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**RYAN WHITE**  
**CONFERENCE ON**  
HIV CARE & TREATMENT

# Adapting and Implementing the Youth-focused Case Management Model of Care for the SPNS BMSM Initiative

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# Learning Outcomes



At the conclusion of this activity, participants will be able to:

1. Understand the key components of the Youth-focused Case Management model;
2. Compare adaptations between organizations with different needs and populations; and
3. Apply lessons learned to adapt and replicate the Youth-focused Case Management model of care.

# Acknowledgement



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# Acronyms



**2BU** – Building Brothers Up

**EHE** – Ending the HIV Epidemic Initiative

**ETAP** – Evaluation and Technical Assistance Provider

**MOC** – Model of Care

**PLWH** – People living with HIV

**RWHAP** – Ryan White HIV/AIDS Program

**SPNS** – Special Projects of National Significance

**TVP** – The Village Project

**(Y)BMSM** – (Young) Black men who have sex with men

# The SPNS BMSM Initiative

Sarah Hodge, NORC at the University of Chicago

# About the SPNS BMSM Initiative



- Three-year Ryan White Part F SPNS project: 2018-2021
- *Goal:* Implement, evaluate and support replication of four evidence-informed behavioral health models, in order to improve HIV health outcomes for Black men who have sex with men (BMSM)



- **BMSM are a uniquely vulnerable population.**
  - Increased risk of depression
  - Less likely to achieve viral suppression than national RWHAP average
  - 1 in 2 BMSM will be diagnosed with HIV in his lifetime
  - Experiencing twin traumas of COVID-19 and protests triggered by killing of George Floyd, Breonna Taylor, Ahmaud Arbery, and others
- Critically important for the Ending the HIV Epidemic Initiative to reach populations who are not being reached by traditional models of care.



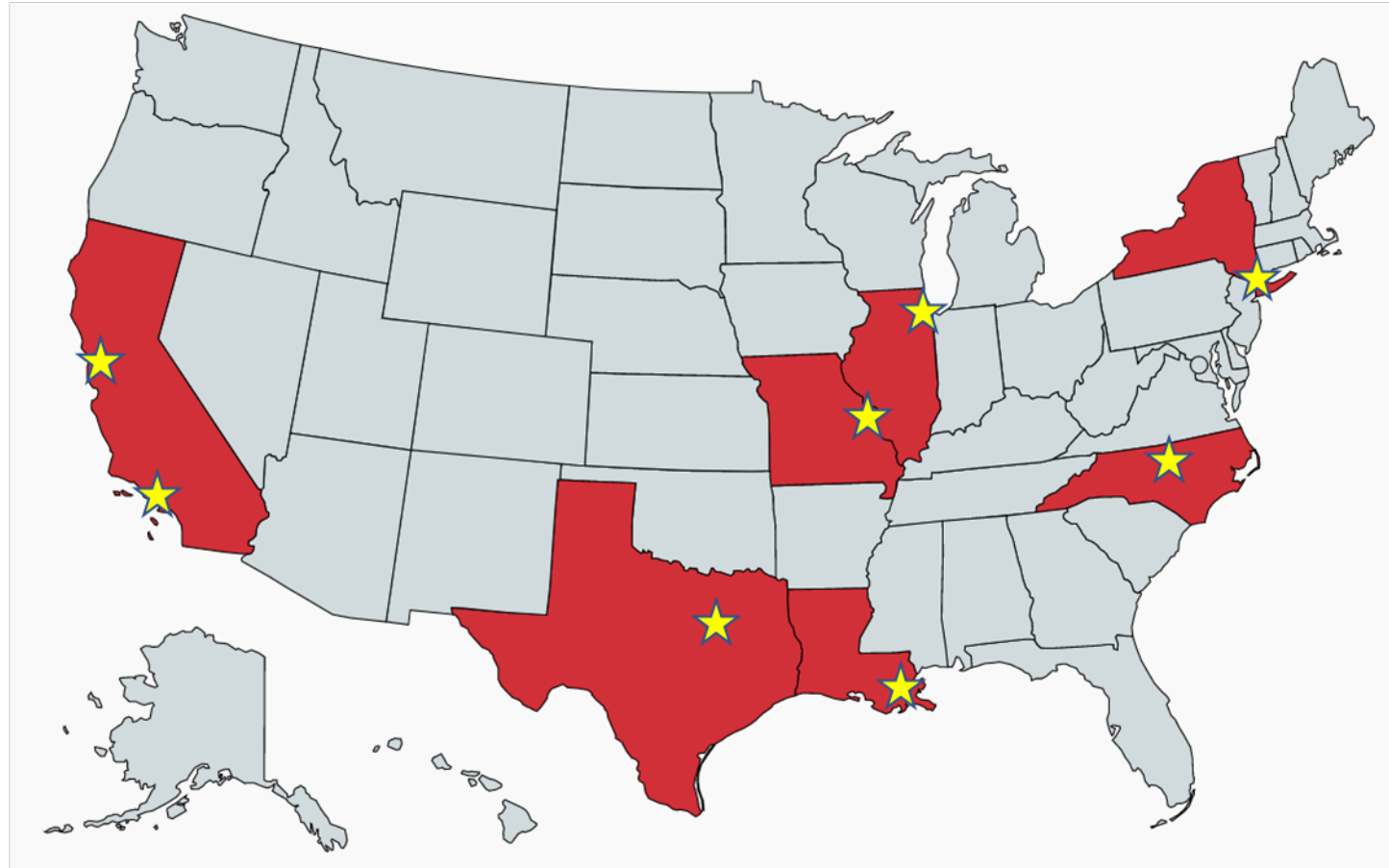
# Initiative Team



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Care  
Engagement  
Project



# Models of Care

- Strength through Youth Livin' Empowered (STYLE)
  - Social marketing and virtual support
- Project Silk
  - Recreation-based drop-in space to support artistic expression
- Brothers United/the Damien Center
  - One-stop shop model
- Youth-focused Case Management
  - Intensive case management support



# Baseline Evaluation Data



- Median age of **34**, with half younger than 30
- Significant economic challenges: **64%** reporting employment instability, **61%** reporting housing instability, and **59%** with incomes below \$10,000 annually
- Only **50%** of newly diagnosed clients linked to care within 90 days
- **63%** are virally suppressed, compared to 87% of RWHAP clients nationally
- Only **9%** who screened positive for behavioral health needs in the previous year actually received behavioral health services



# The Youth-focused Case Management Model of Care

Sarah Hodge, NORC at the University of Chicago

# Youth-focused Case Management



- Developed by Wohl et al. (2011)
- Implemented in two HIV clinics in Los Angeles, CA
- 78% of participants had critical needs at enrollment:
  - Housing
  - Nutrition support
  - Substance use treatment
  - Mental health services
- At six months, 70% retained in primary HIV care

Amy Rock Wohl , Wendy H. Garland , Juhua Wu , Chi-Wai Au , Angela Boger , Rhodri Dierst-Davies , Judy Carter , Felix Carpio & Wilbert Jordan (2011) A youth-focused case management intervention to engage and retain young gay men of color in HIV care, AIDS Care, 23:8, 988-997, DOI: 10.1080/09540121.2010.542125

# Core Components



Staffing	Outreach Methods	Intervention Length	Intervention Delivery	Target Population
<ul style="list-style-type: none"><li>• Two Bachelor-level case managers</li><li>• Supervised by licensed clinical social worker</li></ul>	<ul style="list-style-type: none"><li>• Clinical and venue-based outreach</li></ul>	24 months: <ul style="list-style-type: none"><li>• Weekly sessions for first two months</li><li>• Monthly sessions for next 22 months</li></ul>	<ul style="list-style-type: none"><li>• Psychosocial case management</li><li>• Individualized, tailored treatment plan</li><li>• Treatment education/adherence support</li><li>• Regular sessions with case managers</li><li>• Additional phone and text contact as needed</li></ul>	<ul style="list-style-type: none"><li>• Black/African American and Latino MSM</li><li>• Aged 18-24</li><li>• HIV+</li></ul>

# Intervention Steps



1. Client referred to case manager (CM)
2. CM conducts a comprehensive assessment
3. CM develops an individualized treatment plan
4. CM provides referrals
5. CM meets with clients to assess progress in their treatment plan

Note: Site adaptations were made pre-COVID-19.



