



Peer Navigator Program

Interim Evaluation Report

April 1, 2011 to May 31, 2012

**POSITIVE
LIVING
SOCIETY** 
OF BRITISH COLUMBIA



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Table of Abbreviations

10C	10C, the HIV ward at St. Paul's Hospital
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy (can also be abbreviated as ARV)
BC	British Columbia
BCCDC	British Columbia Centre for Disease Control
BCCfE	British Columbia Centre for Excellence
DTES	Downtown East Side
CD4	Cluster of Differentiation 4, is a marker to identify a type of human T helper cell
HCP	Health Care Provider
HIV	Human Immunodeficiency Virus
IDC	Immunodeficiency Clinic at St. Paul's Hospital
POC	Point of Care HIV Test
PHC	Providence Health Care
PLBC	Positive Living British Columbia
PN	Peer Navigator
pVL (VL)	Plasma Viral Load
STOP	Seek and Treat for Optimal Prevention of HIV/AIDS Project
VCH	Vancouver Coast Health (Authority)

Executive Summary

This report provides an analysis of the Positive Living Society of BC (PLBC) Peer Navigator (PN) program. Results were reported from the PLBC Peer Navigator Coordinator in quarterly reports to the STOP HIV/AIDS Project Evaluation Team.

In 2011, PLBC developed and launched PN services for people living with HIV who are newly diagnosed, those re-engaging, or those at risk for falling away from care, treatment and support. PN services are designed to help people living with HIV learn about living with the virus, support them as they enter and stay in care, adhere to treatment protocols, and improve their quality of life.

The Peer Navigators work as an integrated part of a multi-disciplinary team within the STOP HIV/AIDS Project. The STOP Project is a four-year pilot project funded by the Ministry of Health in Vancouver Coastal Health and Northern Health to improve the quality of life for people living with HIV by linking them to care and supporting them to stay in care. STOP also aims to reduce new HIV infections by implementing routine testing for HIV in primary care and expanding public health follow-up where new cases are found.

PN work in tandem with a clinical team comprised of nurses, social workers, and physicians to support clients improve self-management of HIV and improve their linkage and retention in medical care. More specifically, PN work within the Immunodeficiency Clinic (IDC) clinic and 10C Acute Care at St. Paul's Hospital, share clients with the STOP HIV/AIDS Outreach Team Case Managers, and receive client referrals from other AIDS Service Organizations in the community.

Some of the accomplishments of the program include:

- 83% clients rating their PN visit as “excellent” or “very good”
- 67% clients reporting increased knowledge
- 63% clients reporting increased confidence
- Qualitative surveys from internal and external agencies report good working relationships and positive impact of PN on clients
- 79% clients with suppressed (<200) viral load (VL) at post measurement, representing an increase from 40% at referral, an indicator of treatment adherence

Recommendations for future improvements include:

- Expanding the number and range of practices/sites that benefit from the role of PN to ensure we are supporting the patients with the highest need and providing required resources for practices to increase their number of patients for whom they are providing HIV primary care.
- Expanding self-management tools to other languages
- Improved communication and training for staff about the role of PN in interdisciplinary team
- Increase involvement of PN with IDC clinic through rounds, appointment attendance with clients, and sharing of resources
- Review reporting and evaluation tools to improve efficiency

Overall, the PN program at PLBC has been highly successful at helping clients and improving care through interdisciplinary teams. It is recommended that the program be continued and the recommendations above be implemented in future.

Program Overview

No one understands the reality of HIV better than someone who lives with it every day. Peers – specially trained members of the community who are living with HIV/AIDS – have the power to serve as an important role model to others who are learning to cope with the daily challenges of living with HIV. At its foundation, Peer Navigation is an experientially based model that involves listening to clients, from a place of having similar lived experiences, to help clients develop a healthy HIV identity and to improve their self-management skills in relation to their health and care.

