Dimension: Housing

This Intervention Links to the Following Secondary Drivers:

- Effective clinic flow to care and support clients experiencing housing insecurity, including access to case management, referrals and other support systems
- Strategies to address additional barriers, such as food security, legal support, etc.

Level of Evidence: Well-Defined Interventions with an evidence-base

Patient Navigator Model (SPNS Project)

Summary:

This model, tested and evaluated as part of a Special Projects for National Significance (SPNS) project, is a time-limited (generally 12 months) service delivery process that helps people with HIV (PWH) to obtain timely HIV-related care to optimize their health.

The target populations are:

1. Newly diagnosed PWH
2. PWH who have fallen out of care for six months or longer
3. PWH who have never received care
4. PWH who are at risk of being lost-to-care

It may be particularly useful to patients experiencing homelessness and who require more intensive supports.

Core Components

The model includes 5 Steps:

1. **Client Referred to Patient Navigation Services -** After a positive test result, the client is referred to VDH's Patient Navigation intervention via a Disease Intervention Specialist (DIS) or to another community partner. During this step, the client completes a Coordination of Care and Services Agreement (CCSA), which provides his or her consent to receive Patient Navigation services and share information with designated providers.
2. **Client Intake** - The Patient Navigator conducts an assessment of the client's barriers to accessing and staying in care. The assessment is not limited to one interaction; a full assessment may take weeks or even months. During this step, the Patient Navigator and client work hand-in-hand to develop a linkage-to-care plan, which addresses the client's barriers to care and strategies to address these barriers.
3. **Routine Client Encounters** - Once connected to care, the Patient Navigator and client work together on a retention plan, which outlines challenges or barriers that have been resolved and outstanding

challenges that require continued attention. During these client encounters, the Patient Navigator may also identify other HIV infected individuals through HIV testing of clients' partners and contacts.

4. **Client Transition** - The Patient Navigator performs an assessment of the client's readiness for transition out of the Patient Navigation program at least every six months. When the client is determined to be successfully engaged in care, the client is transitioned out of the Patient Navigation intervention into community care—such as case management services—or into self-managed care
5. **Client Discharged** - The Patient Navigator documents the client's transition plans when discharging him or her from care and that the transition has occurred. Although the intervention is designed to result in self-management, clients may be re-enrolled based on new or changing needs. Re-enrolled clients would need to go through the same referral and initial assessment process and would be required to sign a new CCSA form.

Tips and Tricks:

- While this model can utilize trained peer navigators, it should not be confused with a Peer Navigation. See also the intervention titled "**Use of Peer Navigators**".
- This model includes using Motivational Interviewing strategies, methods and tools. See also the Intervention titled "**Staff Training on Using Basic Motivational Interviewing Skills, Strategies and Tools**".

Additional Resources (Existing Guides, Case Studies, etc.):

- **SPNS Project Patient Navigation Intervention Fact Sheet**
- **Intervention Guide—SPNS Demonstration Model on Patient Navigation Intervention**

Suggested Measures:

Process Measures

- The extent to which the Clinic has the resources included in the Toolkits Resources Checklist
- % of clinic staff who agree or strongly agree that the use of the Patient Navigator Model has resulted in better health outcomes for their patients.

Outcome Measures

- % of patients that have not achieved viral suppression that demonstrated improved viral suppression rates within 6 months
- % of patients that achieve viral suppression (percentage of patients with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year)

Citations and Acknowledgements:

U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau, Improving Health Outcomes: Moving Patients Along the HIV Care Continuum Intervention Guide: SPNS Demonstration Model on Patient Navigation Intervention. Rockville, Maryland: U.S. Department of Health and Human Services, 2018.