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# Adapting and Implementing the Youth-focused Case Management Model of Care for the SPNS BMSM Initiative

Presented by Jonathan Gute & Frontline Team of Parkland Health & Hospital System in Dallas, Texas under the leadership of Principal Investigator – Crystal Curtis



# Parkland Health & Hospital System Overview



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Parkland HIV Services Department (PHSD) is a department within the Parkland Health & Hospital System (Parkland), the community health system for Dallas, Texas. For over 30 years, PHSD has been the largest provider of HIV healthcare services for uninsured patients in Dallas and bordering counties.

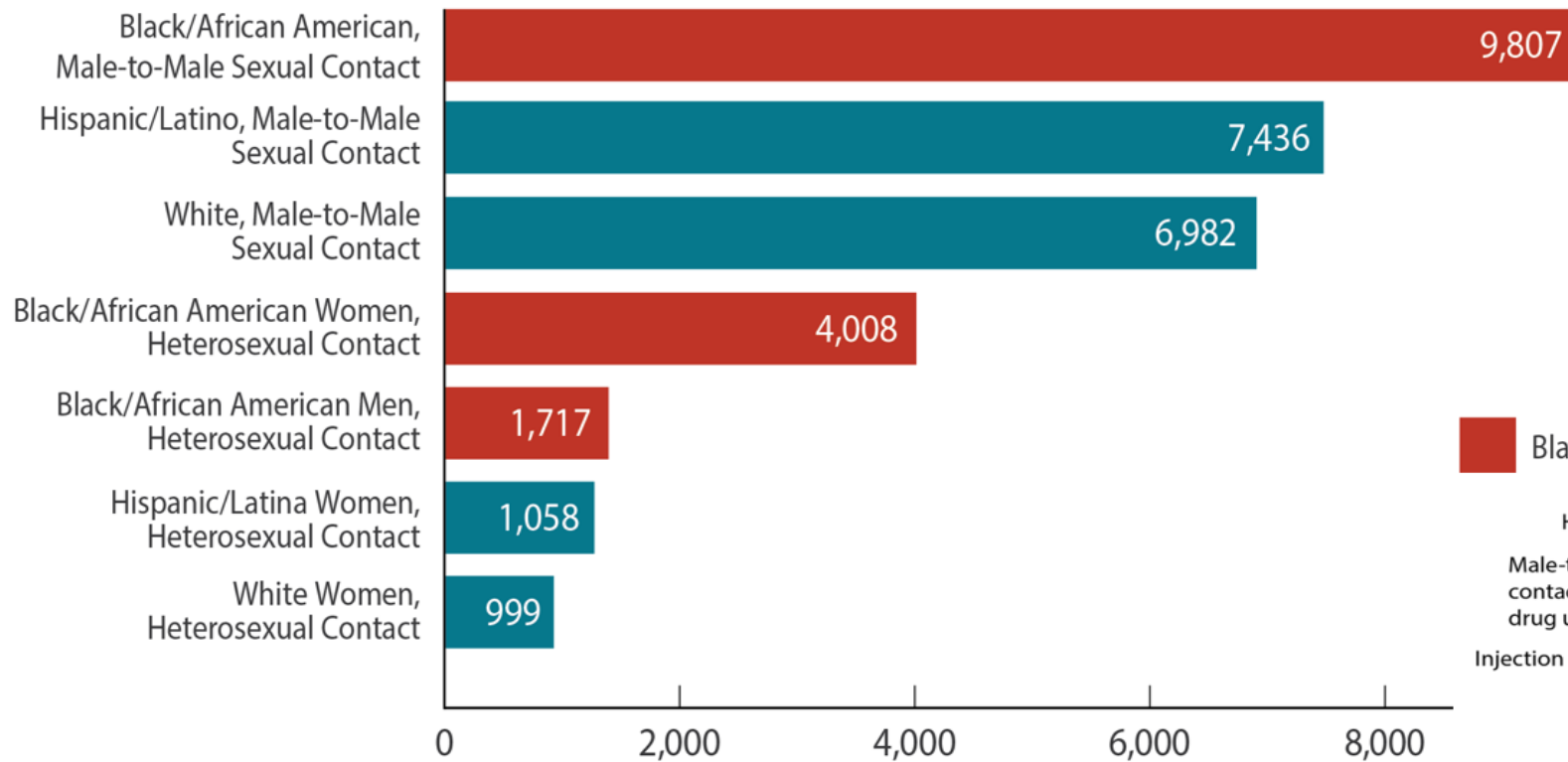
In 2016, PHSD provided outpatient medical care to approximately 23% (7,381) of the 21,062 persons living with HIV. Being one of the largest public hospitals in the nation, PHSD is able to integrate the care provided at the five HIV clinics, the emergency department, the inpatient units on the main campus and Parkland's 100+ specialty clinics.

In addition to outpatient medical care, PHSD provides the following services: case management (medical and nonmedical), emergency financial assistance, medical transportation, mental health counseling, and early intervention activities.



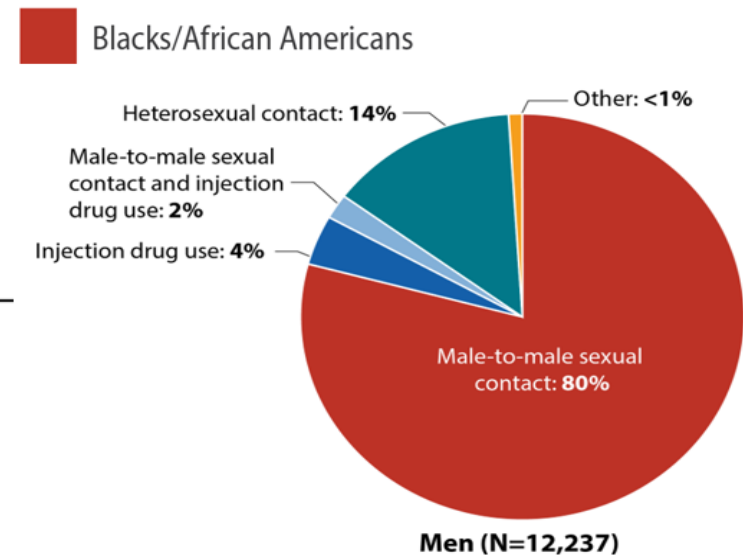
# Basis for Special Project Health Disparities in HIV Black /African American MSM Population

## New HIV Diagnoses in the US and Dependent Areas for the Most-Affected Subpopulations, 2017



**BMSM Newly Diagnosed**

New HIV Diagnoses Among Blacks/African Americans by Transmission Category and Sex in the US and Dependent Areas, 2017



Content source: Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention

# HIV Landscape: PHSD vs. Dallas At Large



Gender	
Dallas PLWH	PHSD PLWH
Male 81%	Male 70%
Female 19%	Female 28%
Trans M-F NDA	Trans M-F 1%
Trans F-M NDA	Trans F-M <1%
Dallas New	PHSD NEW
Male 83%	Male 72%
Female 17%	Female 26%
Trans M-F NDA	Trans M-F 2%
Trans F-M NDA	Trans F-M 0%

Age Ranges	
Dallas PLWH	PHSD PLWH
13-24 4%	13 -24 3%
25-34 20%	25-34 18%
35-44 24%	35-44 24%
45+ 52%	45+ 55%
Dallas New	PHSD NEW
13-24 24%	13-24 16%
25-34 39%	25-34 39%
35-44 19%	35-44 20%
45+ 18%	45+ 25%