In 2011, PLBC developed and launched Peer Navigation services for HIV-positive people who are newly diagnosed, those re-engaging, or those at risk for falling away from care, treatment and support. Peer Navigation services are designed to help people living with HIV learn about living with the disease, support them as they enter and stay in care, adhere to treatment protocols, and improve their quality of life.

The Peer Navigators work as an integrated part of a multi-disciplinary team within the STOP HIV/AIDS Project. The STOP Project is a four-year pilot project funded by the Ministry of Health in Vancouver Coastal Health and Northern Health to improve the quality of life for people living with HIV by linking them to care and supporting them to stay in care. STOP also aims to reduce new HIV infections by implementing routine testing for HIV in primary care and expanding public health follow-up where new cases are found.

PN work in tandem with a clinical team of nurses, social workers, and physicians to support clients improve self-management of HIV and improve their linkage and retention in medical care. More specifically, PN work within the Immunodeficiency Clinic (IDC) clinic and 10C Acute Care at St. Paul's Hospital, share clients with the STOP HIV/AIDS Outreach Team Case Managers, and receive client referrals from other AIDS Service Organizations in the community.

Peer Navigator program goals are to:

- Reduce forward HIV transmission;
- Delay disease progression;
- Promote the value of care, treatment and support;
- Improve the transition and length of time between diagnosis and uptake of community supports and clinical care; and
- Increase the number of HIV-positive people accessing peer supports.

Originally conceived as an HIV self-management workshop series for gay men, the pilot project evolved into a series of one-to-one educational and supportive discussions for anyone newly diagnosed with HIV or re-engaging in their HIV care. With funding support from Vancouver Coastal Health and Providence Healthcare as part of the STOP HIV/AIDS Project, the PN project was asked to create two distinct but interconnected types of PN: Clinic Peer Navigators and Outreach Peer Navigators.

Clinic Peer Navigators

As members of the interdisciplinary health care team at the Immunodeficiency Clinic (IDC) of St. Paul's Hospital and 10C Acute Care, Clinic Peer Navigators foster trust in the health care system of St. Paul's Hospital. A community-based peer's presence in a busy clinic or hospital helps close the gap and provide immediate access between health care providers, patients, and community programs.

Clients are assisted in navigating the sometimes intimidating world of HIV treatment and services by providing a range of support activities that include:

- Providing emotional support and explaining the basics of HIV/AIDS;
- Preparing clients to be "Antiretroviral (ART)-Ready" by promoting the value of ART therapy and helping them understand how ART works;
- Promoting the value of self-care in supporting long-term health outcomes;
- Connecting both 10C and IDC patients to appropriate community services outside the hospital setting;
- Assisting with appointment reminders to ensure patient engagement;
- Promoting patient-centred care and the value of the physician/patient relationship, including accompanying clients (when asked) to appointments within the clinic;
- Helping clients transition out of 10C and into IDC or an outside clinic;
- Assist with the intake process at IDC;
- Support out-of-town IDC patients who are isolated from the HIV community and unfamiliar with Vancouver;
- Encourage harm reduction strategies for HIV transmission prevention.

Outreach Peer Navigators

Teaching self-management skills is different for this type of Peer Navigation. Outreach Navigators engage unstable, vulnerable people (those with mental health or addiction issues) in their own environment (usually hotels, recovery homes, or shelters), building trust, helping people stabilize and mobilizing them back or into existing healthcare and community services. Outreach Navigators use a therapeutic relationship model to engage clients at the social and cognitive level they are currently at and at a pace they are comfortable with.

