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HIV Navigation Services (HNS)

New Guidance and Expectations

December 12, 2018

HIV Navigation Services Webinar

This webinar will:

- Outline the definition of HIV Navigation Services (HNS)
- Highlight information from recent NYS-wide trainings
- Describe new AIRS data entry processes

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HIV Navigation Services Webinar

Important Note:

- CJI and SEP contractors will receive additional guidance from their contract managers

HIV Navigation Services (HNS)

HIV Navigation Services

Definition:

HIV Navigation Services (HNS): Is a process to help a person (living with HIV or engaging in high risk behaviors) obtain timely, essential and appropriate medical, prevention, and support services to optimize their health and prevent HIV transmission and acquisition. The goal of HNS is to actively engage the client in a comprehensive assessment process to identify barriers and/or unmet needs and develop an action plan to eliminate or reduce these barriers. HNS is accomplished through ongoing and active methods of client engagement (action plan implementation) including but not limited to transportation/escort to appointments, assistance with health insurance forms, addressing food insecurity, etc. HNS is not a one-time encounter with a client. HNS is intended to support positive change and ultimately foster a client's self-sufficiency in navigating HIV health and prevention services through the completion of action plan goals.

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HIV Navigation Services

- For individuals
  - Living with HIV ***OR*** engaging in high risk behaviors that put them at risk
    AND
  - Experiencing barriers to prevention or HIV-related medical services
- Foster self-sufficiency to
  - Optimize health
  - Prevent HIV transmission/acquisition
- Utilizes
  - Comprehensive assessment
  - Action planning; and
  - Ongoing and active engagement

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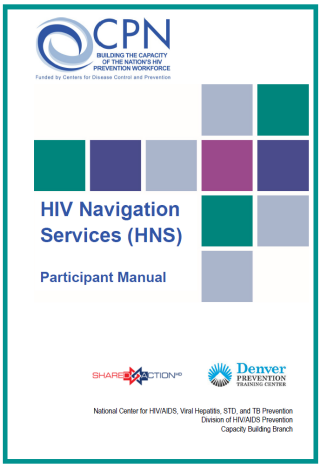
HIV Navigation Services

- Trainings held across NYS for staff and program managers
- Outlined theory, goals and methods of HNS implementation
- AI Division of HIV/STD/HCV Prevention is releasing new guidance as follow-up



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HIV Navigation Services

What makes someone eligible for HNS?

A person is eligible for HNS if they are living with HIV and not fully engaged in HIV care and treatment or HIV negative and engage in high risk behaviors.

Can the AIRS Intake Form be used as the comprehensive risk assessment tool for HNS?

The AIRS Intake Form is not a comprehensive behavioral risk and needs assessment tool and ***cannot*** be used to conduct a comprehensive risk assessment for the purposes HNS.

Can HNS be used to navigate a person to learning their HIV status / receiving HIV testing services?

The training materials outline that a person who engages in high risk behaviors have a recent HIV test. In most cases, a person can access HIV testing through a referral and would not need HNS to get an HIV test.

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HIV Navigation Services

Is it considered HNS if an agency begins to work with a client to get the them into care, then "hands the person off" to another person/agency, who will continue to work with the person to complete his/her (ART, Viral Suppression, PrEP adherence, self-sufficiency) goals?

Depending on the person's action plan and goals, it may be considered HNS. HNS is not making a referral to another service. HNS is designed to actively assist a person to reduce barriers and increase access to needed services.

Is there flexibility in what is considered reaching an HNS Goal?

For HNS, goals are determined by the person's comprehensive behavioral risk and needs assessment and action plan. Goals are reached once the person receives the needed service(s) and uses care and prevention services on their own.

How is self-sufficiency defined in the context of delivering HNS?

For the purposes of HNS, self-sufficiency means that a "client is able to use care and prevention services on their own without assistance from others". It does not mean that a client is fully self-sufficient in all aspects of their life.