	Population	Number of Clients	% of Clients
Race	White	931	17%
	Black	2,917	54%
	Hispanic	1,431	26%
	Other/Unknown	176	3%
Sex	Male	3,817	70%
	Female	1,566	29%
	Transgender M-F	72	1%
Age	Infants (under 2)	0	0%
	Children (2-12)	0	0%
	Youth (13-24)	176	3%
	Adult (25-44)	2,326	42%
	Adult (45-64)	2,698	50%
	Adult (65+)	255	5%
Mode of Transmission	Heterosexual	1,473	27%
	IDU	159	3%
	MSM	3,121	57%
	MSM/IDU	141	3%
	Transfusion/Transplant	11	0%
	Other/Unknown	550	10%
	<b>Total</b>	<b>5,455</b>	<b>100%</b>
Target	<b>Black MSM (15-34)</b>	<b>391</b>	<b>7%</b>

Race/Ethnicity	
Dallas PLWH	PHSD PLWH
Black 43%	Black 55%
Hispanic 24%	Hispanic 25%
White 28%	White 17%
All Other 5%	All Other 3%
Dallas New	PHSD NEW
Black 48%	Black 51%
Hispanic 31%	Hispanic 32%
White 18%	White 16%
All Other 3%	All Other 1%

Exposure Category	
Dallas PLWH	PHSD PLWH
MSM 69%	MSM 45%
Hetero 19%	Hetero 47%
IDU 10%	IDU 5%
All Other 2%	All Other 3%
Dallas New	PHSD NEW
MSM 74%	MSM 50%
Hetero 18%	Hetero 45%
IDU 8%	IDU <2%
All Other 0%	All Other 3%

# The Village Project Intervention Goals



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Original Model of Care: Wohl et al Youth-focused case management (YCM) intervention\* to engage and retain young gay men of color in HIV care

Adaptation: The Village Project is a 9-month case management based model of care that provides BMSM with weekly visits by a dedicated Case Manager, Peer Patient Navigator as well as a Client Advocate & an HIV Counselor for the first 6 months, followed by monthly contact for the final 3 months. Visits will be in-person and virtual. TVP will utilize phone calls, text messaging, and Skype.

## Components of The Village Project

- Intake Assessment/Evaluation
- Care Coordination/Case Management
- Peer Health Navigation
- Peer Support/Group Sessions
- Referral to Behavioral Health Care Services
- HIV Education/Risk Reduction
- Mental Health Services
- Outpatient/Ambulatory Health Services

Staffing Plan: Case Manager, Peer Patient Navigator, Client Advocate, HIV Counselor, Senior Data Analyst, Performance Improvement Analyst (Evaluator), Project Management Coordinator (Manager), and HIV Grant Director (Principal Investigator)

## Village Project Goals

The Village Project staff will recruit, retain, and link BMSM, ages 17-34 to clinical and behavioral healthcare and supportive services. The improvement objectives are as follows:

1. Increase linkage to care <30 days by 27% (2017 baseline\*: 35% <30 days)
2. Increase retention in care by 15% (2017 baseline\*: 52%)
3. Increase viral load suppression by 12% (2017 baseline\*: 68%)
4. Target enrollment number: 150 newly dx/LTC/intermittent to care at PHSD



# Project Structure & Staffing Plan

## Core Components

- Intensive Case Management
- Peer Navigation Services
- Nine Month Program – weekly contact
- Co-located, co-integrated Behavioral Health Services
- Comprehensive Assessment every 90 days (Acuity Scale)
- HIV Education/Risk Reduction
- Outpatient Ambulatory Health Services
- Mental Health Services
- Psychosocial Support Group – Heart & Soul (weekly)
- Customized Care Plan
- Work with patient to create problem list and actionable
- Assistance with Medication Adherence
- Care Coordination – referrals to community resources (housing/transportation)
- Sexual Health Education
- Graduation and transition to standard of care
- Mentorship opportunities (MVP Program)



## Staffing Plan

- Case Manager
- Peer Patient Navigator
- Client Advocate
- HIV Behavioral Health Counselor
- Performance Improvement Analyst
- Data Analytics Team Lead
- Project Manager/Research Coordinator
- Principal Investigator

# Model of Care Adaptations



Intervention Components	A.R. Wohl YBMSM Model of Care	The Village Project Model of Care
Length of Intervention	24 month intervention	6 month intensive/3 months transition
Age Qualifier	15-64	17-34
Target Population	HIV+ Youth Latino & Black MSM	HIV+ BMSM
Staffing	Two BA Level Case Manager	LMSW Case Manager, Peer Patient Navigator, HIV Counselor
Service Delivery	Case Management, Care Plan, Treatment Education/Adherence Support, Text Messaging	Intensive Case Management, Care Plan creation based on Acuity Scale every 90 days, Peer Patient Navigation, Psychosocial Support Group, Co-integrated Behavioral Health Services, honed warm-handoff process
Enrollment Goal	63	150

# Recruitment Experiences

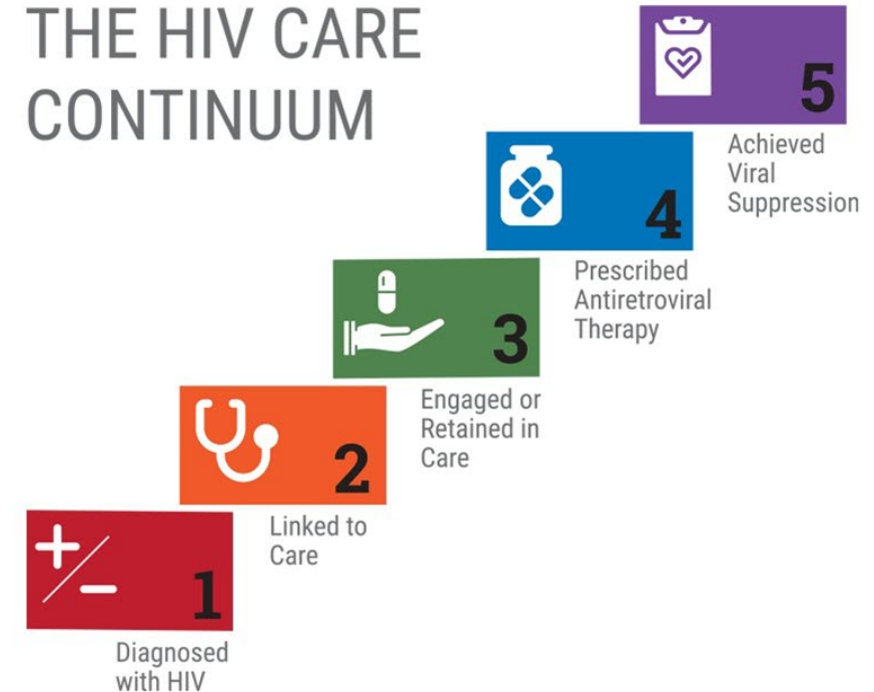
## Inreach Strategy – Internal Patient Engagement (80%)

- Lost to Care Team – 6+ Out of Care – reengagement
- Prevention Team – testing team links to care/TVP
- CM/PPN – review of DAR daily
- Internal Referrals – CM/Providers
- Patients referring friends, meeting patients in clinic

## Outreach Campaign - Community Engagement (20%)

- Build awareness of resources
- Bi-directional referrals to meet comprehensive needs
- PPN developed warm handoff process and referral completion component (attends visits with pt. in community)
- Collaborate with mental health and substance use partners

## THE HIV CARE CONTINUUM



## Best Practices:

- Rapid Start Protocol that allows same immediate access to ART/same day visit
- Maximizing the electronic health record (EPIC)

# Heart & Soul Series: Psychosocial Support Group



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## Heart & Soul Series

- Weekly social support group, one branded as Guy's Night Out
- Hosted by Peer Patient Navigator
- Discuss mental, physical, and spiritual well-being
- Encourages engagement in Behavioral Healthcare
- Held at 3 different times of day (9:00, 3:00, 6:00)
- Each session begins with a meditation and an HIV or health related fact
- Discussion questions are prepared in advance to guide conversations surrounding relationships, boundaries, friendship, and self-love
- Sessions can result in a warm handoff to the HIV Behavioral Health Counselor if additional support is evident
- Hosted onsite at PHSD and offsite at the Empowerment Center (a partner community resource)
- Participants often exchange phone numbers and build relationships, two have even obtained jobs through networking

CARE TEAM  
+  
CARE PLAN  
+  
REFERRALS  
+  
PEER SUPPORT  
=  
EMPOWERMENT



# Consumer Advisory Board Mentors of the Village Project (MVP Program)



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**YOU'RE INVITED**

MEN HAVING A CONVERSATION FROM AN  
UNAPOLOGETICALLY BLACK POINT OF VIEW.

