Disclosures

Fulvia Alvelo and Terriell Peters have no financial interest to disclose.

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Learning Objectives

1. Understand how to design and implement effective techniques to find and engage hard to reach HIV-positive individuals (e.g., lost to care or marginally engaged and not virally suppressed) with the use of trained HIV peer navigators.

2. Identify strategies for how to effectively navigate people living with HIV/AIDS to sustained engagement in medical care by utilizing trained HIV peer navigators.

3. Understand the successes and challenges of data sharing and/or data collection tools to monitor impacts of linkage to care, engagement and treatment adherence initiatives.

Obtaining CME/CE Credit

If you would like to receive continuing education credit for this activity, please visit:

http://ryanwhite.cds.pesgce.com

Positive Change in Action

Alliance for Positive Change helps New Yorkers affected by HIV and other chronic illnesses make lasting positive changes towards health, housing, recovery, and self-sufficiency.

Each year, we help New Yorkers:

- Get tested for HIV
- Overcome addiction
- Access medical care
- Escape homelessness
- Rejoin the world of work
- Replace isolation with community
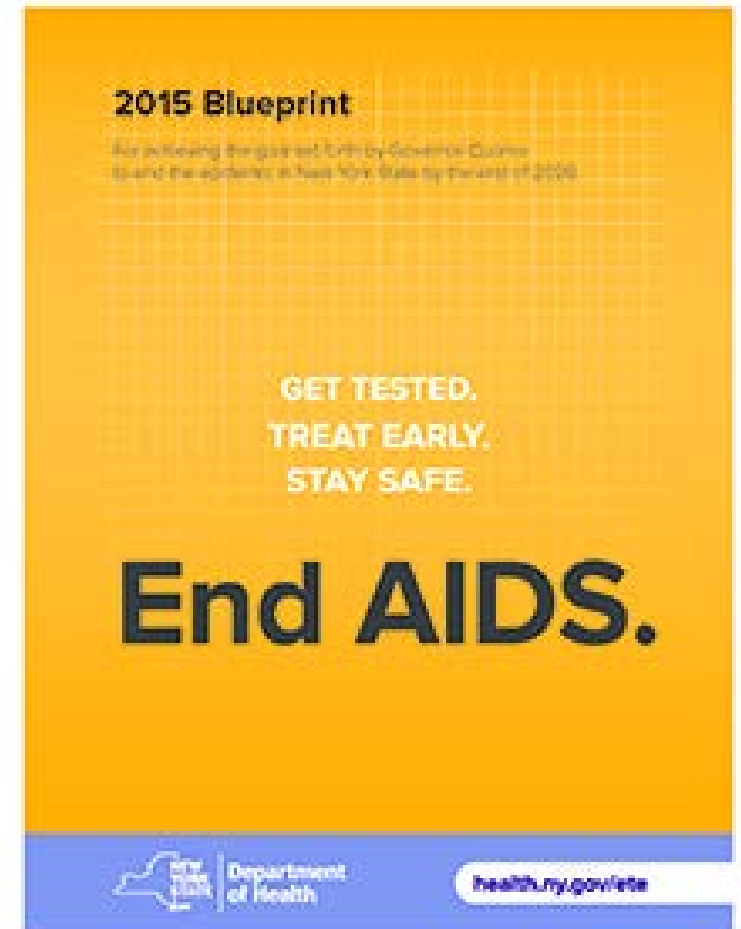- And lead healthier and more self-sufficient lives.
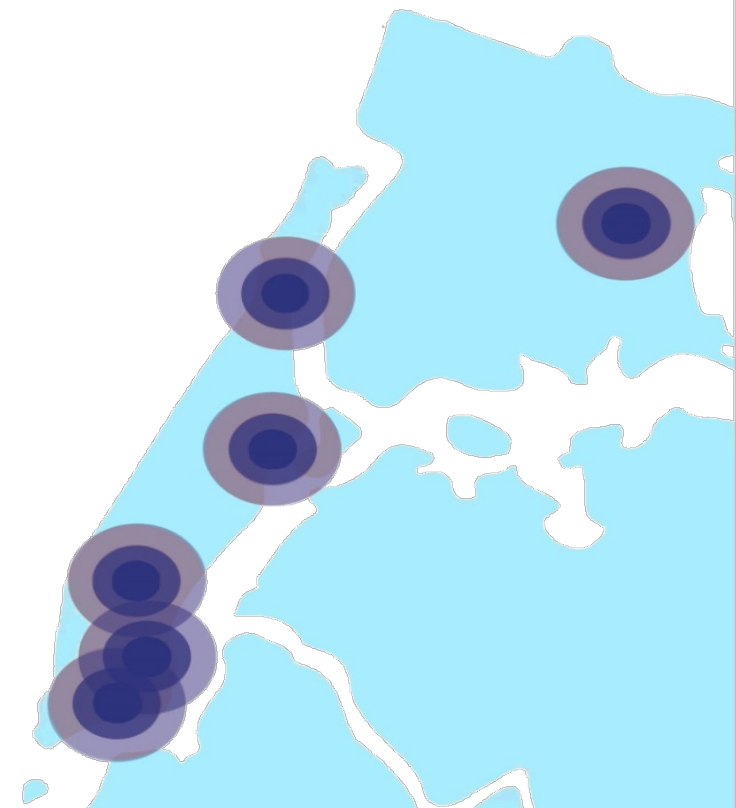
Alliance's **individualized, full-service approach** gives each person the unique mix of support he or she needs to **feel better, live better, and do better.**