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Current AIRS Data Entry Process

Current Process – AIRS Data Entry

Data Entry Process:

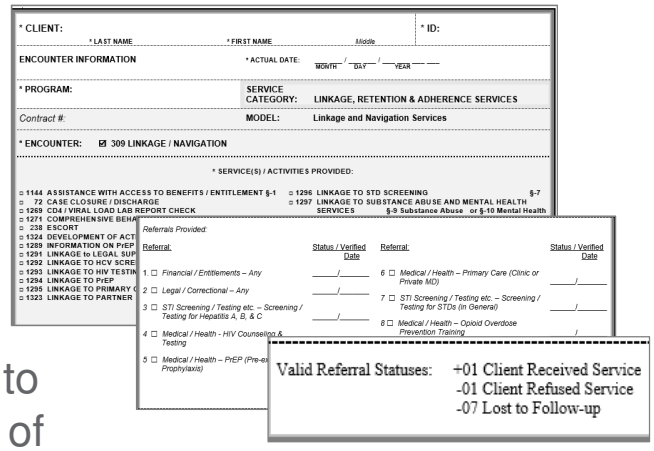
1. Record Comprehensive Behavioral Risk Assessment Service
2. Record Linkage Service
3. Enter Referral for Linkage Service
4. Record Outcome of Referral for Linkage Service

Current Process – AIRS Data Entry

Linkages only counted for clients who FIRST had a **Linkage Service**

AND

THEN a **completed referral** to that service with an outcome of Client Received Service



New AIRS Data Entry Process

New Process – AIRS Data Entry

- There are several **NEW** AIRS Services available for HNS
  - Implementation of Action Plan (1417)
  - Assistance with Housing Services (1421)
  - Assistance with Employment/Education (1422)
- The following Services are considered **Priority Services**
  - Linkage to HIV Testing (1293)
  - Linkage to HCV Screening (1292)
  - Linkage to STD Screening (1296)
  - Linkage to Partner Services (1323)
  - Linkage to Primary Care (1295)
  - Linkage to PrEP (1294)
  - Linkage to Substance Abuse & Mental Health Services (1297)
  - Assistance with Access to Benefits/Entitlements (1144)
  - Assistance with Housing Services (1421)
  - Assistance with Employment/Education (1422)

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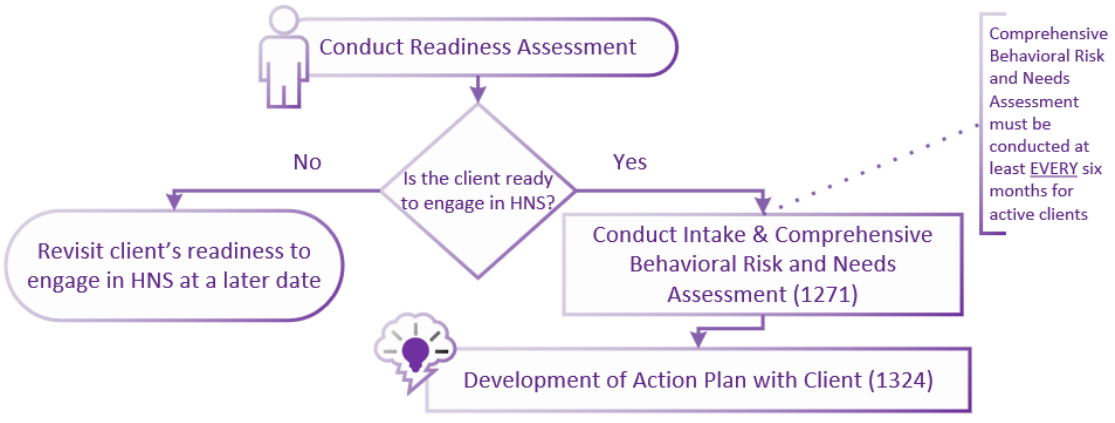
New Process – AIRS Data Entry