OUR PEOPLE.  
OUR PROBLEM.  
OUR SOLUTION.

TUESDAY, APRIL 2, 2019

6:30 P.M.

PAPPADEAUX SEAFOOD KITCHEN

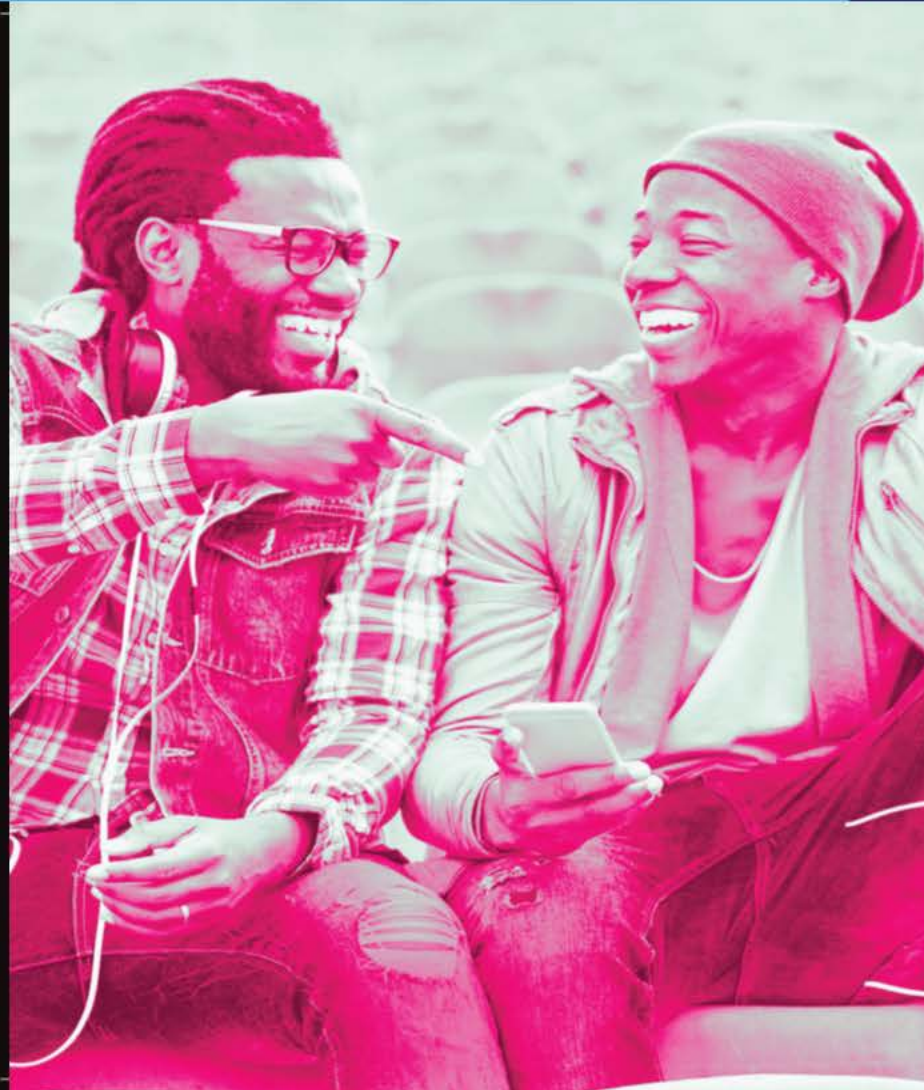
3520 OAK LAWN AVENUE

DALLAS, TEXAS 75219

RSVP BY 4/01/19  
JONATHAN.GUTE@PHHS.ORG  
214-590-7059

REGISTER ONLINE AT  
<https://bit.ly/2Ohz5OM>

FULL DINNER PROVIDED +  
DOOR PRIZES & GIVEAWAYS



*The Village Project*  
**MVPs**

# iSTAT Clinic: Rapid Start Protocol

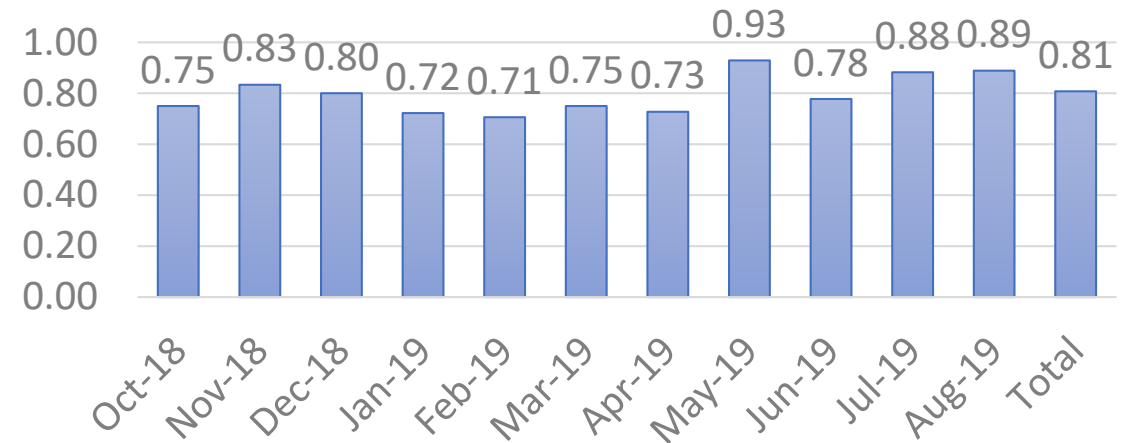


The Village Project patients are prioritized for the two daily appointments offered by the iSTAT Clinic.

The Rapid ART Initiative is a clinical program intended to further the goals of the Parkland 2020 strategy, to reduce new HIV diagnoses, improve linkage to and retention in primary care services, and improve virologic suppression.

The potential benefits include: improving individuals' health by decreasing time to virologic suppression, improving rates of early engagement in care and long-term retention in care, and reduction of new HIV infections through viral suppression of known HIV+ patients.

Proportion of patients seen within 7 days of Case Management Intake at Amelia Court



147/182 pts (81%) with new diagnosis were seen within 7 days

# Behavioral Health Integration



The behavioral health referral process is as follows: assess acuity, identify needs, discuss resources, provide referrals, and develop a mutually agreed upon care plan.