Outreach Navigators also help clients navigate the oftentimes intimidating world of HIV treatment and services by providing a range of support activities that include:

- Providing emotional support and low literacy basics of HIV/AIDS;
- Preparing clients to be "ART-ready" by promoting the value of ART and helping them understand how ART works and the importance of stability;
- Promoting low threshold self-care strategies to support long-term health outcomes,
- Supporting behaviour change, including addictions counselling, recovery, and mental health supports;
- Promoting social responsibility and improved communication skills, fostering client independence, improved interactions and accountability;
- Encouraging harm reduction strategies for the prevention of HIV transmission and the prevention of other infections and diseases.
- Accompaniments to medical appointments and social supports

In addition to working directly with HIV-positive individuals, Outreach Navigators assist the STOP Outreach Team by attending Rapid Testing community events to promote the value of getting tested for HIV. This includes, breaking down myths about living with HIV, promoting the value of outreach nurses to respond to non-HIV client health needs, and being available to support someone should they test HIV-positive at the event.

Facilitating Self-Management Discussion Groups

Self-management education research has shown that programs with successful learner outcomes can include one-to-one learning and ongoing group reinforcement¹. This research unequivocally supports the value of peer-to-peer learning at HIV or recovery discussion groups. Having a peer in a leadership role in a discussion group demonstrates a clear understanding that the life experience of peers and their deep understanding of group members' struggles will have a positive impact on the overall outcomes of the group and its individuals. The PN program provides group facilitation for four different HIV groups in Vancouver; 10C, IDC, PLBC and YouthCO AIDS Society.

For many, attending group situations alone can be a significant barrier to accessing support. To address this barrier, PN accompany clients to HIV discussion groups at PLBC, YouthCO, the Women's Health Collective and the Pender Clinic in the Downtown East Side (DTES), as well as recovery groups at Three Bridges and the Roundhouse Community Centre, and the lunch program at Positive Women's Network. Clients attending groups include those referred from the STOP Team, St. Paul's IDC Clinic and HIV ward (10C), PLBC as well as clients who self-refer.

Working collaboratively with other health care and wellness providers

The range and complexity of factors that influence health and well-being, as well as HIV disease and illness, requires knowledgeable people from diverse health professions to work together in a comprehensive manner.

HIV-positive people require diagnosis of health problems, access to treatment, and health information. In addition to their health needs, they require allied health support for behavioural change, prevention information, support accessing community programs, referrals, self-management plans and access to HIV-positive people with experiential knowledge and insight into living with HIV. By including PN as part of an interdisciplinary team, combined knowledge and skills provide a powerful mechanism to enhance the health of the HIV population.

The importance of clients' privacy is well known. PLBC has been a long time community leader in maintaining the privacy rights of the HIV community. All PN sign confidentiality agreements for both PLBC and Vancouver Coastal Health (VCH). Navigators are extensively trained on issues of privacy, PLBC policies, and how to work within a Continuity of Care framework.

As stated above, PN are part of an interdisciplinary team and are closely linked with the IDC clinic and 10C Acute Care at St. Paul's Hospital, including taking part in patient rounds. PN have an established office space within that clinic where they are able to meet with clients receiving PN services.

1. Alberta Health Services. (2009). *The Peer Educator Model for Health Promotion: Literature Review*. Calgary, Alberta: Alberta Health Services.

Evaluation Design

Logic Models

Logic models were created listing the inputs, activities, outputs and expected program outcomes for services offered through VCH and PHC (IDC and 10C). Due to the short-term nature of the current project funding expiring on March 31, 2013 only the short-term outcomes listed are being measured. The two logic models are appended (Appendix A).

Key evaluation indicators

Table 1

Output indicators
Number PN hired and completed the training
Individual client description: <ul style="list-style-type: none"> referred by referral source client characteristics (age, gender, Aboriginal, exposure category) newly diagnosed clients (within last 3 months) clients reengaging after fall from care clients at risk for falling off care or meds
Individual client services provided: <ul style="list-style-type: none"> enrolled and received a needs assessment clients referred to each partner agency client referred to key programs individual sessions held clients accompanied to appointments
Group services provided: <ul style="list-style-type: none"> groups held by location group attendance by location
In collaboration with STOP Team, IDC/10C: <ul style="list-style-type: none"> clients linked to HIV medical care

