Co-locating Care Management Staff and Peers in Medical Clinics

This fact sheet contains highlights from a Ryan White HIV/AIDS Program (RWHAP) recipient on the *Co-locating Care Management Staff and Peers in Medical Clinics* intervention, a medical-community partnership to link clients to HIV care and decrease missed appointments.

INTERVENTION OVERVIEW: The Co-locating Care Management Staff and Peers in Medical Clinics intervention is a co-located linkage to care program in which a medical-community partnership was launched to facilitate linkage to and reengagement in care for HIV clients and address the challenges created by missed appointments and emergency room care.

PRIORITY POPULATION: People with HIV who are not engaged in care.

ORGANIZATIONAL SETTING: Alliance for Positive Change (Alliance), a community-based organization (CBO), and Ryan Health, a Federally Qualified Health Center (FQHC), both located in New York, NY.

FUNDING SOURCE(S): Health Resources and Services Administration's (HRSA) RWHAP Part A and New York State's Medicaid Health Home Care Program.

INTERVENTION PURPOSE/GOAL: This intervention aims to facilitate linkages to care through the co-location of services for individuals with HIV and complex medical health care needs.

INTERVENTION SUCCESSES: Co-locating Care Management Staff and Peers in Medical Clinics implementers sustained an enrollment of 50–60 clients each year. In 2020:

- 98% of enrolled clients had at least 2 primary care appointments in the past 12 months.
- 100% of clients were engaged with the Health Home Care Management team monthly.

In 2022, the intervention re-engaged 43% of clients in care.

SUSTAINABILITY: This program has grown through the innovative use of diverse funding mechanisms, notably by using RWHAP Part A funds and Medicaid dollars generated through the Health Home Care Management initiative. Additionally, revenue was generated through case management facilitated by the Health Home Care Management Team. Two organizations that facilitated the intervention, Alliance for Positive Change (Alliance), a community-based organization, and Ryan Health, a Federally Qualified Health Center (FQHC), offset costs by taking on aspects of the program "in-kind." Alliance has since leveraged this approach in expanding their co-location model in working with other clinical locations.

INTERVENTION CORE ELEMENTS:

Bring Partners Together and Generate Buy-in. Convene community and clinical partners to delineate roles, including how staff will work together, track, and coordinate intervention activities. Convene staff and review the intervention to ensure understanding of its purpose and partner expectations.

Establish Co-location Team. Establish a Health Home Care Management team comprised of a Health Home Care Manager (and Assistant Health Home Care Manager and Health Home Care Coordinator, as appropriate) and Peer Navigators at the clinical partner location who are trained in reading electronic health records (EHR), Health Insurance Portability and Accountability Act (HIPAA) compliance, and informed consent.

Embed Team at Clinical Partner Site. Identify agreed-upon space at the clinical provider location for community partner staff. Generate standard operating procedures and evaluation metrics.

Work with Clinical Provider to Generate a List of Clients Who Need Services. Generate a list of clients who have missed appointments, experienced two or more emergency department visits in the past year, and/or have fallen out of care using EHR and population health databases.

Review the Needs of Identified Clients Requiring Services. Participate in case conferencing at the clinical partner location to address clients' needs identified through record reviews.

Implement Provider Peer Navigation. Engage clients identified at the clinical partner location, participate in onsite case conferencing, and support medical appointment and wraparound service access. Contact clients not at the clinical provider location through virtual and in-person engagements. Ensure client "alignment" with clinical care (two or more consecutive visits in a 12-month period).

Conduct Regular Team Meetings. Hold cross-organizational team meetings for community and clinical partners to review and refine protocols and review evaluation metrics.

INTERVENTION STAFFING:

- ***Health Home Care Manager:*** Works onsite at the clinical location, coordinating with clinical staff to review cases of clients with HIV who have fallen out of care. Presents updates during case conferences and grand rounds, updates client medical records, and works with Peer Navigators to ensure clients are re-engaged in care and connected to wraparound services. Additionally, the Health Home Care Manager alerts clinical partners of clients who cannot be found, have moved, or shifted to different medical providers.
- ***Assistant Health Home Care Manager:*** Reports to the Health Home Care Manager and is co-located at the clinical location. Supports the review and presentation of data during case conferences and grand rounds and works with Peer Navigators to facilitate outreach to clients, updates to their EHRs, and connection to services.
- ***Health Home Care Coordinator:*** Reports to the Assistant Health Home Care Manager, supporting data sharing with the clinical partner team during case conferences and grand rounds and works with Peer Navigators to re-engage clients who have disconnected from care.
- ***Peer Navigator:*** Leverages Motivational Interviewing and health promotion strategies to engage communities and individual clients needing HIV and wraparound services; including screening, enrollment, linkage to care, and accompaniment to appointments. Peer navigators work directly with the co-located Health Home Care Management team, providing detailed information about the lived experiences and circumstances that clients may not share with clinicians.

IMPLEMENTATION CHALLENGES:

Staff burnout and turnover. This intervention demands a high level of skill, attention to detail, and engagement with staff working across two agencies and in the community. High staff turnover can lead to a loss in institutional knowledge. This can be mitigated through ongoing training and record keeping, ensuring that junior staff can be readily promoted, and newly recruited staff have the resources necessary to learn the job quickly.

Power imbalances. Community and clinical settings will need to anticipate possible power dynamics between their organizations. Clinical settings are often better resourced than their community counterparts. They may encourage community personnel to leave their organization and join the clinical organization at a higher salary or not take the information provided by the Health Home Care Management team fully into account. Health Home Care Management staff, in turn, may not find the right tone in community client needs during case conferencing and grand rounds, either coming on too strong or deferring too much to medical providers. These issues can be addressed through training, regular partner meetings, and annual retreats to re-evaluate intervention operations.

Institutional silos. To overcome institutional silos and work in a collaborative care model, co-located community-based and clinical staff must establish strong relationships that clearly define work schedules and physical workspaces. These approaches are key to developing strong working relationships and collaboration to benefit clients.

RESOURCES:

Co-locating Care Management Staff and Peers in Medical Clinics Intervention Overview and Materials: **https://targethiv.org/intervention/co-locating-care-management-staff-and-peers-medical-clinics?utm_source=bpURL**

Alliance/Ryan Health Pilot Project: Care Management & Peer Navigation presentation from the 2020 National Ryan White Conference on HIV Care and Treatment: **https://targethiv.org/sites/default/files/RWNC2020/16080_Duke.pdf**

HRSA IHIP Co-locating Care Management Staff and Peers in Medical Clinics Intervention Implementation Guide: **https://targethiv.org/sites/default/files/media/documents/2023-09/IHIP_Co-Locating_Care_Implementation_Guide.pdf**