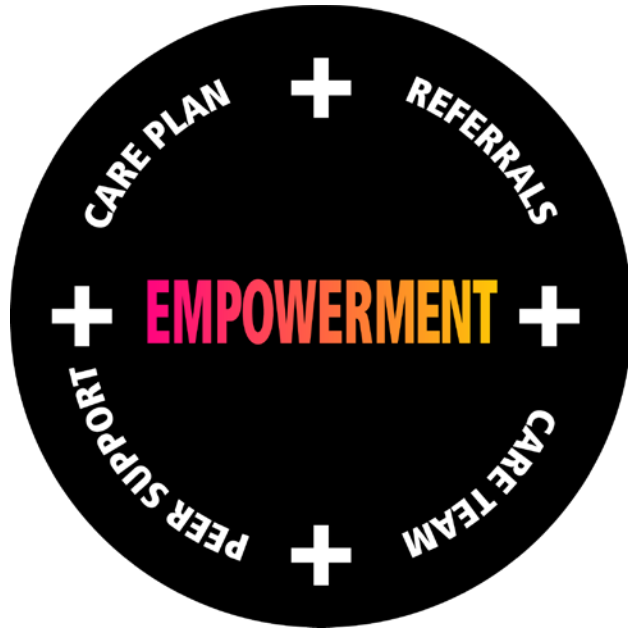
## **Facilitators, Tools, Strategies for BH Integration**

- Licensed CM staff recognizes mental health issues in the beginning
- Tools to warm handoff to someone who can assess issues in line with the care plan built by patient and Case Manager
- Direct personal connection with external mental health providers in the community – enables quick response and immediate access
- HIV therapist that has contacts at Legacy/Homeward Bound – to provide options for patients with acute needs
- Specialized therapy options including HIV Counselor with EMDR & EBT credentials to provide options for mental health
- Acuity scale assessment every 90 days that informs referrals –  
Extensive progress note documentation to provide further clarity
- SAMISS – completed by CM - elaborate and assess needs for digging deeper and documenting
- Medication Assistance Treatment (MAT) certified providers
- Metro Care – for immediate medication access for depression, anxiety, suicidal ideation/homicidal ideation, schizophrenia, bipolar disorder etc.

## **Improving BH Services: Meet the Unique Needs of BMSM**

- Integrate peer navigation and sound mental health and risk reduction strategies. Referrals will be maintained via 'warm handoffs' with our on-site BH team
  - Internal referrals: an introduction will be made for each client to the Behavioral Health Team (whether or not need is established at intake)
  - External referrals: the Peer/Patient Navigator will attend the initial off site BH/SS visit to complete the referral loop, noting in EPIC (EMR) the completed referral.
- Measure Heart & Soul dosage data to establish effectiveness on engagement. Show rate will determine quantitative competence.
- Explore the impact of depression on healthcare utilization (emergency room visits, late stage acute HIV, missed visits). Knowledge, Attitudes & Skills (KAP) will assess stigma & access to navigate barriers
- Address barriers to care by integrating motivational interviewing techniques into client documentation, normalizing behavioral health care via social support groups, offer flexible scheduling, providing internal and external services and assimilating appointments.
- Behavioral Health Team (two HIV Counselors and one Psychiatrist) will utilize the PHQ2/9, WHODAS and/or GAD-7 tool during the initial BH visit.

# Multidisciplinary Case Conference

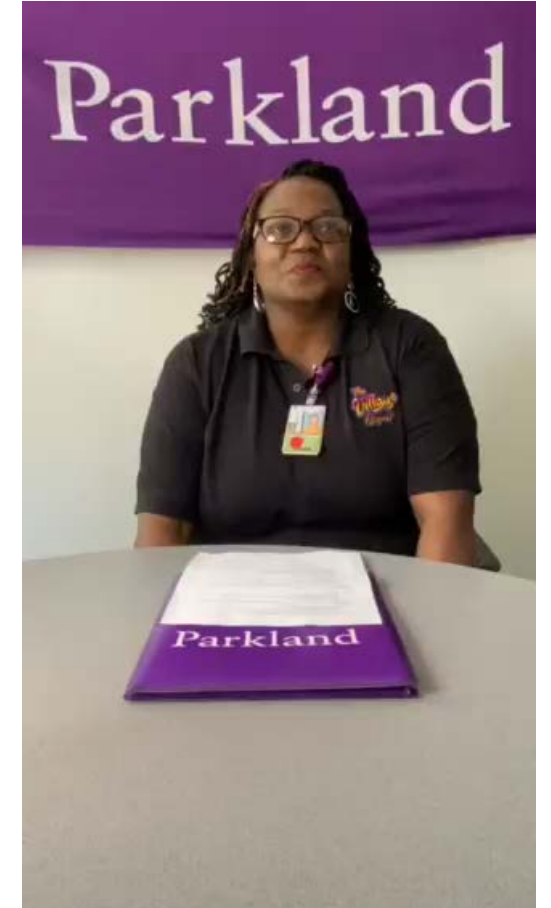


## ***Program Maintenance & Care Coordination***

- Weekly Case Conference to bridge gaps in care
- Template – organizes group discussion with action items and expectations for next steps including responsible party and documentation in EPIC (EHR)
- Attendees: Case Manager, Peer Patient Navigator, Clinician, Programmatic Management, Behavioral Health Counselor
- Potential for expansion to other members across the HIV Care Team

## ***Optimizing Health Outcomes***

- Improve Care Coordination – arrange access, reduce barriers to obtaining services, establish linkages, and other activities recorded in progress note
- Team Communication - provide holistic, coordinated, and integrated services across providers, and to reduce duplication
- Case Manager – Progression Chart Analysis – unreachable clients presented to team
- Peer Patient Navigator – Heart & Soul, MVP Program, Guy’s Night Out Series
- Retention Strategies & ART Adherence - share individual strategies
- Emphasis on Project Goals (Link, Retain, Suppress, expand BH access )



# Collaborative Efforts: Community Partnerships



- Dallas County Health and Human Services (Health Department) – established relationship produced 35% of our referrals – mostly newly diagnosed
- AIN – transportation provider in Dallas County – worked together on bidirectional referrals on taxi vouchers and medical van transport
- Legacy Counseling – strong community partner for mental health services and counseling
- Resource Center – our team worked with a subgroup of Resource Center called United Black Ellument (UBE) that focuses on Black/African American services and building culturally competent programming
- Prism Health – a fellow medical provider – we have found our patients go back and forth between providers
- Homeward Bound – temporary housing resource and substance use resource including inpatient/outpatient detox



LEGACY  
COUNSELING CENTER

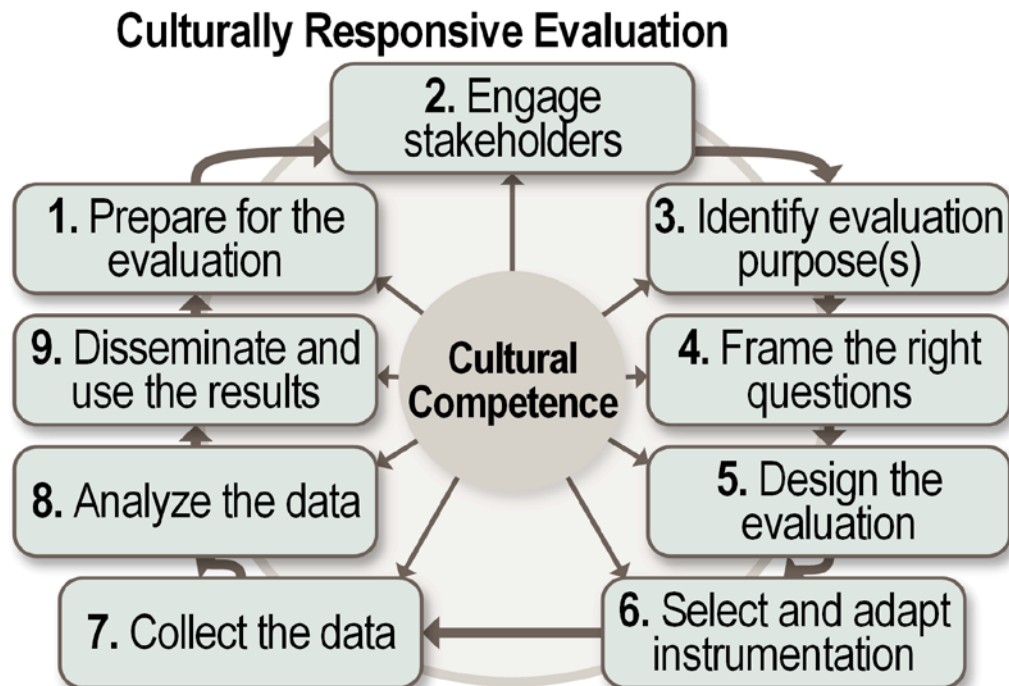


PrismHealth  
NORTH TEXAS

PERSONALIZE YOUR HEALTHCARE



## Mixed Method - (Qualitative/Quantitative)



The Village Project's Local Evaluation is layered with the Multi-Site Evaluation (MSE) tools in conjunction with internal quality management tools.