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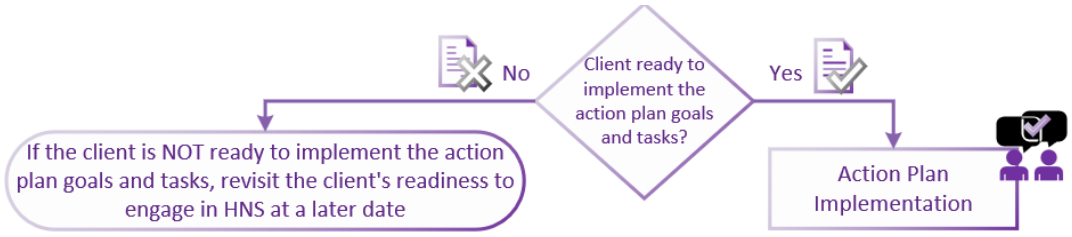
New Process – AIRS Data Entry



HNS Specialist will be actively engaged with the client to reduce and eliminate barriers and support positive change

New Process – AIRS Data Entry

Beginning January 1st, 2019

- The **Development of an Action Plan** must now be recorded as a service in AIRS
- **Linkages** will no longer be recorded in AIRS **at the time they are provided** to the client
- Recording **Active Referrals** and referral outcomes for linkage services will **no longer be required**

New Process – AIRS Data Entry

Moving Forward:

Only **COMPLETED** services and Linkages should be **entered in AIRS**

HNS for HIV Negative Persons Engaging in High Risk Behaviors

- ✓ Implementation of action plan (1417)
- ✓ **Assistance with Housing Services (1421)**
- ✓ **Assistance with Education/Employment (1422)**
- ✓ **Linkage to HIV Testing (1293)**
- ✓ **Linkage to HCV Screening (1292)**
- ✓ **Linkage to STD Screening (1296)**
- ✓ **Linkage to Partner Services (1323)**
- ✓ **Linkage to Primary Care (1295)**
- ✓ Information on PrEP (1289)
- ✓ Screening for PrEP (1305)
- ✓ Linkage to PrEP (1294)
- ✓ Treatment Adherence Counseling(PrEP) (1309)
- ✓ Linkage to Overdose Prevention Training (1107)
- ✓ **Linkage to Substance Abuse & Mental Health Services (1297)**
- ✓ Legal Support (1291)
- ✓ **Assistance with Access to Benefits /Entitlements (1144)**
- ✓ Translation/Interpretation (827)
- ✓ Escort (238)
- ✓ Transportation Coordination (1201)
- ✓ Prevention Counseling (1145)
- ✓ Supportive Counseling (1146)

HNS Services Provided in Support of Action Plan

HNS for Persons Living with HIV

- ✓ Implementation of action plan (1417)
- ✓ **Assistance with Housing Services (1421)**
- ✓ **Assistance with Education/Employment (1422)**
- ✓ CD4/Viral Load Lab Report Check (1269)
- ✓ Treatment Education and Adherence Counseling (1310)
- ✓ **Linkage to HCV Screening (1292)**
- ✓ **Linkage to STD Screening (1296)**
- ✓ **Linkage to Partner Services (1323)**
- ✓ **Linkage to Primary Care (1295)**
- ✓ Linkage to Overdose Prevention Training (1107)
- ✓ **Linkage to Substance Abuse & Mental Health Services (1297)**
- ✓ Legal Support (1291)
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- ✓ Translation/Interpretation (827)
- ✓ Escort (238)
- ✓ Transportation Coordination (1201)
- ✓ Prevention Counseling (1145)
- ✓ Supportive Counseling (1146)

In other words, only Linkages verified as successful (services received) should be entered

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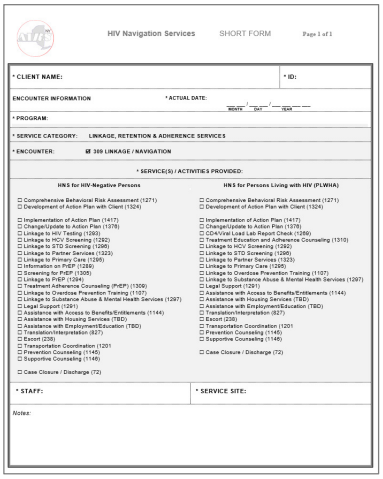
New Process – AIRS Data Entry

