Liesl: Great. Thank you all so much for joining us today and good afternoon from the East Coast and good morning to the West Coast and everyone in between. Welcome to this virtual presentation hosted by CBA@JSI. My name is Liesl Lu and I'm one of the Curriculum Developers at our CBA project at JSI. Today, we're hosting a presentation on the lessons learned from integrating HIV patient navigation services. For those of you just joining us, if you make sure to answer the poll on the right hand side and type your response into the chat box, we would really appreciate it.

As you can see, there's a great range of familiarity with the topic and some of the interest that people have for joining the webinar today. Most of you want to become familiar with patient navigation model. A few of you are already a Patient Navigator and are also interested in hearing from the speakers. Thanks for that. It looks like a number of you are looking at better ways to increase retention to care and understanding ways to help patient be engaged and retained in care, and also learn about challenges that may come up when you're integrating patient navigation services. Thank you all so much for chatting in your responses.

Just a few housekeeping items before we get started. If you can mute your line during the presentation, we would greatly appreciate it. We will be able to have time for questions at the end when you can speak in, so please make sure to mute your lines so that we don't have any background noise interfering. Then also, you can type your questions or any issues that you may be having if you're having any audio or internet connectivity issues with seeing the slides, you can type your questions into the chat pod on the left-hand bottom side of the screen. Also, we would greatly appreciate it if you would stay connected and participate in all the activities until the end of the session today. We will have an evaluation at the end of the webinar that we would love to get your feedback on how today's workshop has gone.

Just to tell you a little bit about who we are, CBA@JSI is a provider funded by CDC to deliver capacity building assistance for community-based organizations. We, CBA@JSI, we've been working with a great variety of organizations across the US to support the implementation of high impact HIV prevention programs and services, and those that align directly in and directly funded non-profit and also aligning funded non-profit organizations programs with the National HIV/AIDS Strategy. Today, we're going to focus on patient navigation services. To walk you through how to integrate these services, we have some great speakers who have joined us.

First, we have Arman Lorz, who is a CBA@JSI Specialist. He provides training, technical assistance, and other English and Spanish capacity building assistance services for CDC and locally funded agencies across the US. Caitlin Canfield is an

Evaluation Coordinator at the Louisiana Public Health Institute in New Orleans, Louisiana. She previously worked at the NO/AIDS Task Force as a Bilingual Case Manager and Patient Navigator. Then, we also have Joey Olsen who is the Counseling Testing & Referrals Manager at NO/AIDS Task Force, also known as CrescentCare. He oversees all the testing and linkage to care programs for NO/AIDS and has worked in HIV prevention for five years. We have a great wealth of knowledge here today to share and pass on some lessons learned and best practices about patient navigation. Now, I'll pass it on to Arman to start us off.

Arman: Thank you very much Liesl. Our hope today is to increase your knowledge of patient navigation models and what your organization might need to consider to implement some of the patient navigation services and also to increase some of your comfort on addressing some of the barriers that your organization might be facing while integrating these services onto the ones that you are currently offering. After your participation on today's webinar, you will be able to describe at least five components of a patient navigation model. You also will be able to list various tasks performed by Patient Navigator. Also you will be able to identify three elements of the patient navigation program which can be incorporated into the existing services that you're offering at your organization. Lastly, you will be able to identify how to obtain formal training and technical assistance to integrate patient navigation services into your agency.

Because as Liesl mentioned at the beginning, most of you wanted to learn what is patient navigation, I would like to start everyone to establish a common understanding. I want to describe the role of a Patient Navigator. The role is to assist HIV positive persons through the process of accessing medical care and other support services as necessary. In addition, the Patient Navigator also assist medical providers by preparing clients for their appointments to ensure linkage and engagement occurs at all times.

We want to assess a little bit of your interest and familiarity with patient navigation models. This is going to help us to personalize this presentation to your interest and the knowledge that you have as much as we are able to do so. Please take a couple of minutes to respond to the two questions that are on the right to your screen. On the first one, it's a ranking scale. Just represent your familiarity with patient navigation models, 0 being not having any familiarity at all and 5 being extremely familiar to the topic. Also, below, we want to understand amongst you who already have the patient navigation position or program already into your place.

Arman: Thank you very much. As we can see on the first question, the majority, you mentioned that you are not as familiar with the patient navigation model. Hopefully, this webinar is going to provide a better understanding of what are these and some of the purposes and some of the best practices that Joey and Caitlin are going to share with us. On the second question, if you have a patient

navigation program or a position, the majority of you have a program with your agency and some of you don't and some other, they do have a position.

As an introduction to the topic, let's focus on the National HIV/AIDS Strategy. The strategy represents a comprehensive road map for HIV prevention and treatment with three primary goals. The first one is the reduction of new infections, new HIV infections. The second goal is to increase access to care and improve health outcomes for people living with HIV. The third goal is the reduction of HIV-related health disparities.