Table 2

Outcome indicators
Peer Navigators: <ul style="list-style-type: none"> have increased knowledge to provide HIV self-management support have increased self-confidence to provide HIV self-management support
Individual clients: <ul style="list-style-type: none"> have increased knowledge of HIV have increased self-confidence to manage HIV are satisfied with PN services/have improved HIV journey have decreased or suppressed VL have increased CD4 count
Partnerships: <ul style="list-style-type: none"> STOP team, IDC/10C and partner agency staff are satisfied re: coordination and collaboration with Peer Navigation team

Methods

Data collection

Data was reported in June 2012, with information on clients seen from March 2011 to the end of May 2012. The data on client characteristics, navigation services offered and their self-management and health outcomes were collected by the PN team. The data relating to individual clients were entered into Excel, while other data on outputs were reported using a template in Word document.

Client satisfaction data were collected using several approaches:

- Short survey filled-out by drop-in clients at IDC and returned in a box located in the waiting room;
- Focus group facilitated by IDC/VCH staff during a client group at PLBC; or
- Short individual in-person or telephone interviews with IDC case managed clients receiving PN services conducted by IDC staff.

Further, IDC staff contacted key IDC physicians through email or in person to collect satisfaction feedback. Lastly, an interdisciplinary staff focus group was held with members of the PN team, STOP Outreach team, IDC, and 10C staff at St. Paul's Hospital. The focus group was facilitated by the STOP Project Evaluation Team and an IDC clinician.

Data analysis

The individual client data were analyzed using SPSS V19. In addition to the 137 individual clients for whom a full set of data were available, there were another 11 clients who were referred and were excluded from the reporting for the following reasons: 1. did not meet criteria for the program (2 clients); 2. moved out of catchment area (4 clients); 3. failed to engage with navigation services due to severely unstable behaviour (5 clients).

Since clients were referred, their needs assessed and engaged throughout the reporting period, a pre/post analysis was conducted on changes in CD4 count and VL based on the laboratory results at intake and the latest laboratory results available for each client, regardless of the time elapsed between the two tests. Only the 100 clients with two or more laboratory results reported were included in these analyses to determine if any statistically significant changes had occurred.

Some data elements (e.g. regarding group attendance and process) were computed by the Navigation Coordinator as part of the reporting process to STOP Project.

Results and Discussion

Peer Navigator Staff Training

There were six navigators hired throughout the reporting period. They were trained to provide navigation support and all reported increased knowledge and self-confidence to provide HIV self-management support as a result of their training.

Individual Client Group Description

There are 137 clients who have become engaged with the navigation team for whom data were available, analyzed and are reported.

1. Referral source

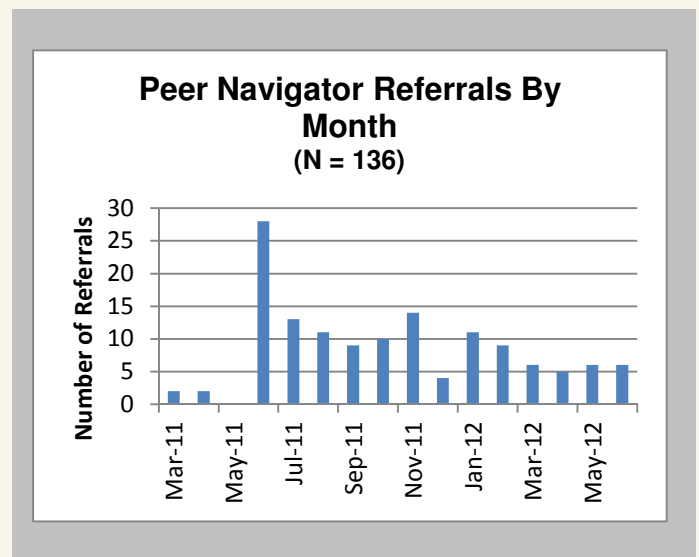
Table 3

Source Name	N	%
PHC IDC	71	52.0
VCH STOP Team	32	23.5
Self-referred	14	10.0
PHC 10C	11	8.0
Community Agency	4	3.0
VCH Community Clinic	2	1.4
Prison	1	.7
Private Therapist	1	.7
Vancouver Native Health	1	.7

The majority of individual clients were referred by PHC IDC or the VCH STOP Team. The PN started working with the 10C patients later in the evaluation period who are now regularly making referrals. PLBC has also been letting their own members and community agencies know about the program and several appropriate clients were referred through this route.

