skip pattern to correct for imbalances in gender and borough of residence. The ACCESS NY intervention group consisted of ACCESS NY clients who were assigned a patient navigator (n = 286). The ACCESS NY comparison group consisted of ACCESS NY clients who were not assigned a patient navigator (n = 570).

Comparison
The comparison group consisted of ACCESS NY clients who were not assigned a patient navigator.

Relevant Outcomes Measured
- Engagement in HIV care was defined as connection-to-care and measured as the number of days that elapsed between enrollment in ACCESS NY and the first HIV primary care visit post-enrollment for participants who were unconnected to care. The PRS project considers this outcome as re-engagement in HIV care for participants who dropped out of care.
- Retention in HIV care was measured using the number of days between the first HIV primary care visit post-enrollment and successive visits. A participant was considered retained in care if the number of days between the first HIV primary care visit post-enrollment and successive visits was less than 190 days.

Participant Retention
Because participant retention is not a criterion for the Structural Interventions chapter, the Prevention Research Synthesis project does not evaluate that information.

Significant Findings on Relevant Outcomes
- Intervention participants had a significantly shorter time to first HIV primary care visit than comparison participants (adjusted hazard ratio (HR): 1.37, 95% CI: 1.11 - 1.69). Additionally, intervention participants had

a significantly shorter time to first HIV primary care visit than comparison participants among the following subgroups (which are based on their HIV care status at AC enrollment and if they made contact with their assigned PN):
  - Participants who made contact with their assigned PN (adjusted HR 1.89, 95% CI: 1.46 - 2.44)
  - Participants who dropped out of care (adjusted HR: 1.32, 95% CI: 1.02 - 1.71)
  - Participants who dropped out of care and made contact with their assigned PN (adjusted HR: 1.91, 95% CI: 1.40 - 2.61)
  - Participants who were unconnected to care and made contact with their assigned PN (adjusted HR: 1.96, 95% CI: 1.20 - 3.20)

Considerations

Additional significant positive findings on non-relevant outcomes

- None reported

Non-significant findings on relevant outcomes

- There were no significant intervention effects on retention in HIV care. There were also no significant intervention effects on engagement in HIV care among the following subgroups (which are based on their HIV care status at AC enrollment and if they made contact with their assigned PN):
  - Participants who were unconnected to care
  - Participants who did not make contact with their assigned PN (for overall participants, those who were unconnected to care, and those who dropped out of care)

Negative findings

- None reported

Other related findings

- The intervention also meets evidence-based criteria for the Linkage to, Retention in, and Re-engagement in HIV Care Chapter of the PRS *Compendium.*

Implementation research-related findings

- None reported

Process/study execution findings

- None reported

Adverse events

- None reported

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REFERENCES AND CONTACT INFORMATION

Messeri, P., Yomogida, M., Ferat, R. M., Garr, L., & Wirth, D. (2020). An HIV health plan patient navigation program: Engaging HIV positive individuals in primary medical care. *Journal of HIV/AIDS & Social Services*, *19*(1), 55-73.

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