Now, the strategy highlights these specific goals and these goals can easily apply to the National Patient Navigation Services as outlined by CDC last year. We list some of them here on the screen and these are not all the goals, but they are some of the ... We thought it would be relevant to bring up on this presentation. The first one is to increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis and that's an increase of 20%. Also, to increase the proportion of clients who are in continuous care retention into care, again, by 70%, and increase the proportion of HIV diagnosed gay and bisexual men including black and Latinos with undetectable viral load. That means viral suppression.

Some of the actions that can be taken are being taken and could be still taken include establishing a seamless system to link people into care immediately right after they are really diagnosed. Also, to increase the number of diversity of available providers of clinical care that are servicing people with HIV. The last one is, also develop an improved mechanism to monitor and report progress toward achieving the national goals. We thought these would be relevant and this is a little bit different on perspective in regards to the presentation that we're going to be seeing and hearing today.

During the presentation last year and to support HIV, the continuous care, last year, the CBB branch at CDC described that patient navigation as a process which uses interrelated activities to guide a patient through barriers with linkage, with retention and also re-engagement for life-long viral suppression. Having shared this information, we have a little bit of the basics. We're going to go keep it in mind, keep it as a background and let's learn together what Caitlin and Joey have done at CrescentCare in New Orleans to integrate a successful patient navigation program. Caitlin and Joey, all yours.

Joey: Hey everyone, can you hear us?

Liesl: We're muted.

Arman: Yes, we can hear you.

Joey: All right. Thanks for having us today. My name is Joey. I oversee the Counseling and Testing program here at linkage to care at NO/AIDS Task Force. We wanted to start by giving a quick overview of HIV and AIDS in Louisiana and then a little bit about our agency just so you understand the infrastructure that we're working with and so you can compare it to your own infrastructure. Louisiana, just quick stats, ranked fourth in the nation for the estimate HIV case rates. New Orleans, specifically ranked fifth for HIV. We ranked fourth for AIDS when looking at major and metropolitan areas in the United States, and there are 388 metropolitan areas so we can see we're pretty high up on the list. Our agency, we have roughly 1400 clients who are HIV positive who have enrolled in services with us. In the 2013, 2014 reporting here, we conducted about 3300 rapid HIV test, 87 were positive which is a positivity rate of about 2.6%.

Our agency, we have pretty comprehensive and integrated services. We don't have everything, but we either refer to a lot of places, other places in the community, but we actually do have a lot of stuff available in-house with our agency as well. You can see those here listed on the screen. We have a pretty comprehensive program which helps us with our linkage to care, but we'll talk a little bit later about the relationships with other partners in our community for things that we aren't able to offer within the agency and how that's useful for patient navigation.

Just a quick look at our data over the years, you can see on the left on the bottom, it says, early NO/AIDS Task Force years. Back when we first started, the agency first started about 30 years ago, we didn't have patient navigation. It was just a call line. Condensing all those years with that first couple of bars, jumping up to 2011 right before we implemented our patient navigation program, we had a linkage to care rate of about 53%. The data is really spotty at that point because it wasn't an official program, but roughly 53% is where we were standing.

You can see right there around June 2012 is when we hired our Patient Navigator, and over the course of the time through the January-June 2014, we were able to increase our linkage to care rate up to 92%. This was actually through three different Patient Navigators we've had through those three years. Caitlin, being one of them. We can see that through our model patient navigation, even with transitioning through Patient Navigators, the methods that we've used have proven successful and we've continued to grow and make choices based on best practices that we'll share with you in a few minutes.

Just one other quick look on our data. From October through December 2012 to April through June 2014, not all of our quarters were above the national linkage to care goal of 85%. You can see there there's an 82% and 83%. While not all of our quarters go above the 85%, averaging out, we have an overall linkage to care rate of 90% for newly diagnosed positives and that's within the 90 days.

Caitlin: This is Caitlin. I'm going to jump in a little bit and describe to you exactly what happens when a client tests positive and how they interact with the Patient Navigator to give you a sense for our model. We currently employ a rapid testing system in which a client receives two rapid HIV tests and can immediately be linked to care. The client will receive their initial positive test result within 20 minutes with an oral antibody test. At that point, their counselor immediately conducts a rapid blood test which takes one minute and the client receives the result in one minute. At that point, the client's counselor provides additional counseling as needed and they begin the process of referring the individual to the Patient Navigator to set up a follow up appointment.