- The HNS AIRS Short Form no longer has space for referral tracking
- Linkage services will be selected only once the client has attended the appointment
- Verification should be recorded in the client file



HIV Navigation Services SHORT FORM Page 1 of 1

* CLIENT NAME: * ID:

ENCOUNTER INFORMATION * ACTUAL DATE: ____/____/____ (MONTH / DAY / YEAR)

* PROGRAM:

* SERVICE CATEGORY: LINKAGE, RETENTION & ADHERENCE SERVICES

* ENCOUNTER: ☑ 389 LINKAGE / NAVIGATION

* SERVICE(S) / ACTIVITIES PROVIDED:

HNS for HIV-Negative Persons

☐ Comprehensive Behavioral Risk Assessment (1371)
☐ Development of Action Plan with Client (1324)

☐ Implementation of Action Plan (1417)
☐ Change/Update to Action Plan (1078)
☐ Linkage to HIV Testing (1293)
☐ Linkage to HCV Screening (1292)
☐ Linkage to STD Screening (1296)
☐ Linkage to Partner Services (1323)
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☐ Legal Support (1291)
☐ Assistance with Access to Benefits/Entitlements (1144)
☐ Assistance with Housing Services (TBD)
☐ Assistance with Employment/Education (TBD)
☐ Translation/Interpretation (827)
☐ Escort (238)
☐ Transportation Coordination (1201
☐ Prevention Counseling (1145)
☐ Supportive Counseling (1146)

☐ Case Closure / Discharge (72)

HNS for Persons Living with HIV (PLWHA)

☐ Comprehensive Behavioral Risk Assessment (1371)
☐ Development of Action Plan with Client (1324)

☐ Implementation of Action Plan (1417)
☐ Change/Update to Action Plan (1078)
☐ CD4/Viral Load Lab Report Check (1269)
☐ Treatment Education and Adherence Counseling (1310)
☐ Linkage to HCV Screening (1292)
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☐ Case Closure / Discharge (72)

* STAFF: * SERVICE SITE:

Notes:

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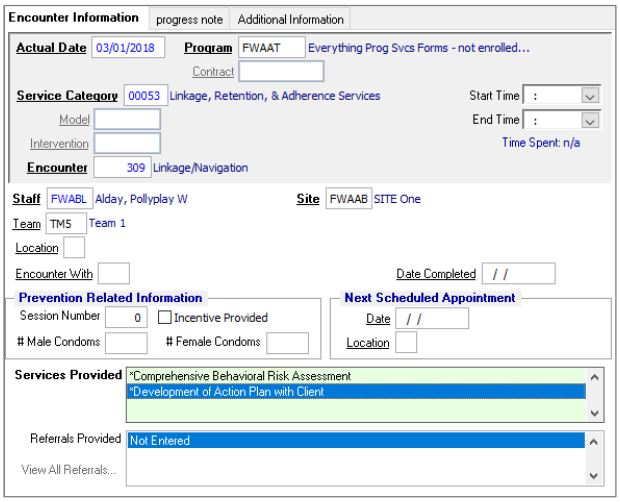
Scenarios

Scenario - John

Session with Client

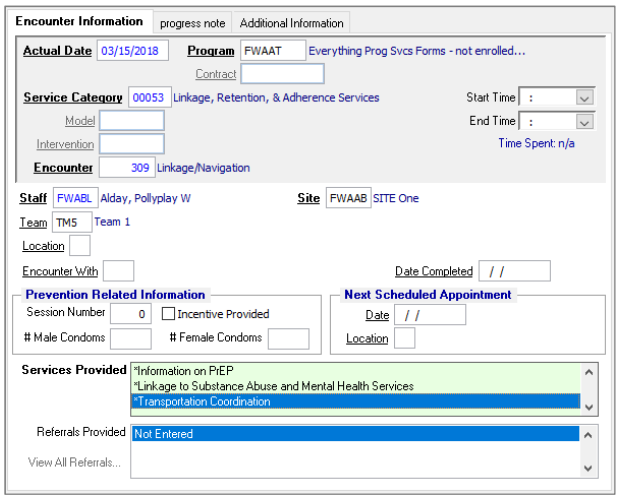
On March 1st, John comes in to learn about the program and decides to enroll. You complete the Readiness Assessment, Comprehensive Behavioral Risk Assessment and work collaboratively to Develop an Action Plan, which includes accessing STD Screening, Mental Health Services and exploring the potential use of PrEP.



