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# Chronic Health Navigation Program

## Programming Connection

### Case Study

**Organization:** ASK Wellness Centre
**Region:** Kamloops and Merritt, British Columbia
**Prepared:** 2014

### Quick Facts

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| Goal (immediate) | To provide acute support for people living with HIV, hepatitis C or other chronic illnesses to stabilize their housing, health and finances |
| Goal (ultimate) | To improve client health outcomes, to increase clients' independence in achieving those outcomes and to reduce the number of people accessing acute care inappropriately |
| Population | People living with hepatitis C, People living with HIV |
| Participants | People living with HIV/AIDS, hepatitis C or other chronic illnesses |
| Type of Program | Support |
| Setting | Community |
| Required Resources | 1. Health navigators<br>2. Sustained, base funding |
| Scope and Duration | 120 clients. Ongoing. |
| Date Started | 2010 |
| Region | Kamloops and Merritt, British Columbia |
| Recruitment | Referrals |

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| Challenges | 1. **Structural financial barriers.** The Chronic Health Navigation Program supports vulnerable people on fixed incomes. User fees for services are a significant barrier to the work of navigators. Clients do not necessarily have full coverage for the services or medications they need. ASK Wellness Centre has developed a small fund to cover the cost of these fees so that clients can access the healthcare services they need.<br>2. **Healthcare provider education.** Especially in smaller communities outside of Kamloops, healthcare providers have not had as much education on the social determinants of health, HIV and hepatitis C as their peers in larger centres and this can sometimes pose a barrier between clients and adequate healthcare.<br>3. **Lack of services.** While Kamloops is one of the largest centres in the interior of British Columbia, there few HIV or hepatitis C specialists in the area.<br>4. **Inequity of health services.** In the rural areas and communities surrounding Kamloops, comprehensive health services are insufficient to meet demand, and this can lead to health inequities among community members. |
| Evaluation | An assessment conducted by ASK Wellness Centre in 2010 estimated that its case management of clients with chronic health conditions cost $46,300 but saved the City of Kamloops $81,000 in health services.<br><br>On the basis of its Streets to Homes to Health (and now to Employment) model of service, ASK Wellness tracks:<br><br>• the number of people housed and retention in housing after six months<br>• the number of referrals from ASK Wellness housing to health services<br>• the number of people accessing HIV, hepatitis C and other diagnostic testing<br>• the number of people supported to manage their illness<br>• the number of referrals to addictions programs<br><br>ASK Wellness is currently developing measures to track the impact of its employment programs.<br><br>Success is also measured through anecdotal evidence that clients' health and lives are improving as a result of their involvement with a health navigator. |

## What is the program?

ASK Wellness Centre's Chronic Health Navigation Program is a critical component of the linkage to care system in Kamloops, British Columbia, for people living with HIV, hepatitis C and other chronic illnesses. The program uses "health navigators," individuals who work to improve client health by educating, guiding and advocating for clients along their health journey. Health navigation is part of ASK Wellness Centre's Streets to Homes to Health to Employment model of service.

ASK Wellness Centre does not expect its navigators to identify as peers of their clients (although some of them are). Rather, the program employs people who have an ability to connect with and build strong relationships with clients.

Anyone living in housing managed by ASK Wellness Centre has access to a health navigator should they need one. The service is also available to anyone else in Kamloops and the surrounding areas who lives with HIV or hepatitis C.

The primary objective of the Chronic Health Navigation Program is to improve individual client health outcomes. One of the secondary goals of the program is to reduce the burden that clients with chronic diseases place on emergency health services. This is achieved by increasing client stability, confidence and independence through access to housing and healthcare. As they work with clients to meet these goals, health navigators develop individualized care plans and strive to respond flexibly to the needs of each client and engage clients in a long-term relationship. Health navigators set goals with clients and build supportive networks in the community that clients can access in times of need.

ASK Wellness Centre has two navigators in Kamloops and one in Merritt, about 85 kilometres from Kamloops; this

case study will focus on the work of the two navigators in Kamloops and their 120 clients. A brief description of the work of the health navigator in Merritt can be found at the end of the How does the program work? section of this case study.

## Why Was the Program Developed?

The Chronic Health Navigation Program was developed to improve the health outcomes of people who use emergency services heavily by providing them with a knowledgeable and reliable health navigator.