## Tools for Analysis

### Local Evaluation

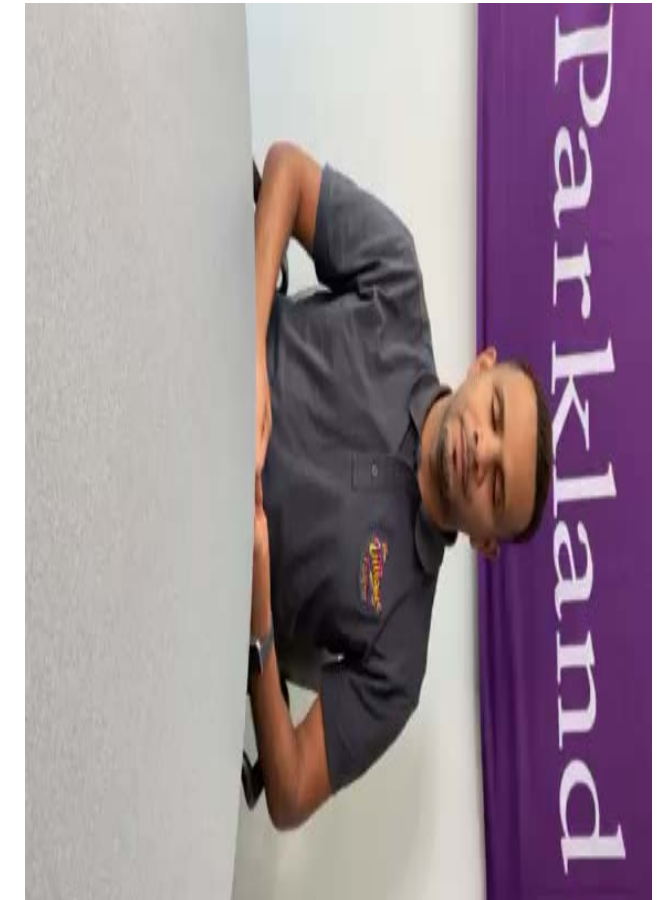
- Knowledge, Attitude and Practice Assessment (KAP) Tool
- Groupwork Engagement Measure (GEM) Tool

### Multi-Site Evaluation (MSE)

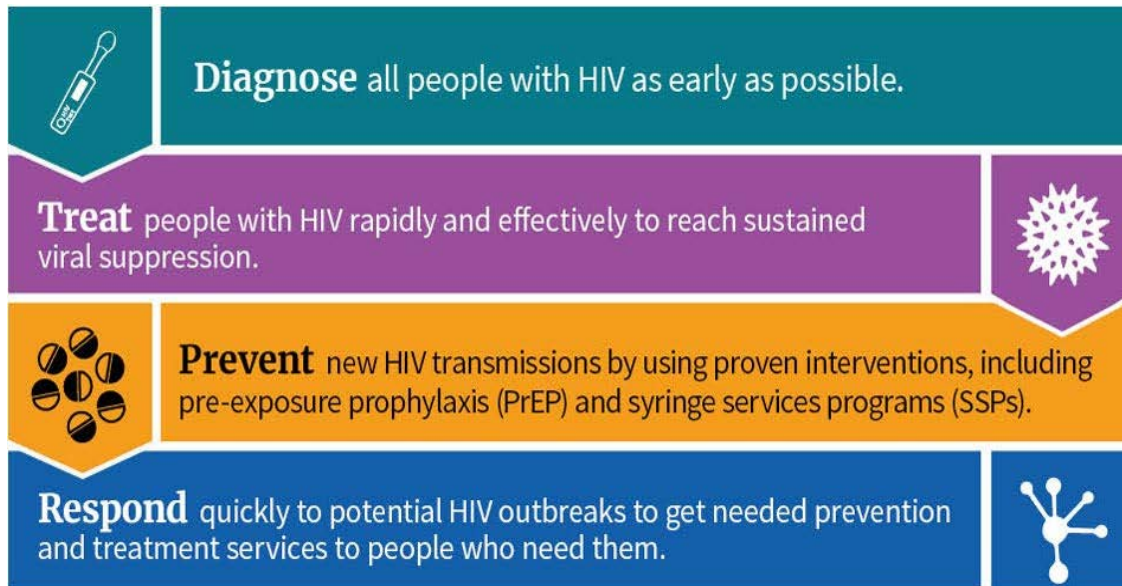
- BMSM-PS (Black Men who have Sex with Men – Patient Survey)
- MOI (Main Outcomes Instrument)
- IACW (Interview-Assisted Cost Worksheets)
- DSAT (Demonstration Site Assessment Tool)

## Social Determinants of Health Impacting PLWH

- Availability of resources to meet daily needs (e.g., safe housing & local food markets)
- Access to educational, economic, and job opportunities
- Access to health care services
- Quality of education and job training
- Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities
- Transportation options, Public safety, Social support
- Social norms and attitudes (e.g., discrimination, racism, & distrust of government)
- Exposure to crime, violence, and social disorder (e.g., presence of trash & lack of cooperation in a community)
- Socioeconomic conditions (e.g., concentrated poverty & accompanying stressful conditions)
- Residential segregation, Language and literacy, Culture
- Access to mass media and emerging technologies (e.g., cell phones, Internet, & social media)



# Lessons Learned & Replication Considerations



- ❖ Peer Patient Navigation is a key to success
- ❖ Cultural competence must be continuously nurtured and infused into healthcare models
- ❖ Support group participation often leads to breaking down stigma and leads to behavioral health services exploration
- ❖ Intensive case management fosters relationship growth and trust which leads to better health outcomes
- ❖ HIV is not the only topic of discussion our priority population wants to discuss and tend to
- ❖ Social support systems are integral to health outcomes
- ❖ Community involvement is crucial – must create an atmosphere where black voices are valued and integrated into care
- ❖ Frequent Acuity assessments are necessary and valuable for care plan accuracy (evolution of needs)
- ❖ Consumer Advisory Board access promotes authenticity in program components and design
- ❖ Exploring the SDOH & stigma are important pathways to improved health outcomes
- ❖ Social engagement is vital – patients want to connect and discuss other life skills
- ❖ Rapid Start prioritization improves linkage, retention, suppression





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# ***Building Brothers Up (2BU)***