NYS Ending the Epidemic (EtE): 2015-2020

In June 2015, Governor Andrew M. Cuomo adopted the Blueprint to end the AIDS epidemic in NYS by 2020 by implementing a 3-point plan:

1. **Identify all persons with HIV** who remain undiagnosed and link them to health care.

2. **Link and retain those with HIV** in health care, to treat them **with anti-HIV therapy to maximize virus suppression** so they remain healthy and prevent further transmission.

3. **Provide Pre-Exposure Prophylaxis** (PrEP) for high risk persons to keep them HIV negative

2015 Blueprint

For achieving the goal set forth by Governor Cuomo to end the epidemic in New York State by the end of 2020.

GET TESTED.
TREAT EARLY.
STAY SAFE.

End AIDS.

Department of Health

health.ny.gov/ete

NYS DOH DSRIP: 2015 -2020

Medicaid Redesign resulted in DSRIP—Delivery System Reform Incentive Payment—intended to develop an efficient, patient-centered and coordinated system of healthcare over a 5 year period.

DSRIP Goals:

1   *SYSTEM TRANSFORMATION*:
- From fragmented and overly focused on inpatient care towards integrated and community, outpatient focused

2   *IMPROVE PATIENT CARE*:
- From a re-active, provider-focused system to a pro-active, community- and patient-focused system

3   *REDUCE HEALTHCARE COSTS*:
- Reduce avoidable admissions, strengthen the financial viability of the safety net, and allow providers to invest in changing their business models

NYS DOH DSRIP and EtE: 2015 -2020

- **EtE** was a catalyst for the **creation of a Peer Workforce** through the development of NYSDOH Peer Certification

- **DSRIP** was Medicaid's strategy towards practice transformation and value based payment.

- The convergence of **EtE** and **DSRIP** resulted in expanded opportunities for **paid Peer positions**, as health coaches, linkage to care navigators.

Role of MCO Peer Navigators

Shared Lived Experience:
- Culturally
- Linguistically
- Socially
- Economically

Reduce Barriers to Care:
- Home Visits
- Navigation to medical appointments and public entitlements
- Health promotion messages and education

Promote Long-term Engagement:
- Navigation to medical appointments and public entitlements
- Referrals to services
- "Warm hand-off" to care coordination

Photo: David Nager/Alliance

Alliance-MCO-EtE Collaboration

Alliance partnered with *THREE* **New York City Medicaid Managed Care Organizations** (MCO) to create **peer-delivered linkage to care programs**, informed by multiple data sources, that located and engaged hundreds of HIV-positive Medicaid MCO members who had fallen out of medical care, and/or were not virally suppressed.

MCO-EtE Linkage to Care

Photo: David Nager/Alliance

Alliance successfully located **39%** of PLWHA MCO members in 2018 (434 out of 1120 MCO members) and **82%** of those members are re-engaged in medical care.