The idea for the Chronic Health Navigation Program emerged from the local health authority's Chronic Disease Management Plan. According to the health authority, good chronic disease management requires care and support that is coordinated across healthcare providers and points of care, is easily accessible and focuses on health promotion and well-being. Advances in HIV and hepatitis C treatment mean that both of these infections are chronic, manageable conditions. ASK Wellness Centre knew from its long history working with people with both HIV and hepatitis C, however, that its clients needed additional support to manage their health. For ASK Wellness Centre, it made sense to support clients to learn to manage their health with the help of a knowledgeable professional who was not part of the healthcare system.

Before the Chronic Health Navigation Program was launched in 2010, ASK Wellness Centre, in partnership with other service providers in Kamloops, studied the emergency service expenditures (ambulance services and emergency departments) for the 15 heaviest users of these services over a nine-month period. When the program was started, each of these users was offered the services of a navigator, and all of them accepted the offer.

Over the nine months of the study period, it was determined that access to a navigator would have saved emergency services $81,000 annually, even after subtracting $46,300 for the cost of the navigator.

## How Does the Program Work?

The Chronic Health Navigation Program is available to people living in ASK Wellness Centre housing and to people living with HIV or hepatitis C in Kamloops and surrounding areas. Most people referred to the Chronic Health Navigation Program come to the program in crisis, when they are experiencing an acute need for extra support. Some are newly diagnosed with HIV (or another chronic illness); others have been living with untreated HIV, hepatitis C or other chronic illnesses (e.g., epilepsy, Parkinson's, cancer, chronic obstructive pulmonary disorder) for years and their health is deteriorating. About 80 percent of the program's clients live with HIV or hepatitis C.

The role of health navigators is to educate, guide and advocate for clients along their health journey. They support clients to access housing, healthcare and additional financial assistance to improve their health and well-being.

ASK Wellness Centre has two full-time staff positions for navigators. Unlike Peer Navigation Services in Vancouver and the Peer-to-Peer Program in Regina, ASK Wellness does not exclusively hire people living with HIV to provide navigation. It selects individuals who demonstrate an understanding of the barriers and challenges marginalized people living with a chronic illness (including HIV and hepatitis C) may face and an ability to build on the strengths and abilities of clients to achieve better health outcomes. Health navigators in this program do not necessarily have personal experience with these illnesses.

## Housing-first model

ASK Wellness Centre uses a housing-first model in all its work in Kamloops. This model is based on the idea that clients who are homeless or at risk of homelessness must be stabilized in housing before they can tackle more complex issues such as their health. ASK Wellness Centre (as of January 2014) manages 130 housing units in Kamloops, including units in single room occupancy hotels, apartments and townhouses. ASK Wellness Centre's direct management of these units facilitates access to housing for those who are most marginalized.

Although housing is a top priority, navigators also work with clients to take care of the psychosocial and healthcare needs clients identify as critical. They do this by working with pharmacists, street nurses and outreach workers to minimize the delays in people receiving the care they need.

## Using a self-management approach to health navigation

The Chronic Health Navigation Program uses a self-management approach in its work. Clients are encouraged to take on as much of their own care as they can manage, and they have to demonstrate that they are committed to becoming more independent as they achieve the goals of their care plan. What this actually entails for each client is different. For one client this might mean applying for additional social assistance without the help of a navigator; for another, it might mean making one appointment with a counsellor once a week without the help of a navigator.

For this approach to be effective, the health navigator and the client must have a trusting relationship. For the most part, health navigators work with people who may distrust authority figures and healthcare providers. A self-management approach, which may feel to some like "tough love," may trigger some clients to disengage if used too early in the client-health navigator relationship. Health navigators work over months and years to develop a trusting relationship that allows them to use a self-management approach without alienating clients.

Using a self-management approach in health navigation builds confidence in clients. Many clients use the program when they are at their most vulnerable, when they are experiencing difficulty accessing healthcare, financial support and housing services. Over time, while working with a health navigator, clients learn how to navigate health and social services independently. When their navigator observes and encourages their efforts, they gain the confidence to become even more independent.

## Referrals

Many of the referrals to the program come from ASK Wellness Centre's housing intake workers. Intake workers have integrated the offer of chronic health navigation services into their intake processes for new housing applicants. New residents at housing projects affiliated with ASK Wellness Centre, such as Crossroads Inn and Henry Leland House, where the intake process is different, have meetings set up with a health navigator to go over the services they offer and ensure that new residents' health needs are being met.