Scenario - John

Session with Client

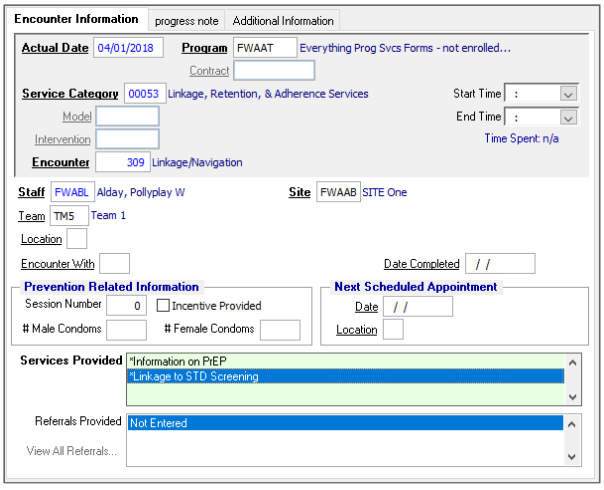
John comes back for an appointment on March 15th where he reports that he hasn't gotten a chance to test for STDs due to difficulty getting to the clinic location. You provide him with bus fare and review the bus route/schedule together. John lets you know that he called a therapist he used to work with had his first therapy appointment last week. You end the appointment by discussing information on PrEP and brainstorming solutions to John's concerns about remembering to take a pill everyday.



Scenario - John

Session with Client

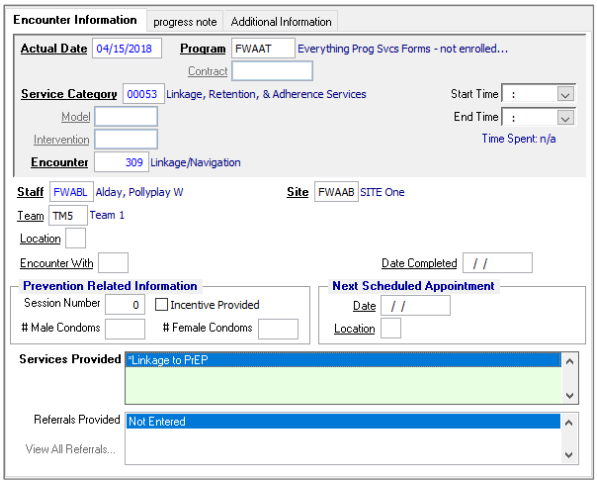
During your meeting on April 1st, John reports that he was able to use the local bus to get to STD screening after your last session. He feels empowered by reaching this goal and plans to repeat testing every 6 months. You also provide John with a list of area PrEP prescribers and together you identify and reach out to one that is conveniently located to John to set up an initial appointment. You also provide John with information on the importance of keeping follow-up PrEP appointments.



Scenario - John

Session with Client

Two weeks later, John lets you know that he attended his appointment with the PrEP prescriber you both discussed at his last appointment. You talk over any potential barriers that may arise and get in the way of him making his PrEP appointments but John lets you know that the clinic is easy to get to and they have appointment times that work with his availability.