2. Referrals timeline and length of PN services

There were 136 clients with a known date of referral. The first months of the program were focused on hiring and training the staff, then liaising with partner organizations to identify appropriate clients. June 2011 was the month where most referrals were made as the PN were building their initial client load.



As of the last reporting period ending on May 31st 2012, the length of stay in the PN program varied as follows.

Table 4

Months since intake	N clients	%
0-3	44	33
4-6	29	22
7-9	33	25
10-13	27	20
Missing data	4	--

Results and Discussion

3. Reason for referral/client needs

Table 5

Reason for referral	N	%
New HIV diagnosis	65	47
At risk of falling from care	37	27
Reengaging after falling from care	35	26

The HIV self-care curriculum offered by PN was initially conceived to provide support for the newly or recently diagnosed and those interested in better understanding how to self-manage living with HIV. As the program was implemented, a need for working as part of an interdisciplinary team with IDC and STOP clients that were being case managed (to support reengaging in care or strengthening their link to care) was identified.

4. Client Demographics

Table 6

Characteristics	N	%
Gender		
• Male	115	84
• Female	22	16
Age Group		
• 19 or less	0	-
• 20-35	47	35
• 36 and over	87	65
Self-identifies as Aboriginal	24	17
Exposure category		
• MSM	75	55
• IDU	37	27
• Heterosexual	17	12
• Unknown	21	15

The individual client demographics are largely representative of the overall population living with HIV. A 0.25 full-time equivalent (FTE) female outreach PN with an expertise in working with women with addictions was promoted to 1FTE some months after the beginning of the program. This was instrumental in providing enhanced outreach support for appropriate female clients with addictions.

Individual Client Services Provided

1. Referrals to key partner agencies/programs

Table 7

Agency Name	N	%
AIDS Vancouver	43	31
IDC Mental Health	35	25
IDC Addictions	33	24
YouthCo	29	21
Dr Peter Centre	14	10
Positive Women's Network	13	9
Vocational Rehabilitation	6	4

The clients' needs were assessed and referrals made as appropriate. The key partner agencies identified based on client needs are those that can provide support and/or facilitate overcoming barriers to self-care

Link to medical care: during the initial assessment, the PN determined whether each client was linked to a medical care provider and made referrals as appropriate. All 137 individual clients are linked to medical care for their HIV.

Results and Discussion

2. Individual curriculum sessions held

There were 117 clients who were deemed suitable for the curriculum, among these 106/137 (77%) clients participated in one or more individual self-management sessions. At the time of report writing there were 34 clients who had completed the curriculum.

Table 8

Session Frequency	N	%
1-5	65	61
6-10	35	33
11-30	6	6

3. Clients accompanied

There were 43 clients who accepted accompanied to health care appointments or to new programs they were being referred to. These are marginalized clients who are at risk of falling from care. The number of times a client was accompanied varied between 1 (4 clients) and 100 (1 client).

Table 9

Frequency	N	%
1-10	27	63
11-20	8	19
21-30	5	12
31 or more	3	6

4. Level of engagement with PN services

The level of engagement varies over time based on client need. A score was given based on the current visit frequency. Some clients have been discharged but are free to re-engage at any time should they feel a renewed need for support.

Table 10

Current visit frequency	N	%
Weekly	51	37
1-2 times per month	32	24
Every three months	47	34
Discharged	7	4

There were six clients who were lost to PN services for a period and then became re-engaged.