The Patient Navigator receives the client paperwork. Ideally, our standard is that they receive the paperwork within 72 hours, but normally, they receive that paperwork within less than 24 hours. The Patient Navigator creates a client file, enters client information into our databases, turns in that original paperwork to Louisiana Office of Public Health because as I'm sure, anyone who does the HIV testing has certain mandated paperwork that they must turn in to their local Office of Public Health. At that point, the Patient Navigator reaches out to the client, sets up an appointment and meets with them.

At that initial appointment, they have already prepared the client to come in with certain paperworks that they will be required to have in order to enroll in case management. What our model currently employs is that ideally, at the date of that first meeting with the Patient Navigator, the client also is enrolled in case management til they successfully complete their case management enrollment and they have their first medical appointment scheduled. It can be a very long day, but we found that that is very, very successful at being ... It's more patient-centered, client-centered, and it also ensures very rapid linkage to care.

One note with regards to the Day1-Day2 model is that we wanted to break it up a bit, but in reality, what sometimes happens is our Patient Navigator is also an HIV counselor and tester, so there may be times where a patient, where a client test positive and the Patient Navigator is there, and so that initial meeting can take place the very same day that the client tests positive. That's something that happens quite frequently as well.

In terms of our model, the definition of linkage to care is achieved and this is also according to ... This is how it's defined by our funders, so by CDC and HRSA. That linkage to care is achieved when a client attends a nursing appointment where blood is drawn and CD4 and viral load tests are performed. Now, that definitely does not equal retention and care, partly because the client hasn't even seen either a medical doctor, a nurse practitioner, et cetera. Our Patient Navigator actually tracks not only that initial appointment, where they do their nursing intake and the blood is drawn, but they also track the initial physician's appointment which typically takes place two weeks after the preliminary nursing

appointment and at which time, the blood work has gone over and a care plan is developed between the medical provider and the client.

Diving in a little bit into our model and what we think are the key components for success. One is that our Patient Navigator is a hybrid employee. They exist between the prevention and the primary care department and we found that to be a very, very crucial element in allowing them to navigate our agency's system and also to be client-centered and help them then also navigate the system. In addition, one element that we believe assists in having a successful patient navigation program is the fact that we have devoted funding to a Patient Navigator. Our Patient Navigator, while they do have certain duties and they do maintain a good amount of hours of performing HIV counseling and testing, they are primarily the Patient Navigator and that is their job description.

In addition, flexibility and personality is a very, very crucial element as I'm sure that those of you who have patient navigation programs have found to ensure that the Patient Navigator's successfully interfaces and interacts with the clients as well as the providers. Then also maintaining really good records. Having a good data or an electronic medical record, EMR system, is really, really crucial to be able to track individual clients but also to be able to track trends over time.

Diving in a little bit into these elements and thinking about why a hybrid employee would be important. Like I said, our Patient Navigator originally was actually funded by both our Prevention and Primary Care departments. That's no longer the case, but as a vestige of that original funding structure, they really are embedded within both the Primary Care and the Prevention departments and know very intimately the steps that the client will need to go through in order to access services in both and in order to transition from prevention to primary care.

In terms of prevention duties that the Patient Navigator is required to do, they need to do follow-up with the client, they need to link them to care. They also need to maintain the client database, submit reports to the Office of Public Health. One really crucial element that we found as well that helps our local Office of Public Health is that we have a very ... Our Patient Navigator maintains a very close relationship with our local Disease Intervention Specialist or DIS, and they often times, will meet together with the client. That helps facilitate DIS' program and getting them to their bottom line so that they're able to meet with clients more efficiently and more quickly. In addition, the Patient Navigator attends all counseling as well as testing and linkage trainings that are offered by the Prevention Department.

Within primary care, on the other hand, the Patient Navigator is going to be troubleshooting transportation assistance for the client. They're going to be providing the client with perhaps health education for before they ... assessing their level of knowledge about HIV, HIV transmission, et cetera before they walk

in to their appointments that they're empowered to ask questions that are going to be important to them and important to retaining them in care. In addition, the Patient Navigator attends case management and Primary Care departmental meetings so that they're up to date on the most recent, any changes that might be taking place in terms of those programs.

Again, even though the Patient Navigator is funded by the Prevention Department, they still intimately know what's going on in the other department. In addition, one really crucial element that we found for our patient navigation program is that our Patient Navigator has always been bilingual in both Spanish and English, and so they're able to provide translation and case management appointments and appointments in primary care or in their appointments with the client one on one.

Some of the challenges and benefits of being a hybrid employee. Some of the challenges are that the Patient Navigator is required and we have found that it's been really important that the Patient Navigator be on call. That may be a challenge. You need to be able to hire someone who's going to be willing to be on-call and can have a flexible schedule. In addition, their ability to meet the client same day can be really, really crucial to making that linkage take place very, very quickly and also establishing rapport between the Patient Navigator and the client as fast as possible. Maybe it's going to be important that the Patient Navigator has access to a car so that they can run out to wherever the client has tested positive. Then they also need to maintain those working relationship with all departments and they need to be positive and good working relationship, which can be a challenge at times.