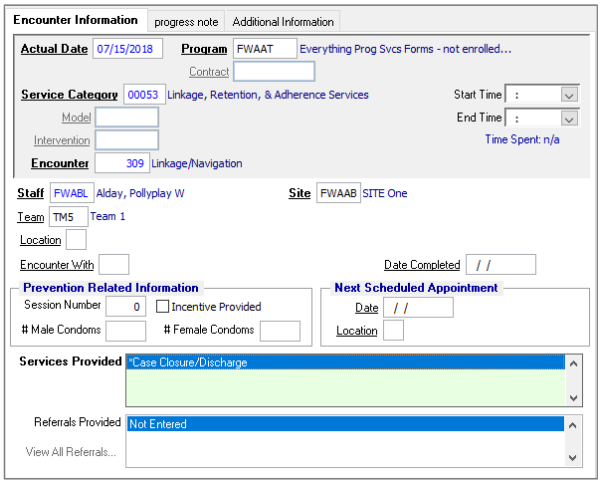


Scenario - John

Session with Client

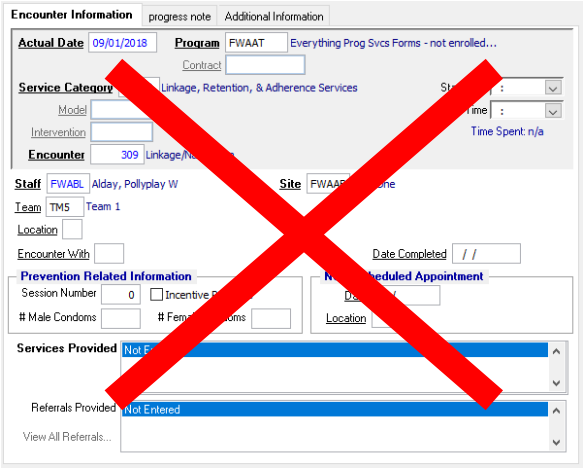
Over the next few weeks you continue to work with John to support and encourage continued action towards reaching and maintaining his goals. You work together to address barriers as they arise and for the most part John seems to be becoming more self-sufficient.

He reports in July that he has attended his 3-month PrEP appointment and is feeling really good about the progress he has made.



Scenario - Jane

Jane comes to visit the HNS Specialist after learning about the HNS Program during an outreach event. She is looking for information on HIV and STD testing during the evenings when she is usually off work. The HNS Specialist provides Jane with a calendar of testing events and locations and Jane feels confident she can make it to one of them.



Reporting

Reporting

New reporting will focus on:

- Completion of the Comprehensive Behavioral Risk Assessment
- Development of an Action Plan
- Priority Services with Successful Outcomes

BCBS CoC MSM

Service	All Clients	HIV -	HIV +
Initial Services			
Total Served:	77	71	6
CBRA*	31	30	1
Dev of Action Plan	26	24	2
HNS Clients*	26	25	1
Priority Services			
Linkage to HIV Testing	0	0	0
Linkage to HCV Screening	0	0	0
Linkage to STD Screening	1	0	1
Linkage to Partner Services	1	1	0
Linkage to Primary Care	2	2	0
Linkage to PrEP	15	15	0
Linkage to Overdose Prevention Training	0	0	0
Linkage to Substance Abuse/Mental Health Services	0	0	0
Assistance with Access to Benefits/Entitlements	4	3	1
Assistance with Housing Services	0	0	0
Assistance with Employment/Education	0	0	0
Additional Services			
Other Services	57	53	4
Case Closure/Discharge	16	15	1

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Wrap-up and Next Steps

- HNS
  - Helps individuals living with HIV or engaging in high risk behaviors
  - Uses a comprehensive assessment process **AND** a collaborative Action Plan
  - Fosters self-sufficiency to optimize health and prevent HIV transmission/acquisition

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Wrap-up and Next Steps

- Review Packet of HNS Materials
  - HNS Services Flowchart
  - HNS FAQ Document
  - HNS Definitions Document
- Moving forward
  - Planning File **MUST** be loaded as soon as received
  - AIRS Upgrade **MUST** be completed as soon as available
  - Beginning **1/1/19**, AIRS services should **ONLY** be entered once the service is verified/the outcome is achieved

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Questions? Comments?

General HNS questions should be sent to DOPAI@health.ny.gov

For program specific HNS questions, please reach out to your contract manager

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