Referrals for people living with HIV and hepatitis C and who live in the community come through a variety of sources, including the Ministry of Social Development and Social Innovation, Royal Inland Hospital, Kamloops Regional Correction Centre, community-based agencies, Round Lake Treatment Centre, public health staff and other healthcare providers in Kamloops and the surrounding areas.

## Intake

When a potential client is referred to the Chronic Health Navigation Program, the two health navigators determine which one of them is the best fit for the client's needs. Typically, the navigators divide clients by gender, with the male navigator taking men and the female navigator taking women. The female navigator also takes on some male clients because there are more men enrolled in the program than women. This gendered division of clients is done to provide female clients with a navigator who can more comfortably help address health issues that are specific to women. As much as possible, men who say they would prefer to work with a man are paired with the male navigator.

Once a prospective client is assigned a health navigator, the health navigator sets up a meeting with them. Together, the health navigator and the client complete an intake form (available in the Program Materials section of the case study). Space is provided on the form for the client and the navigator to discuss and record goals and care planning.

## A client's first six months

Clients of the Chronic Health Navigation Program are usually referred to the program with acute healthcare needs. Using a housing-first model, health navigators work intensively with clients to provide housing if they are homeless or at risk of homelessness. While a client's housing is stabilized, health navigators help clients to make and attend healthcare appointments to diagnose and treat any health issues they face. HIV infection, complications from hepatitis C, chronic pulmonary obstruction disorder and cancer are the most common health problems clients of the program live with.

During the first six months, clients are in weekly contact with their health navigators and the health navigator will get to know the client and their history. This helps the health navigator support the client to develop a tailored set of goals for improving their health and independence. These are usually based on a healthcare provider's

recommendations. This intensive engagement, where a health navigator is a constant and reliable support to the client, builds trust between them and provides the foundation for a more long-term relationship.

Once a client's immediate housing, health and food security issues are stabilized, the client and the health navigator work together to achieve more long-term goals for the client's health and well-being. Each client's goals are different; they can range from getting new dentures so a client can go back to work to a client living with HIV achieving an undetectable viral load.

## Health navigator's role

The health navigator's role is to provide education, support and guidance to clients, tailored to the needs of each client. This includes assessing risk factors for HIV and hepatitis infection, providing harm reduction services and referrals for mental health and addictions services, facilitating referrals to primary healthcare providers, developing a support plan for medication adherence and accompanying clients to appointments.

Health navigators also advocate for their clients to break down barriers that may exist as their clients try to obtain health and social services. Health navigators work to re-engage both client and service provider in the client's care, which may have been neglected for years. For some clients this may mean the health navigator facilitates appointments with healthcare providers, and for others this may mean the health navigator advocates for them with the Ministry of Social Development and Social Innovation or the Canada Pension Plan.

Re-engaging clients in their own healthcare also involves developing clients' capacity to make and keep appointments and ask questions of their providers, skills that are key to improving health outcomes. Health navigators do this by accompanying clients to appointments in Kamloops or Vancouver to provide support, setting up appointments with pharmacists when new medications are prescribed, and coaching clients before appointments on how to ask questions of their healthcare providers. Over time, health navigators have observed clients develop the confidence to make appointments and see their healthcare providers more independently as a result of this type of support.

Typically, health navigators work with clients to identify community services and community members that might act as additional supports so that the health navigator is not the only person involved in a client's care. This helps the client build a support network and makes them less dependent on their health navigator.

## Ongoing client engagement

The reliable support of their health navigator in the first six months of a client's involvement with the Chronic Health Navigation Program goes a long way to building strong long-term relationships between clients and navigators. This is key for most of the Chronic Health Navigation Program's clients because they are marginalized people who live with chronic illnesses and will require, in some form, support for their whole lives. Health navigators never close a file on a client. Clients are welcome to use the program whenever they need it.

Most clients have periods of intensive engagement with their health navigator as a result of their street involvement and/or their chronic illness; these periods are followed by times of less intensive support. Aside from the initial six months, during which most clients receive intensive support from a health navigator, clients tend to seek more support during the first few months of diagnosis and treatment for HIV, hepatitis C, cancer or other chronic illnesses or when they experience a personal crisis.

Outside of periods in which they require intensive support, most clients maintain an ongoing relationship with their navigator and check in on a drop-in basis. When health navigators have not heard from a specific client in a few months, they follow up with them over the phone or in person.