In terms of benefits of having a hybrid employee, we found that that really intimate knowledge of all departments results in a better experience for the client. It's a more streamlined experience for them. It's less stressful and any possible glitches has been anticipated ahead of time by the Patient Navigator. In addition, because the Patient Navigator is so embedded in primary care, they're also able to offer expedited linkage, so if a client appears very, very ill, they clearly probably have an AIDS diagnosed that they really need to get in to be seen ASAP. Because the Patient Navigator has a positive relationship and has earned the trust of our providers, they are able to get in a lot of very ill clients that very same day that they first meet with the Patient Navigator.

In terms of database and electronic medical records, the data that we found to be very, very important to collect both in terms of tracking individual level client characteristics and making sure that you link that client to care, but in addition, pulling out data that might tell you something about your program and identify ways that you can improve, are just basic contact information. Definitely including phone number, email, but also clients might prefer to communicate via Facebook, et cetera. Really identifying what's best for that client is important.

In addition, identifying any demographics; race, ethnicity, gender, sex, all in all, those are category, whether or not they are known positive or a new positive, any data that is collected by your Counseling Testing & Referral program is also going to be really important to keep track of. Keeping track of when you initially do that referral to your Disease Intervention Specialist at the Office of Public Health and when initial contact was made with the DIS, and then also any appointment data. When was that first primary appointment care scheduled? Did the client attend it? If not, when is the next one scheduled for? Did they attend that appointment? Then also of us to keep track of that secondary appointment when they meet with the provider.

Then another really crucial element that we've found in terms of maintaining records is that our Patient Navigator has access to the EMR, the electronic medical records system of the agency. They also have the ability to schedule patient appointment for their clients that they are seeing. Having that really intimate access to the EMR helps to facilitate how embedded they are in the program and making sure that they can really make sure that the client has adequate access to care. Next slide is Joey.

Joey: Here's a concrete example of a good reason to have very good data records like Caitlin was mentioning. One of the things we're able to do with that data is create this slide and put out different populations and their linkage to care rates within our agency. We can see here that purple line which is for young, black men who have sex with men, you can see very clearly that our linkage to care rate was a lot lower than the average MSM and the total MSM. One of the benefits of keeping very good data records is that you can pull data requests like this to see where you can improve both so that you can better serve underserved populations in your community, but also so that you know where you can achieve the biggest gains in linkage to care and raising your linkage to care rate. You can see, this is the same slide, that same 90% linkage to care rate as that first slide earlier in the presentation. This is just broken down.

Then again, for records and why we try to keep very specific records on all of this data that's coming in. You can see here, this slide is like one of the ones at the first, beginning of the presentation, excuse me. The darker line here is the Office of Public Health. Our Office of Public Health linkage to care rate for us. When we submitted the data request, this is what they said our linkage to care rate was. The lighter blue line is our linkage to care rate that we have tracked ourselves. Caitlin mentioned that one of the things that we value in our patient navigation program is our strong relationship with our Office of Public Health and our Disease Intervention Specialist.

At the start of that relationship, we went to that and we were wondering why there is this discrepancy in our linkage to care numbers and we found out that some of our clients that we have actually linked to care and been maintained in care or maybe some haven't been, but at the very least, attended that first

nursing appointment where their CD4 and viral load is drawn. By definition, linkage to care for all funding purposes. The Office of Public Health was not counting that as links to care as it was happening out of state, so if someone had tested with us but was moving in a month and linkage to care in another state, that wasn't as linkage to care.

There were a couple other things that they weren't counting as linkage to care. We found that our linkage to care rate was actually higher than the reporting when we asked the Office of Public Health for data request, which is crucial because when we're going for other new grants, annual progress reports, interim project reports, we were able to show that our linkage to care was actually higher than outside data we're showing.

Joey: Then, going in to flexibility and personality, Caitlin already touched on this briefly. Some of these inputs for the patient navigation position were very crucial. We do testing not only in our clinics around town, but we also have testing at some of the bars in the French Quarter. We did at the bathhouse in the French Quarter. Some of the Walgreens locations around town. In various locations. Some of the bar testing times, we'll be testing there til 11:00, 12:00, 1:00 in the morning. Not that the Patient Navigator is always ready to go and jump out of bed and get to that location, but ... Caitlin will touch on this in a minute.