Impact of peer navigation on linkage to care

Time Period: January to July 2018

	MCO A	MCO B	MCO C	TOTAL
MCO Referred	689	298	133	1,120
Located Patients *(N)*	248	113	73	434
Located Patients *(%)*	36%	38%	55%	39%
Engaged in Care *(% of located patients)*	84%	72%	89%	82%

Major Finding:
- Overall found (located patients) rate: 39%
- Overall (located patients) linked to care: 82%
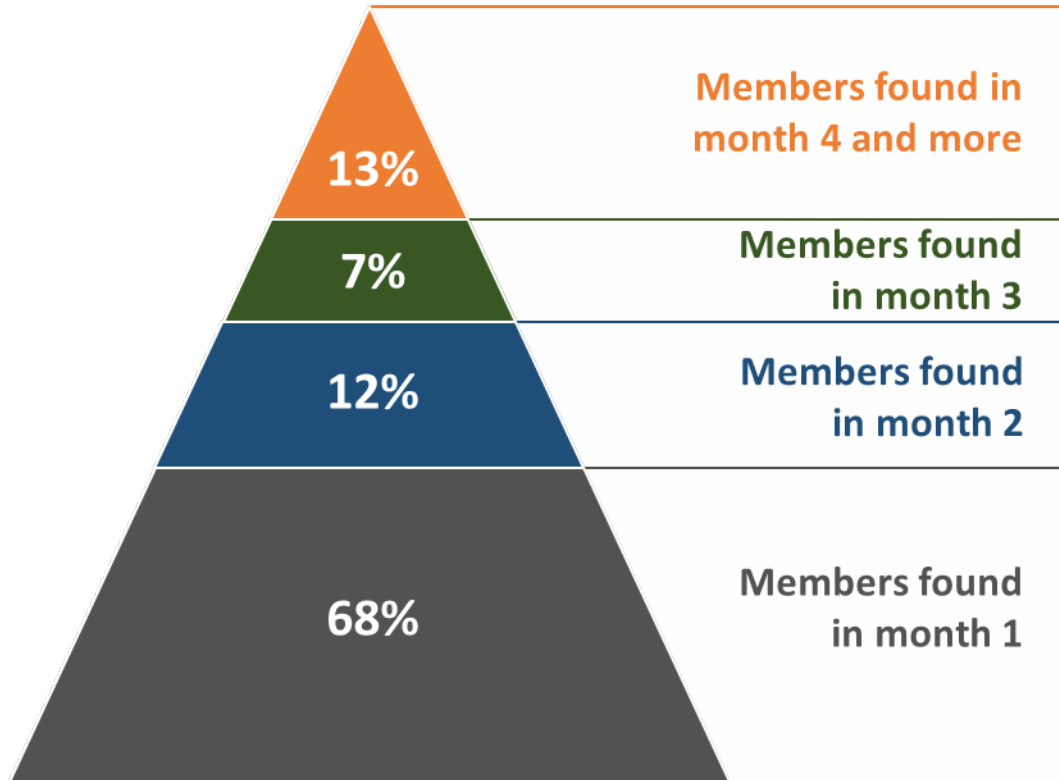
MCO-EtE Linkage to Care

- Alliance successfully located **80% of PLWHA MCO members within the first two months of outreach.**

- Alliance outreach teams heavily relied on **face-to-face encounters (71%)** to locate and engage members who were lost-to-follow-up

- Successful engagement took an average of **3.9 attempts per patient**

- <u>Staff Pattern</u>: One Program Coordinator, Two Peer Navigators, plus Supervisor and Evaluator.
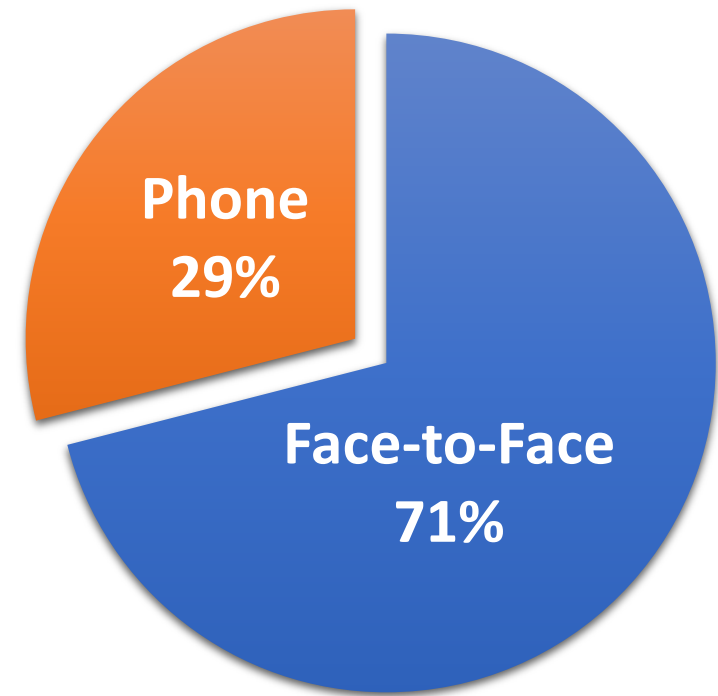
Photo: David Nager/Alliance