## Periodic client review

For all clients, periodic reviews take place—typically twice a year—with the health navigator connecting with clients during scheduled appointments or when they drop in. At these sessions the peer navigator and client review the personal care plan that was developed during the intake process and discuss what has been achieved to date, what is still left to accomplish and any other goals the client has identified.

This review allows the client and the health navigator to continue to work toward the client's goals and to identify

new goals. This usually requires that the health navigator work with the client to set up additional appointments with social service and healthcare providers. For both the client and the health navigator, periodic reviews provide some structure to their relationship.

## Linkage to other health navigation services

Although Kamloops is a larger centre in the Interior of British Columbia, many specialist appointments, especially for people living with HIV, take place in Vancouver. In some instances, health navigators will accompany clients to Vancouver, but for those clients who are more independent and who travel to Vancouver on their own, the ASK Wellness Centre navigators refer clients to the Peer Navigation Services of Positive Living BC (PLBC).

This collaboration has allowed ASK Wellness Centre to extend the reach of its support at the same time as it reduces costs. Travelling to Vancouver for medical care can be a significant barrier for many clients. The city may be unfamiliar to them or may be triggering for clients with addictions who once lived there. Being able to see a peer navigator in Vancouver provides added support at what may be a difficult juncture in each client's care. Overall, this collaboration improves linkage to and retention in care for many ASK Wellness Centre clients.

As an additional way to reduce barriers for clients, ASK Wellness Centre is currently exploring the feasibility of using TeleHealth services to link clients to specialists on a regular basis without the need for extensive travel to Vancouver and Kelowna.

## Health navigation suites

Since 2011, the Chronic Health Navigation Program has set aside two supportive housing units for its clients. The suites, which are only a few blocks from the ASK Wellness Centre office in Kamloops, are designated for individuals living with HIV or hepatitis C who have significant healthcare challenges.

Originally, the suites were designated for people with complex healthcare needs who could benefit from acute support and having somewhere to live as they stabilized their health (street-involved people living with HIV who also had cancer, for example). The units are offered with a significant subsidy for rent, and the health navigators work closely with appropriate community services (for example, nursing, physiotherapy) that can offer in-home service.

Initially, the suites were offered to clients for two years. It was assumed the client's health would be stable enough after two years for them to move to other units within ASK Wellness Centre's housing projects or into market-rent suites in the community. In practice, the clients who have lived in these suites have usually needed such significant supports in the long term that transition to more independent living would not be recommended.

Thus, the Chronic Health Navigation Program no longer has a two-year limit on residence in these suites. Clients who need permanent long-term support are transitioned to long-term care facilities on a timeline that makes sense for the client. Clients who are reaching the end of their lives are allowed to remain in their suites as long as the care they receive there is adequate.

## Health navigation in Merritt

In addition to the two health navigators in Kamloops, ASK Wellness Centre has a health navigator in Merritt, a city of 7,000 people 85 kilometres southwest of Kamloops. This navigator also serves clients in the surrounding rural area. Health navigation clients in this area are almost exclusively street-involved people needing support during a crisis. Unlike the program in Kamloops where clients are housed either before or at the same time they are assigned a navigator, the Merritt program does not require that clients have housing before being assigned a health navigator because there are fewer subsidized housing units available in Merritt.

The lack of a requirement that clients be housed makes it challenging for health navigators to work with clients in Merritt, and the interaction between the client and health navigator is almost always only during periods of acute need. Clients typically disengage after their acute need has been met and return only during another moment of crisis. For most clients, long-term care planning can seldom take place, although files on clients are never closed.

This model requires flexibility on the part of the navigator so that they can help their clients to achieve their immediate and critical goals. These goals can include support to get to specialist appointments in Kamloops or

Vancouver or to seek assistance from other social services. Achieving them starts a relationship with the navigator that can last for years. Most new clients are referred to the program through other clients, which suggests that this model appeals to the population.

## Required Resources

1. **Health navigators:** One navigator for every 40 clients. Provide support, advocacy, skills building and accompaniment services.
2. **Funding:** A navigation program of this kind must come with sustained, base funding for full-time health navigators.