The Patient Navigator also has a cellphone so that she can respond to text that come in in the middle of the night if she chooses and we allow for her to flex her time around that. If she is taking a call from a client who's distraught at the bar at 11:00 at night, then she can come in later that next morning and then maybe meet with them at 11 in the morning the next day. The flex time is crucial, too. Then, going along with that meeting clients in non-traditional settings, she's run out before to other clinics, to the Walgreens, wherever the client is. Like Caitlin said earlier, this is allowed for many clients to be with the Patient Navigator that same day and she's also able to handle this high stress situation.

Personality is also crucial for the Patient Navigator. She's able to jump in to many different settings and feel very comfortable. Is good with empathizing while maintaining a professional relationship. A lot of her clients currently are calling her along with their case managers, those that have already linked to care, has still maintained that relationship with the Patient Navigator because it was so strong right at that initial moment. Anecdotally, we're seeing evidence that that's helping people maintain retention in care because of that strong relationship right from the start of their diagnosis.

Arman: Joey, this is Arman.

Arman: I would like to hear a bit ... Because I've been hearing a lot of the best practices and some of the benefits of having people, having the dual role, I would like to

hear from the participants some of the challenges that you have, you participants, meaning, some of the challenges that you have encountered when linking person to care at your agency. If you can just type in on the chat pod next to the slide, we really appreciate it. Hopefully Caitlin and Joey can give us a little bit insight of what they have done. Let's take a couple of minutes to ... When everyone is done typing.

Arman: Some of the challenges that people are listing here is having difficulty reaching clients frequently so they don't respond to emails or they don't respond to calls. Also, when the patient wants more time to become comfortable with their diagnosis before linking in to care, some needs, I'm assuming patients with mental health and diagnosis and transportation, how to maintain clients into care, especially with the ones that do not want to go into care and how to integrate addiction issues into patient navigation.

Arman: What to do when Patient Navigators are running in various directions with multiple clients at a time.

Arman: If you want to keep your questions coming, we would truly appreciate it. That would help us to continue the conversation, but for the sake of time, we are going to move on. Caitlin, could you tell us a little bit of what similar situations to the ones that some of the participants are posting here have you encountered at the NO/AIDS Task Force and how you were able to respond to them.

Caitlin: Absolutely.

Caitlin: Are we moving on to the next slide, Arman?

Arman: Yes.

Caitlin: Great. A lot of the challenges that you all were identifying are very similar to those that we have seen with our clients as well. Perhaps they have an unstable living situation. We have a very large homeless population in New Orleans. Perhaps they lack regular access to phone and email or they don't give accurate information as someone mentioned, which we've definitely seen a lot of. Denial, shock, anger, stress, in addition to ... That maybe just triggered by an HIV diagnosis and there may be some additional mental health concerns there or substance abuse, which can definitely lead to having competing priorities. People might not value linking to care. It just might not be ... It may not ever be something that they want to do or it may not be something that they're ready to do right now.

Some of the things that we have done in order to address these. For example, if the client is in an unstable living situation, what we see as being really, really crucial, if they're in an unstable living situation, they probably don't have access to stable transportation. Once we get them enrolled in our case management

program, we are able to provide them with bus tokens and even for those clients that are very, very ill, able to provide them with one-time cab rides in order to get them to their appointment. If they lack regular access to phone and email, that's where it really comes in where the Patient Navigators needs to be flexible and meet clients where they are. That includes, in terms of communication. If communicating with them via Facebook is going to be the best, that's what is going to happen.

It's really, really crucial that our Patient Navigator has a cellphone. I cannot emphasize enough how important that is. We have found people who do not want to talk on the phone. I don't think that anybody wants to talk on the phone these days anyways. I sure know that I don't, but people do not want, especially when they are in very high stress situations, texting is so much easier for them. They could shoot you back a quick little response. It's faster. It's more private. They can text you while they're in a public setting and no one will know what you're talking about. We really can't emphasize enough how crucial that texting capability has been.

Joey: Just a quick note on that. We received consent from the client when they test positive, on their preferred method of contact by the Patient Navigator. When they give us their contact information, that's how we get that and the consent to follow up with them by text.

Caitlin: One other note with regards to that since this came up a couple of times in the comments is, people mentioned folks not giving accurate information. It may just be that someone's phone changes and that you can't really ... You're going to have to deal with that, however you're going to deal with it. If they give you inaccurate information, they may have given the counselor inaccurate information before they tested positive and so it's important that after they've tested positive, that that counselor double-checks with them and reconfirm that that information is accurate.

Joey: More than once, we've had clients change the information that they gave us, their contact information, once they've tested positive and know that they need to link to care.

Caitlin: In addition, your local DIS, they are super [inaudible 00:39:08]. They have access to information that we do not. They are pretty amazing in terms of the information that they can get on individual folks, so if you have not been able to get in touch with someone, you don't have a working phone number, you have no idea where they are, check with your DIS because they really might be able to track folks down.