Outreach to Found

Members found in month 4 and more
13%

Members found in month 3
7%

Members found in month 2
12%

Members found in month 1
68%

Over **2/3 of MCO clients** were found in the first month of outreach.

Majority of **MCO clients (71%)** were found through **face-to-face** outreaches.

Phone 29%

Face-to-Face 71%

EtE-MCO List of Indicators

MCOs used Medicaid **utilization data and lab data** to generate a target list of HIV-positive MCO members who would benefit from reengagement and linkage to care.

NYSDOH identified residents, sorted by MCO designation who have:

- No PCP Claims in over 6 Months
- No Viral Load test in over six months
- No Pharmaceutical refills in over 3 Months
- Detectable viral loads or Viral loads over 100,000

Alliance method of data utilization strategy

Alliance **utilized numerous data sources** to locate hard to reach clients:
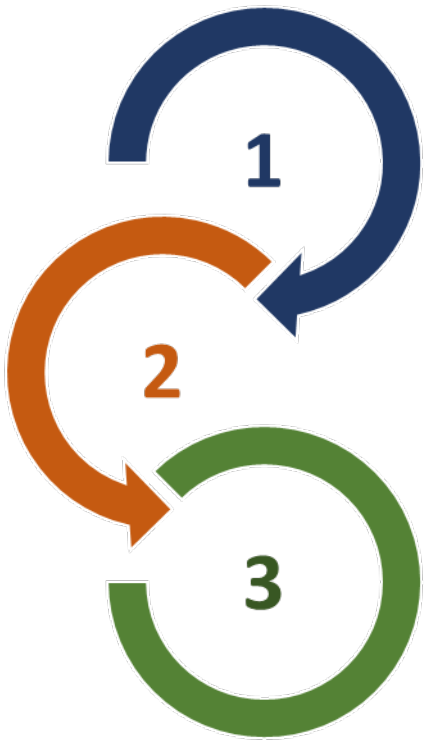
1. **Medicaid Portals**
   - Updated address and phone number
   - Insurance Eligible
   - Last billing

2. **Google Maps**
   - Clusters addresses by zip codes to maximize outreach efficiency

3. **Criminal Justice databases**

Lesson Learned: Identify patients efficiently

List Identification

- *Success*: MCO staff identified members who need care
- *Challenge*: Access to viral load information; widely differs by MCO
- *Challenge*: ARV Refill information does not necessarily mean someone is adherent to medication

QI/QA MCO/CBO Collaboration

- *Success:* Weekly management meetings and case conference
- *Challenge:* Differing leadership styles between MCO and CBO managers

Lesson Learned: Improve Data Access

Data Sharing Techniques
- *Success*: Shared EHR and Secured e-mail exchange
- *Challenge*: Sporadic access to labs

Electronic Health Record Systems
- *Success:* Electronic Chart Review
- *Challenge:* Utilizing new systems at program inception
- *Challenge*: Differing levels of access between outreach peers and CBO management and MCO management.

Lessons Learned: Power of Peer Navigation

Success:

- Peers are involved in case conferencing and leadership meetings

- Use of telephones/tablets increased services available to difficult-to-reach patients

- Weekly route/map provided to improve peer travel time

- Implemented a Peer Buddy System (teams of two) to increase safety in the field

Photo: David Nager/Alliance

Lessons Learned: Power of Peer Navigation

Advantages:

- Re-connect out of care clients to medical care and into care management.

- Match Peers to clients with similar demographics and languages spoken

- Clients have more trust when they know you are representing a health insurance company

- Helps with medical connections

- Peers learn from case conferences

Photo: David Nager/Alliance

Lessons Learned: Power of Peer Navigation

Employing a Peer Workforce can help your organization provide new value to the community:

- Credentialed training
- Credibility within community
- Increased service resources (for linkage and navigation)
- Low-cost strategy
- Role models

Photo: David Nager/Alliance