**BUILDING BROTHERS UP**

**Friends Research Institute, Inc.  
Kimberly Kisler, PhD, MPH**

# Overview



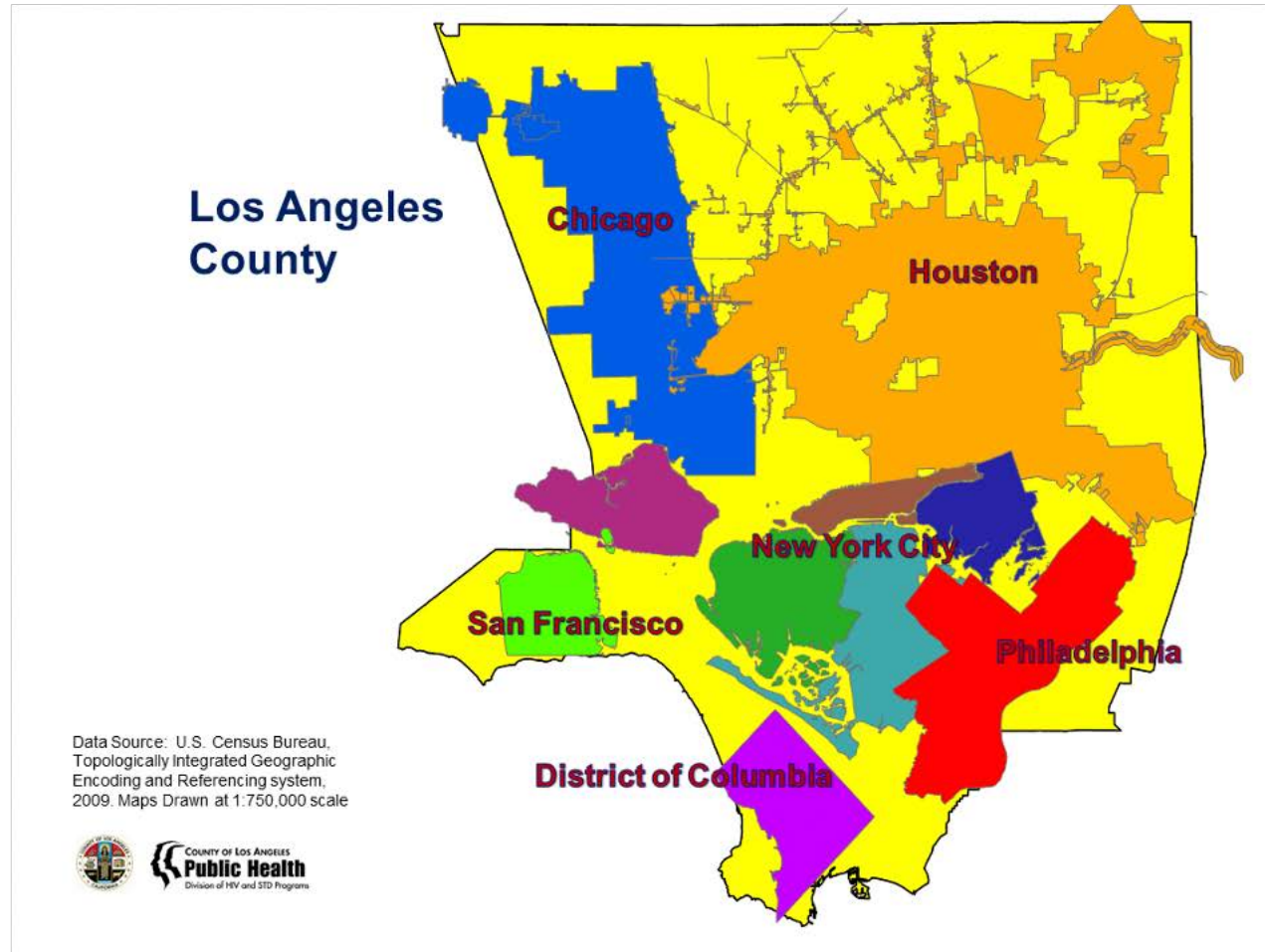
- **WHO:** Friends Community Center (FCC), the community research site of Friends Research Institute, Inc. (FRI)
  - Working with MSM and trans women with multiple syndemic health disparities since 1994
- **WHAT:** Non-clinical community research center
  - *Objective:* Reduce HIV transmission and acquisition and the risks that can result from substance use
  - *Target Populations:* MSM and transgender individuals
  - “Last shop on the block” for many
- **WHERE:** Located in the heart of Hollywood, California



Image Source: <https://hollywoodsign.org/seeing-the-sign/>

# Los Angeles County is HUGE!

**Figure 1. Geographic Comparison of Los Angeles County with Six U.S. Cities**



## **Original Model of Care (MOC):**

*Youth-focused Case Management Intervention to Engage & Retain  
Young Gay Men of Color in HIV Care*



## **Adapted Model of Care:**

*Building Brothers Up (2BU)*



# Adaptations Made to MOC



Adaptation	MOC	2BU
<b>Focus Population</b>	Youth Latino MSM & BMSM	18-65 years BMSM

# Adaptations Made to MOC



<b>Adaptation</b>	<b>MOC</b>	<b>2BU</b>
<b>Focus Population</b>	Youth	18-65 years
	Latino MSM & BMSM	BMSM
<b>Staffing</b>	BA-level Case Manager	Peer Case Manager

# Adaptations Made to MOC

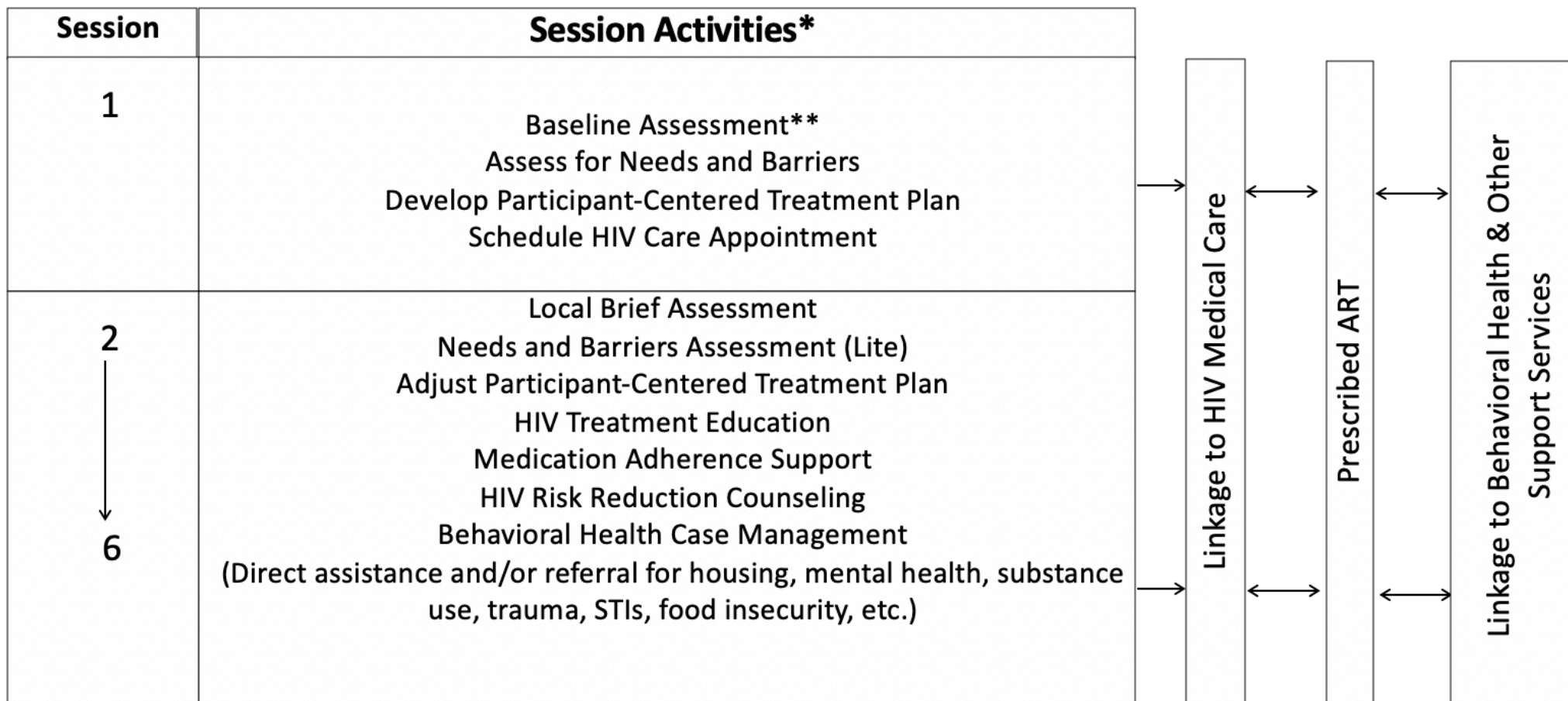


<b>Adaptation</b>	<b>MOC</b>	<b>2BU</b>
<b>Focus Population</b>	Youth Latino MSM & BMSM	18-65 years BMSM
<b>Staffing</b>	BA-level Case Manager	Peer Case Manager
<b>Design &amp; Length of Intervention</b>	Weekly for 2 months, and monthly for 22 months	Weekly for 1 month (Sessions 1-4), and monthly for 2 months (Sessions 5-6)

# 2BU Intervention Delivery System



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\*Sessions will occur weekly in the first month (Sessions 1-4), and monthly in the second and third months (Sessions 5-6).