In terms of mental health issues that may either be precipitated by the diagnosis or maybe existing, that's why getting people into case management as soon as possible is really, really crucial so that they you can get them enrolled in a peer

support program, get them enrolled in behavioral health. Maybe they're off their meds. Maybe they take psych meds and they're off of them and they need to get back on the psych meds before they can even think about attending a primary care appointment. Making sure to bring up those conversations with folks and really identify what those barriers are at the beginning is really important.

Then, if healthcare is a low priority like Joey mentioned, our agency has a whole host of other services that it offers including a food bank, peer support, behavioral health, transportation assistance, et cetera. We're referring people to either medical or non-medical case management can really assist in identifying what those barriers are and helping to redefine and [inaudible 00:40:28]. I saw that someone mentioned or was wondering about what our thoughts are on why are rates are lower, YBMSM. Someone is listening to music. Please try muting it. I'm into it, but it's a little distracting.

I guess [inaudible 00:41:02] about YBMSM and [inaudible 00:41:07]. We're going to talk a little bit about the challenges [inaudible 00:41:13]. In terms of having an unstable living situation, the transportation might specially be an issue for all young people in general, and a lot of their living situations may be more unstable or they may be living with their parents or with their auntie or with whoever they're with. This is why it's really, really crucial that the Patient Navigator's good at networking and that they know their [inaudible 00:41:40] in the community.

NO/AIDS CrescentCare does not have a program specific to YBMSM, however there is a program in the community known as the ACT Program that will follow young individuals, anyone younger than 24 years of age for six months after they test positive. They will also provide them with ... Can you hear me now? I think that we're okay. They will also provide individuals with cab rides to all of their appointments; case management appointments, primary care appointments, et cetera. That is simply not something that NO/AIDS can afford to do, but it is something that this ACT Program can do. It's really important that you know what's out there and what programs are pediatric or adolescent specific because those programs can really ... I was just speaking about ...

I'm getting some request to repeat the last few statements. I was just saying that it's important to know what pediatric or youth specific programs are available in your community for young people who are looking to link to care. They may have additional resources that your agency cannot provide. Like, we can't provide additional cab rides to every single appointment for a young person, but this program, known as the ACT Program in New Orleans does do that. We have a very, very strong relationship with them and any young person that test positive with us, who's younger than 24 is immediately offered a referral to that program.

In addition, like I mentioned, nobody likes to talk on the phone anymore, young people really don't like to talk on the phone. In fact, they never do it. It's just not something that they do and so being able to ... YBMSM means young black men who had sex with men. We're referring to young African-American or black gay or bisexual men. In terms of the cellphone and the importance of that, young folks really don't communicate via calls. They communicate via text. They also have certain language that they use when they text. Being able to do that, what's called code switching, so being able to utilize different phrases, utilize different terminologies that's going to make that client feel welcome and make them feel like you understand who they are is really important.

In terms of referral to behavioral health, peer support, case management, primary medical care, there may be some young people who are mature enough to access your general programming, but you may encounter some young 15, 16, 17, 18, and even some young 22 year olds who are simply not emotionally mature enough or don't have experience interfacing with the healthcare sphere, where they really are not an appropriate referral to general primary care services for HIV or general behavioral health and they would really benefit from a more pediatric focus. We would really encourage you all, and this is something that we are also always looking for additional services for the young people that we refer, to really seek out this pediatric services because that may help you to increase your linkage rates for those young people who are specially vulnerable.

Joey: I just wanted to touch on something real quick on this slide as well. You might see that that right hand column and say, "Well, if you can't link them to care, how are you going to get them into that medical or non-medical case management, the referral to behavioral health, into the transportation?" It's crucial that the staff and/or volunteers that you have providing the HIV testing and counseling are very well-versed in the services that you offer or that you are able to refer to. That way, in the counseling session right from the very beginning, if a client does have other priorities or is in denial or shock or has anger or maybe does have ... is unstably housed and only gets to charge their cellphone once a week, it's good to know those things so that the counselor can let the client know that right from the beginning, that we have things that can help them out in their everyday life. Then for us, the benefit is that it will help us link them to care.

Just in summary, data and rates for sub-population is a great way to look at specific population in your community that you might be able to better serve. Data consistency and comparability, make sure that what you're doing is accurately reported across all systems. Communicate with the Office of Public Health and with your funders. Make sure you're on the same terms when it comes to your reporting. Coordinate with your State Office of Public Health and the Disease Intervention Specialist. You'll be able to help them out for sure and sometimes they may be able to help you get in contact with a client who has been lost to follow-up for a couple of weeks.