## Barriers to Implementation

1. **Structural financial barriers.** The Chronic Health Navigation Program supports vulnerable people on fixed incomes. User fees for services are a significant barrier to the work of navigators. Clients do not necessarily have full coverage for the services or medications they need. ASK Wellness Centre has developed a small fund to cover the cost of these fees so that clients can access the healthcare services they need.
2. **Healthcare provider education.** Especially in smaller communities outside of Kamloops, healthcare providers have not had as much education on the social determinants of health, HIV and hepatitis C as their peers in larger centres, and this can sometimes pose a barrier between clients and adequate healthcare.
3. **Lack of services.** While Kamloops is one of the largest centres in the interior of British Columbia, there are few HIV or hepatitis C specialists in the area.
4. **Inequity of health services.** In the rural areas and communities surrounding Kamloops, comprehensive health services are insufficient to meet demand, and this can lead to health inequities among community members.

## Evaluation

An assessment conducted by ASK Wellness Centre in 2010 estimated that its case management of clients with chronic health conditions cost $46,300 but saved the City of Kamloops $81,000 in health services.

On the basis of its Streets to Homes to Health (and now to Employment) model of service, ASK Wellness tracks:

- the number of people housed and retention in housing after six months
- the number of referrals from ASK Wellness housing to health services
- the number of people accessing HIV, hepatitis C and other diagnostic testing
- the number of people supported to manage their illness
- the number of referrals to addictions programs

ASK Wellness is currently developing measures to track the impact of its employment programs.

Success is also measured through anecdotal evidence that clients' health and lives are improving as a result of their involvement with a health navigator.

For more information on the evidence that supports health navigation in HIV care more broadly, please consult Health Navigation: A Review of the Evidence.

## Learned and Confirmed

1. **Provide housing first**. Housing people at risk of homelessness or who are homeless is the first step in the journey toward health. People who experience periodic homelessness may not be able to address complex chronic conditions when they do not have a stable place to live.
2. **Engage intensively in the first six months.** Navigators work intensively with clients in the first six months to stabilize them. This period also allows navigators and clients to get to know one another and build strong, trusting relationships. In the long term, this strong relationship is the foundation on which many clients build their health and well-being.
3. **Provide a non-judgemental support system.** Health navigators provide a non-judgemental support system to clients who feel they do not have access to appropriate and responsive health and social services. This increases clients' engagement in care and has reduced the need for many clients to access emergency care.

4. **Build strong networks.** Health navigators must spent significant time connecting with physicians, services providers, landlords and other community members to ensure that they have strong, responsive connections that allow clients to access services when they are needed.
5. **Use a self-management approach.** Using a self-management approach to achieving client goals shows the client their own abilities and builds their confidence. Helping clients achieve more independence reduces the burden on the health navigator and also reduces the cost to the healthcare system of chronic illness.
6. **Be flexible in client care.** Each client's personality, history and needs are different and health navigators must demonstrate an ability to meet each client where they are on their journey and offer tailored support so that they can achieve their goals.

## Program Materials

- Intake form (http://www.catie.ca/sites/default/files/Intake Form.pdf)

## Other Useful Materials

### Information found on the CATIE website

- CATIE Forum Webcast on Health Navigation (http://www.catie.ca/en/forum/webcast-archive/concurrent-session-3)
- Treatment (http://www.catie.ca/en/treatment)
- Healthy Living (http://www.catie.ca/en/healthy-living)

### Resources

**Optimizing Entry Into and Retention in HIV Care and ART Adherence for PLWHA: A Train-the-Trainer Manual for Extending Peer Educators' Role to Patient Navigation**
2012, International Association of Providers of AIDS Care (IAPAC), National Minority AIDS Council
Guidelines and manuals
English
More information (http://www.catie.ca/en/resources/optimizing-entry-and-retention-hiv-care-and-art-adherence-plwha-train-trainer-manual-exten)

**Building Blocks to Peer Program Success: A toolkit for developing HIV peer programs**
2009, Peer Education and Evaluation Resource (PEER) Center
Guidelines and manuals
English
More information (http://www.catie.ca/en/resources/building-blocks-peer-program-success-toolkit-developing-hiv-peer-programs)

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Decisions about particular medical treatments should always be made in consultation with a qualified medical practitioner knowledgeable about HIV- and hepatitis C-related illness and the treatments in question.

CATIE provides information resources to help people living with HIV and/or hepatitis C who wish to manage their own health care in partnership with their care providers. Information accessed through or published or provided by CATIE, however, is not to be considered medical advice. We do not recommend or advocate particular treatments and we urge users to consult as broad a range of sources as possible. We strongly urge users to consult with a qualified medical practitioner prior to undertaking any decision, use or action of a medical nature.

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