\*\*Baseline Assessment includes MSE-PS, Local Evaluation, & Local Brief Evaluation



# Adaptations Made to MOC



<b>Adaptation</b>	<b>MOC</b>	<b>2BU</b>
<b>Focus Population</b>	Youth Latino MSM & BMSM	18-65 years BMSM
<b>Staffing</b>	BA-level Case Manager	Peer Case Manager
<b>Design &amp; Length of Intervention</b>	Weekly for 2 months, and monthly for 22 months	Weekly for 1 month (Sessions 1-4), and monthly for 2 months (Sessions 5-6)
<b>Location</b>	Clinic-based	Non-clinical community research center

# Integrating HIV & Behavioral Health as a Non-clinical Site



- A non-clinical community research center with strong community trust and rapport
  - No HIV clinical services other than HIV and STI testing
  - Limited behavioral health services
- No co-located HIV or behavioral health services
  - Must rely on “warm hand-offs” and “red carpet access” to other service providers
  - Must have familiarity with services landscape AND have relationships with direct service providers

# Early Lessons Learned



- Must consistently engage in community events to build relationships
  - Staff turn-over is high at HIV, behavioral health, and support services providers
- May take 3-4 sessions before participant feels comfortable sharing needs
- Peer staff are important
- Participants consider *2BU* a behavioral health service and do not feel they need additional services
- Participants may have had bad experiences with available services at other agencies
- Difficult to get immediate access to behavioral health services when participant is ready (in the moment)

# Considerations for Implementation



- Delivering services via peers is important
  - Essential to provide professional support to Peer Case Managers via clinical supervision (i.e., using a PhD-level mental health clinician)
- Developing and maintaining relationships with HIV and behavioral health service providers is paramount - must be willing to put in the work!
- Community feedback, through a CAB, is vital to program success
- Must be flexible and creative because... a **pandemic** may occur!



# Thank You!



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HIV CARE & TREATMENT



# WITH U: Peer Health Navigation

Washington University in St. Louis; Project ARK

Jeffrey Glotfelty, MPH

Principal Investigator: Katie Plax, MD



# Local Context

- Washington University operates as an integrated Ryan White Part C/D program
- Largest provider of HIV care in the St. Louis region
- Project ARK at WashU coordinates a network of providers that integrates the delivery of HIV primary care with social support services and offers convenient access to research.



# Local Context (con't)



- 6,145 persons are living with HIV disease in the St. Louis region (2016)
- Race:
  - Black/African Americans represent only 20% of residents in the service area
  - Comprise 56% of living HIV/AIDS cases
- Sex and Exposure Category:
  - HIV disease prevalence is highest among males (82.2%) and
  - Highest among men who have sex with men (64.4%)
- Among youth ages 24 and under, Black/African Americans comprise 84.6% of all cases of people living with HIV



# Adaptations to Youth-focused Case Management

- Adapted from Youth-Focused Case Management Model of Care<sup>1</sup>
  - Intensive peer-based health navigation tailored for Black YMSM
    - One-on-One (peer to participant) sessions with activities, based on three main functions: (Peers for Progress<sup>2</sup>)
      - Education
      - Support
      - Navigation/Linkage
- } Includes goal setting around main functions

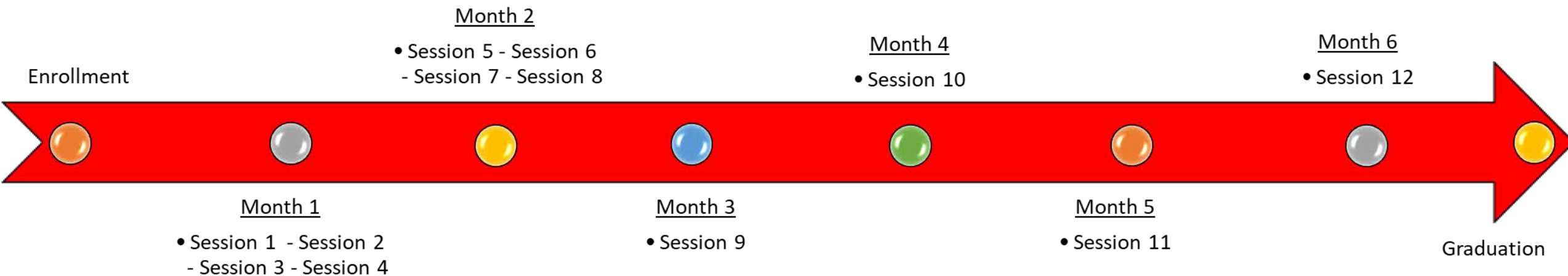
# Adaptations to Original MOC



- Shortened the intervention duration
- Peer delivered within the existing multi-disciplinary team of case managers and providers
- Deliberately integrated behavioral health services (Mental Wellness)
- Added innovative practice management tool

# Intervention Duration

- Because of reported issues with retention in delivery of the 24-month long MOC
- Six month program
  - Two months of weekly sessions
  - Four months of monthly sessions



# Peer Delivered

- Original YCM model: case managers and developed a youth-specific case management program within an adult clinic.
- Project ARK has integrated two Peer Health Navigators as full members of a patient's care team, in partnership with:
  - Ryan White Medical Case Managers,
  - Mental Wellness Specialists, and
  - Infectious disease providers



# Behavioral Health Integration



- Conduct in-depth assessment of mental health status
  - PHQ-9
  - GAD-7
  - PCL-C
  - CRAFFT
- Referral to mental wellness if positive screen
  - Collaborate with mental wellness specialists for warm introduction (when possible)
  - Referral in EMR
  - Active follow-up on referral by peer health navigators

# Practice Management Tool



- Use of practice management tool (internet- and app-based)
- Helps health navigators manage caseloads and communication with clients
- Program/App includes:
  - Direct communication tools (secure messaging, HIPAA-compliant video chat, and group announcements),
  - Online calendar with scheduling function,
  - Documentation capacity for study-specific activities,
  - Goal monitoring, and
  - Ability to create educational content and resources





# Experiences while Implementing

- Participants enjoy working with peer health navigators
- Within our structure, peer health navigators are embraced
  - Peer health navigators are well-integrated into clinic and case management teams
  - HN-lead Multi-Disciplinary Case Conferencing (with MCMs, MW specialists, and MDs when possible) is very important
  - Collaboration helps to find and/or retain participants who are challenged by treatment

# Experiences (con't)

- Quality Improvement opportunities in behavioral health referrals were identified – In the process of collaborating on improvements
- Traditional behavioral health services are still under-utilized by clients – Why? How do we fix this?

<b>Mental Wellness Referrals and Outcomes (n=43)</b>	<b>Number of Clients</b>
Behavioral Health (BH) Need Identified at Baseline Screening	38
Referred to Mental Wellness (MW) Specialist	38
Successful contact by MW Specialist after referral	33
Kept one BH visit with MW Specialist	15
Kept four or more BH visits with MW Specialist	7



# Early Lessons Learned

# Lessons Learned



- Video chatting is well accepted once you get past initial hurdles
- Participants open to discuss mental wellness, but less likely to engage in traditional behavioral health sessions

# Considerations for Replication



- Rethink how we do behavioral health - provide brief, non-traditional mental wellness via video communication
- Peer programs require significant supervision and support
  - Trauma
  - Boundaries
  - Professional development
- Tiered approach to sessions to meet individualized need/capacity

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