5. Clients attending one or more groups

There are 44 clients who attended one or more navigation support groups in addition to getting individual support as follows:

- PLBC group: 23
- YouthCO group: 11
- 10C group: 7
- IDC group: 6
- Positive Haven group: 3

“The Peer Navigators help newly diagnosed people accept that they are HIV-positive and move on toward taking care of themselves. They make us accountable for our own health.”

Results and Discussion

Individual Client Outcomes

1. Client knowledge and self-confidence, ART readiness

There are 120 clients (88%) who have specifically indicated that they were hoping to enhance their capacity for self-care by working with a PN. Twelve did not indicate that this was a goal for them while five had not reported their intention yet.

There are 126 clients with known measures assessing whether working with the PN increased their level of knowledge regarding HIV self-care and level of self-confidence to manage HIV. The results are as follows.

Table 11

HIV self-care capacity	N	%
Increase in knowledge		
• Yes	85	67
• No	41	33
Increase in confidence		
• Yes	80	63
• No	46	37

Many of the clients who have not reported a change are still in the process of learning how to self-manage so the number reporting an increase will likely go up over the upcoming reporting periods.

These are subjective measures reported by the PN based on their assessment of the client's knowledge and improvement over time.

There are 123 clients (90%) who are considered to be ART-ready by the PN. This means that the client:

- **Knows what ART does;**
- **Understands what CD4 count and viral load mean;**
- **Knows when is an appropriate time to go on ART and to discuss that with their physician;**
- **Is emotionally ready to deal with potential issues related to being on ART.**

Client Story – “Alex”*

**All names have been changed in Client Stories*

“Alex” is a 26 year old male living in a rural community. He is a patient at St. Paul’s IDC and sees the Peer Navigators during his Vancouver visits. Due to his location, he is highly isolated and has almost no access to HIV information in his community. Privacy and personal safety are issues for him. Alex first presented in hospital in 2011. He was newly diagnosed with acute HIV and a VL of over 1 million. He started ART immediately. A Peer Navigator worked with Alex to help him develop an HIV identity separate from his presenting illnesses. He took well to all the learning modules and attended the discussion group at PLBC. Having a Peer and attending the group are his only opportunities to interact with HIV-positive people. The Peer Navigator was able to find a Public Health Nurse in a nearby community, who was willing to take on Alex’s secondary health concerns, keeping his HIV private and work with IDC staff for consults. Currently, Alex’s CD4 is 240 and VL is undetectable. Alex and his Peer Navigator keep in touch by phone between visits.

Results and Discussion

2. Client viral load (VL)

There are 131 clients for whom VL data is available at intake. Their VL category is outlined in the table below based on the team referring them to the PN program. The VL at intake varied from < 40 (undetectable) to above 1 million.

Table 12

Referral Agency	VL at referral			Total referred
	≤ 200	201-999	≥ 1000	
PHC IDC	28 (21%)	5 (4%)	35 (27%)	68
VCH STOP Team	8 (6%)	8 (6%)	14 (11%)	30
PHC 10C	5 (4%)	1 (1%)	5 (4%)	11
Prison	1 (1%)			1
Self-referred / community agency	8 (6%)	3 (2%)	10 (8%)	21
Total by VL category	50 (38%)	17 (13%)	64 (49%)	

One of the criteria for client selection was to target those who had a measurable VL over 200 (e.g., newly diagnosed, needing to start or re-start on ART) and 62% of the individual client sample met this criteria. Others were at risk of falling off care as illustrated in Table 12.

There are 100 clients for whom VL data is available at intake and at a post period (at least three months) after the start of their involvement with the PN program. A cross-tabulation of their results appears in Table 13 below.