Network with other agencies and providers. We have a lot of services available in our agency, but we don't have everything and because we have strong relationships in our communities, we are able to partner with them and increase linkage to care across the board. Whether or not you have a lot of services in your own agency, looking out and knowing everything that's in your community will be a huge asset. Then that Patient Navigator personality and flexibility.

Caitlin: We really recommend that you try to keep your patient navigation flow as simple as possible both for staff, but also, we have a lot of volunteers and so keeping it simple is also going to assist those volunteers if they have a positive client, in order to ... They are that first point of entry, that volunteer, and so they are really responsible for getting the client then linked to the Patient Navigator, but in addition, keeping that flow simple is going to keep the process simpler for the client as well.

Making sure that there's really consistent and clear communication between the patient navigation staff, and what's most important is developing a flow that's going to work the best for your organization. Not everyone is going to have committed fundings. Not everyone is going to have super fancy software. We definitely do not. Making sure that you create a flow and a system that works for you and for your staff and then holding everyone accountable to that is really important.

Joey: We also hold regular trainings and updates for our staff and especially for our volunteers so that they are familiar with the patient navigation flow and paperwork and any updates that are happening. Making sure that everyone is up to date so that the clients are best served. Through the past couple of years, everything that we've done, we firmly believe that any agency can increase their linkage to care rate, even with limited time and without fancy software. We started from the ground up and we're able to do this with referrals and just developing, over time, a navigation flow. This is our contact information. Jut it down if you would like. We would be happy to answer any other questions about this. This is what we do.

Caitlin: Yes. Please feel more than free to email us both. I know that were some pretty specific questions and I do have some thoughts on troubleshooting for some of those, so if we didn't get to answer your question, please feel more than free to email. You can email both of us and then we can chat about it and get you back a cohesive response. We're more than happy to troubleshoot with you, moving forward. If we have some time, I think we can do a little bit of Q&A now. Otherwise, feel free to email.

Arman: That is great. That is great. Thank you very much Joey and Caitlin. At this moment, there's a different chat box on the screen to the right. This is the question for the presenters. I see some people typing already some of the questions. While the questions are coming, Joey and Caitlin, can you tell us when

did you start implementing your patient navigation system? Just to have an idea how long it took you to get to this expertise.

Caitlin: Can we pop back to the slides? Is that okay?

Arman: Yeah. Sure.

Caitlin: Let's go back to the slide Joey. The patient navigation program was implemented in June of 2012 and very, very quickly, our linkage rate, you can see, by July-December had risen to 77%, and then by January-June 2013, it was up to the 90s. This patient navigation program was really developed for NO/AIDS. I mean, it was an internally developed program that we created around the existing program. I think that that's why it was so successful so quickly was that it wasn't like a cookie-cutter approach. It was something that was developed by us for us and it's been pretty successful.

Arman: Excellent. Thank you very much. For the person who's asking about downloading the slides, if you go to the attendees list, at the very bottom, there's another pod, it's called Download Today. There, you'll find the National HIV/AIDS Strategy Fact Sheet summarized. You can download that one. You can also download Patient Navigation Fact Sheet that we have created at CBA@JSI. The third one is the slides that we have presented today. Just click and highlight that one and then it says Download File and it will download it for you. Joey and Caitlin, we can go through the other questions if you want to.

Caitlin: Yes. Sure. Let's try and tackle them pretty quickly here. In terms of texting clients about using a personal phone line, you could use like a Google chat service where someone could ... Someone shares a cellphone, you could use a Google chat service that would still be on the cellphone but they would be able to access it online. If they get on to a computer, they would be able to do that. Also, if someone does not ... I thought ... I originally thought this question was if someone has a land line. If someone has a land line and does not have a cellphone, that's where you're really going to want to lean heavily on your DIS because they have the ability to actually go to people's home. Your Patient Navigator may not be comfortable actually going into folk's homes. The DIS, that's part of their job description. You can send them out for you in tag team and see what their response is.

Joey: I see kind of along those lines, someone was asking about the mobile phone and how do we text. We do have a dedicated mobile phone for this, the patient navigation phone that she keeps on her all the time. She doesn't have to take it home at night. Sometimes she does when she's expecting a call from a client, but it is an agency phone that she uses for texting clients.

Caitlin: The EMR that we use internally is Aprima. It's fine. It's a fine EMR. I would say that any EMR would be appropriate. What's really crucial and unique is that the

Patient Navigator has the ability to view, to access the EMR. They have a unique log-in and they're able to schedule that initial appointment. They can also just call our front desk staff, but they do have the ability to schedule that appointment. Then, how do you stress the level of importance of the Patient Navigator program to other hospital personnel? What I would say is, "The Patient Navigator is the face of your hos- ..." Like, ifthe Patient Navigator is an employee of the hospital. They are the face of the hospital to the client.

