Dallas County Health and Human Services

PROGRAM:

EHE – Care Navigation

INTRODUCTION:

The EHE – Care Navigation program seeks to establish a consistent process to support the linkage of individuals living with HIV to medical care. This involves collaboration between EHE community health workers, the county sexual health clinic, and the STI/HIV division. The program is designed to address gaps in care for newly diagnosed individuals or those not consistently engaged in HIV treatment.

TARGET POPULATION:

The program serves diverse and key populations, ensuring that high-risk and underserved groups receive targeted interventions.

- Men who have sex with men (MSM)
- Black/African American
- Hispanic/Latinx
- People who inject drugs
- People living with HIV (PLWH)
- Spanish Speakers
- Women, youth, and aging population
- Transgender and nonbinary individuals

KEY STAKEHOLDERS AND COLLABORATORS:

The program was made possible through collaborations with several key stakeholders, including:

- Federally Qualified Health Centers (FQHCs)
- Mental health and substance use treatment providers
- Private healthcare providers

- Local and State health departments
- Community- Based Organizations (CBOs)
- Social service agencies
- Hospitals and Pharmacies

PROGRAM DURATION:

The program has been running for 1-2 years, during which various phases of care navigation, patient support, and data tracking have been implemented.

PROGRAM GOALS AND KEY ACTIVITIES:

The primary goal of the program is to improve the linkage of clients to HIV care, aiming to link 90% of clients by March 2024, up from a baseline of 76%. The program established baseline data on client engagement and retention and set progressive targets for improvement, including increasing linkage rates by 5%.

Key activities include:

- Weekly Team Meetings: These meetings allow for a comprehensive review of dashboard metrics, helping the team access caseloads, track progress, and discuss areas for improvement.
- One-on-One Touch Bases: In the program's second phase, care navigators and supervisors hold weekly individual meetings to address performance gaps and enhance personalized care for each client.
- Patient Relationship Building: Care navigators attend appointments with clients to provide both practical and emotional support, emphasizing trust and improving patient engagement.
- Longitudinal Follow-Ups: A systemic approach to follow-up care is implemented, ensuring that social determinants of health are addressed for both linked and unlinked patients. This process helps track clients over time to ensure they remain in care.
- Viral Load Tracking: Care navigators collect viral load data from clients every two to three months to monitor their health outcomes and ensure retention in care.

PROGRAM CHALLENGES:

Challenges in data systems and coordination are ongoing, requiring continuous efforts to align workflows. Maintaining accurate data collection is critical for tracking patient progress and meeting program goals. Annual updates to Standard Operating Procedures (SOPs) are also necessary to adapt to evolving needs and incorporate best practices.

COMMUNITY ENGAGEMENT AND DEVELOPMENT:

The program engaged the community through outreach efforts, capacity-building training, and participation in community forums. Care navigators attend local events to promote care navigation services and build awareness. Additionally, partnerships with various local organizations providing medical and social services have expanded the program's reach and strengthened referral networks. By attending medical and non-medical appointments with patients, care navigators build trust, listen to their challenges, and deepen their understanding of the community's needs.

DATA COLLECTION AND MONITORING:

Data collection is managed manually by care navigators, who input information into Excel spreadsheets. These spreadsheets are then analyzed in Power BI by the epidemiology team to create data dashboards. Viral load metrics are tracked using EPIC and THISIS, while attendance is confirmed through patient or clinic calls. Time to linkage is also tracked, from initial contact at the Sexual Health Clinic to appointment attendance, ensuring data transparency across Sexual Health programs.

KEY METRICS AND OUTCOMES:

- Linkage to care for over 90% of scheduled appointments, tracked quarterly.
- Each care navigator aims to attend at least two appointments weekly with clients.
- Collect at least two viral load measurements for each patient, three months apart, within a calendar year.
- Decrease in the average days to linkage for newly diagnosed patients.

CONCLUSION:

The EHE Care Navigation program has made significant strides in improving linkage to care, fostering community engagement, and addressing the social determinants of health for people living with HIV. Through strong collaboration, personalized patient support, and data-driven strategies, the program is well-positioned to continue reducing gaps in HIV care and improving health outcomes for vulnerable populations.