Implementing the Science-Based Translation of Effective Program Strategies (STEPS) to Care model of Patient Navigation


2019 National HIV Prevention Conference (NHPC)
Atlanta, Georgia
Tuesday, March 19, 2019
Disclosures

Presenters have no relevant financial or nonfinancial interest to disclose.
Presentation Outline

- Background on the STEPS to Care Project
- Patient Navigation by Implementation Step
- Where to find STEPS to Care
Background on STEPS to Care
What is STEPS to Care?

- **Funder:** CDC, under a 3-year Cooperative Agreement; Aisha L. Wilkes, MPH, PO

- **Grantee:** Education Development Center, Inc. (EDC); Lydia O’Donnell, EdD, PI

- **Partner:** NYC Dept. of Health & Mental Hygiene (DOHMH); Mary Irvine, DrPH, PI

- **Purpose:** Translation of evidence-informed CCP strategies into web-based tools and training to improve linkage, retention, and reengagement of PLWH in care

- **Final Product:** Provider- and Client-directed Web-based tools
STEPS to Care Strategies

Interdisciplinary team work to establish care plans and meet client needs across the care continuum.

Patient Navigation
- Intensive one-on-one case management to improve linkage, engagement and retention in care.

Care Team Coordination
- One-on-one education sessions to empower clients to manage their own health and adhere to their treatment plan.

HIV Self Management
Project Steps

- Step 1: **Program review** including literature summary and engagement of 4 “model program” agencies as key informants

- Step 2: **Translation** and development of strategies into web-based tools and trainings

- Step 3: **Piloting** these web-based tools and trainings with HIV service provider agencies

- Step 4: **Refine** web-based tools and trainings using agency feedback
Patient Navigation by Implementation Step
Step 1: Program Review

**METHODS**

- Literature review and summary on the 3 strategies, to confirm evidence (beyond NYC) for their promotion of HIV care continuum outcomes
- Site visits and consultation with 4 model CCP-implementing agencies

**FINDINGS RELEVANT TO PATIENT NAVIGATION**

- Importance of appropriate identification and hiring of staff
- Frustration with “dead” time
- Difficulty with scheduling
- Need for more training on soft skills
- Desire for more formal procedural documents
Step 2: Translation into Web-based Tools

**METHODS**
- Conducted Journey Mapping exercise
- Further defined Patient Navigation and developed set of supporting tools

**FINDINGS RELEVANT TO PATIENT NAVIGATION**
- Services include
  - case finding
  - logistics planning
  - accompaniment to medical appointments
  - assistance with entitlements/benefits, health care, housing, and social services
  - health education/promotion
  - assessment/reassessment
  - outreach for patient re-engagement
- 11 online tools developed specifically for Patient Navigation
Patient Navigation Introduction

Patient navigation is a STEPS strategy that provides whole-patient care through intensive case management. Patient Navigators work one-on-one with clients to encourage continued commitment and adherence to medical treatment, access to social services, improved communication, and prompt re-engagement in care.

After reviewing the information and resources below, you will know:

- The purpose and elements of patient navigation meetings
- How Patient Navigators can help clients access necessary services
- Which forms are needed to track patient navigation activities and how to complete them

View: Audio Description for - Patient Navigation
Patient Navigation Training Examples

FIELD SAFETY TRAINING

The Field Safety training below provides an overview of some key points for safety in the field. By the end of this training, you will be able to:

- Identify appropriate precautions for meeting clients offsite
- Make good choices regarding personal safety in the field

Jump to the Trainings section below to launch the training.

Estimated time to completion: 20 minutes
Example Patient Navigation Forms

The Intake Forms

Intake is conducted by completing the two forms below:

LOGISTICS FOR PATIENT NAVIGATION AND CONTACT INFORMATION FORM

This form should be completed during the first client intake session. Staff should use this form to collect basic contact information and scheduling preferences and to set communication norms for Patient Navigation sessions.

This form should be updated regularly, particularly when there is a major change for the client that could affect service delivery. While the Care Coordinator is likely to be responsible for initially completing the form during intake, the Patient Navigator should update this document whenever he or she becomes aware of a change.

These change events could include:

- New housing arrangements
- New daily/weekly schedule (that could be the result of finding employment or child care)
- New cell phone number
- Change in alternative contacts

Download the Logistics for Patient Navigation and Contact Information Form
Step 3: Pilot of STEPS to Care Tools

- **Pilot conducted in 5 NYC agencies — July 2015-February 2016**
  - 3 community health centers and 2 hospitals
  - 2 Bronx-based, 2 Manhattan-based, and 1 Brooklyn-based agency
  - All annually served >300 HIV patients, >75% of whom were Black or Latinx

- **Pilot conducted in three additional agencies — July 2016-February 2017**
  - Federally qualified health center (FQHC) in Atlanta, GA, Hospital in Charleston, SC, & Community Health Center, Boston, MA
  - STEPS to Care clients at these agencies were primarily Black and male
  - Process data collected via Key Informant Interviews and monthly reporting grids
Pilot Findings Related to Patient Navigation

- Patient Navigation was most used service
- 64% of clients with an intake received Patient Navigation

“STEPS gives us an opportunity to provide intensive case management services in a structured way. It expands the reach of our Patient Navigators and potential of our case management team.”
- Program Director

- One of the pilot sites reported how STEPS to Care has expanded the role of their Patient Navigators
Step 4: Refinement & Dissemination

- We used the following to refine tools for each strategy:
  - Local and national pilot feedback
  - Community Advisory Board input
  - CDC clearance process

- Disseminated the refined web-based tools on a dedicated CDC website as of August 1, 2018
Ready for STEPS to Care?

- **Tools on STEPS to Care website**
  - Agency Readiness Assessment
  - Preview Guide and FAQ

- **CDC Capacity Building Assistance**
  - For individualized TA and training on STEPS to Care implementation, visit:
Other STEPS to Care Presentations at NHPC

- **Digital Showcase: Walkthrough of an Online Toolkit to Support Engagement in HIV care: STEPS to Care**
  - Session Date: Today, March 19, 2019
  - Session Time: 1:00 – 1:20 PM
  - Hotel: Hyatt Regency
  - Room Location: Social Media Lab

- **Lessons from the New York City Translation of a Care Coordination Program: Science-Based Translation of Effective Program Strategies (STEPS) to Care**
  - Session Date: Wednesday, March 20, 2019
  - Session Time: 4:00 - 5:30 PM
  - Hotel: Atlanta Marriott Marquis
  - Room Location: A703-A704
# Acknowledgments

**Co-Authors:** Patricia Bessler, Cari Courtenay-Quirk, Julie Rwan, Athi Myint-U, Mary Irvine, Lydia O’Donnell

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*Community Advisory Board members and staff of pilot agencies.*

Disclaimer

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