They are these very first person that that client is going to be interfacing with and depending on how well that first interaction goes, that's really going to have a tremendously strong influence on whether or not the client links and whether or not they are retained in care. A lot of folks had mentioned earlier an interest in retention and care. I really just can't stress enough that initial perception that a client has walking through the door. I know this off of my time as a Case Manager. You just can't emphasize enough how important that is. Also, I mean, the Patient Navigator may be able to identify someone who's really, really, really sick, like, "This may be somebody who really needs to get the very same day." They are also that first line of defense for those clients.

Arman: Thank you very much. I believe those are all the questions that have been posted until this morning.

Caitlin: One other thing, really fast Arman, that I want to get out to people.

Arman: Yeah, go ahead.

Caitlin: While the national definition of linkage to care is within 90 days, we do not ... We have to report on who's been linked within 90 days and all the numbers that we've been showing you are linkage within 90 days. However, our Patient Navigator continues to follow people beyond the 90 days. I actually had a young 15 year old man that I linked six to nine months after his initial diagnosis and he's now linked to care, but at 16, he had a CD4 of below 200, so it was really important that we got him in, but if I hadn't continued to, very respectfully without harassing him, continued to follow up every now and again, he wouldn't have linked to care until he became very, very sick. Not just saying, "Oh, they didn't link to care within 90 days. They're off my docket," but maintaining them as a client in a respectful way that isn't harassing but that continues to encourage that linkage is very important.

Joey: Anecdotally, we've seen that through those text messages, there's a really strong relationship built with the Patient Navigator. It might be six months to nine months of texting and it's definitely not to reach that harassing stage. They want to come in, they're just not sure, they might not be ready. I read someone posted earlier asking a question about what do you do if someone isn't ready for link to care yet. We just stay in constant communication with them. Our Patient Navigator sometimes will act like a friend, text them, "Just checking in. How are

you doing today?" Just some simple messages that can convey that we do care about you and we would really like to work with you as soon as you're ready.

Caitlin: Another cool thing about the texting capability is you can text some links to resources. There's a lot of great video resources out there for young people who have just tested positive and a lot of young folks don't have access to internet at home or computer so they do have 3G. You can text them those resources and they can open up those resources and videos and watch them on their phone. I know that we are running low on time, so Arman, we'll hand everything over to you.

Arman: Thank you very much. Thank you for that great presentation. One other thing that we want to mention is that when we're talking about patient navigation, yes, we're talking about linking newly HIV positive clients into care, but also we need to remind people that there's also linkage to care for high-risk negative. In addition to providing services for people dealing with HIV, some organizations are also taking the task of providing patient navigation for high-risk negative persons. Keep in mind that there is up to 25% of the budgets that could be dedicated to this type of activities for this population and also CDC has established as one of the outcomes as a minimum of 90% of high-risk negatives who receive their required recommended prevention and essential support services facilitated through train and navigators.

Just to give you an idea what happened, CDC outlined last year that the people who were high-risk negative persons could be integrated into patient navigation services by doing an assessment of the risk they might have and to reduce the risk and then testing and counseling procedures and a patient navigation to refer them and follow-up with them with all their services like PrEP or some evidence-based services. Also, when they're ready, they could help us identify other high-risk negatives or other people who don't know their status through the strategies like the social network strategy.

Some of the things that we have mentioned and I already mentioned the fact sheet that we developed that is available to download on the pod to the left. There are three files that you can download, this is one of them. Also, you'll find the presentation and also the national strategy summary fact sheet. We want to remind you that we at CBA@JSI, we have a lot of content, we have a lot of resources that we can put you in contact with. We know a lot of organizations who are implementing patient navigations and we can also refer you to where to obtain some of the formal training and some of the resources that could be beneficial for you.

I know we were going to open it to any questions. If you have any questions, feel free to chat on the pod. I want to just draw your attention to the pod below that says Patient Navigation Web Resources. You'll find a lot of links that are a lot of resources for you. There's our link, CBA@JSI. Also some patient

navigation resources from effectiveinterventions.org, the recommendations from CDC on case management and collaboration with regards to patient navigation, the National Quality Center webinar on Patient Navigation and some others, including, at the bottom you'll see the CrescentCare website that you can link and it will take you to their website.

Having said that, it is 1pm and we want to be respectful of your time. We are going to finish this, but we want to remind you that please complete the evaluation. As soon as we finish this meeting, you're going to be redirected. It's really quick and this will take only a few minutes. If you're having any issues and you're not able to download any of the resources, please email us and let us know, and we'll send it to you just in case. Any other questions, feel free to email us as well. Thank you very much Joey and Caitlin, and thank you very much everyone. Have a great day.

Caitlin: Thanks everybody.

Joey: Thanks everyone.

Arman: Bye.