Client Story – “Rena”

Rena is a female, reengaging in care and was referred through the STOP Team as one of the first outreach clients. During the time that Rena worked with a Peer Navigator, she lost housing a number of times and tried (and failed at) addiction recovery repeatedly, attempted suicide, and continued to work in the sex trade industry. She is now stabilizing and her work in the sex trade has decreased. She is in recovery and her suicide attempts have stopped and her addiction behaviour has decreased. This was a very difficult client to work with and a Peer Navigator worked closely with the STOP Outreach Team to support her. No one gave up on her. She is now on meds with CD4 of 320 and undetectable VL (down from 200,000 when we first met her). Rena has had 15 accompaniments in the last term which has decreased from 48 accompaniments in the previous term. To date she has completed four modules on HIV self-management.

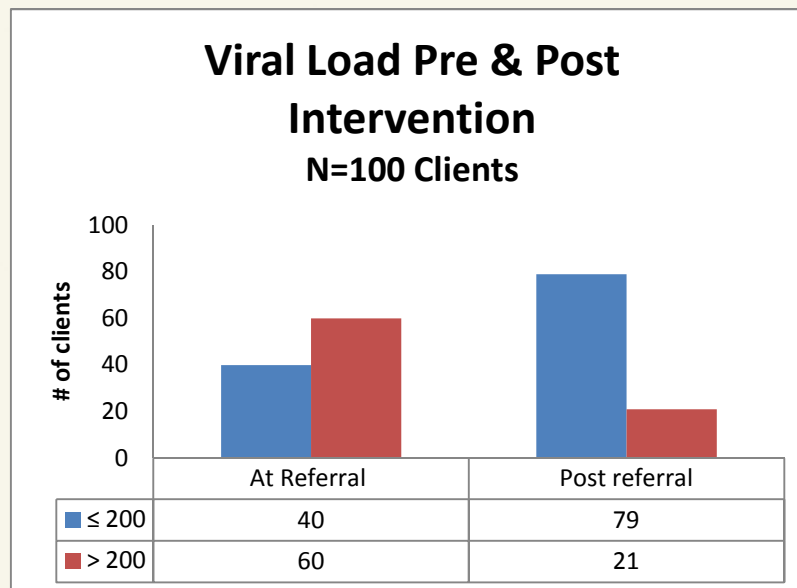
Results and Discussion

Table 13

VL at referral	VL at post		
	≤ 200	201 - ≥ 1000	Total at Referral
≤ 200	38	2	40 (40%)
201 - ≥ 1000	41	19	60 (60%)
Total at Post	79 (79%)	21 (21%)	100 (100%)

While 60 (60%) clients did not have VL <200 at referral, 40 (40%) were suppressed at the post period. Two clients had an increased VL from suppressed to above 1000 at the post period.

Figure 1. Client Viral Load



A statistical analysis was conducted to determine if there were any significant differences in the VL over time. The mean viral load decreased over time and this difference was statistically significant ($p < .03$, $t = 2.2$). The decrease in VL cannot be said to be caused by participation in the PN program, and the reduction may have happened even if they were not enrolled with PN. However, for these clients at this time their VL has statistically decreased showing an improved health outcome. This indicates that in collaboration with the health care and case management teams, the PN services have supported clients to achieve a suppressed viral load.

Results and Discussion

3. Client CD4 count

There are 129 clients whose CD4 at referral is available. Among these, as reported Table 14 below, there were 24 (19%) who met the clinical criteria for AIDS diagnosis ($CD4 \leq 200$).

Table 14

Reason for referral	CD4 at referral				Total referred
	≤ 200	201-500	501-800	≥ 801	
New HIV diagnosis	12	26	17	5	60 (46%)
At risk of falling from care	7	16	11	3	37 (29%)
Reengaging after falling from care	5	13	11	3	32 (25%)
Total by CD4 category	24 (19%)	55 (43%)	39 (30%)	11 (8%)	

There are 98 clients with a CD4 count available at intake and at a post period (at least three months) after the start of their involvement with the PN program. A cross-tabulation of these results appears in Table 15 below. There were 41 clients (42%) whose CD4 count improved to a higher range during their involvement with the PN program. There were four (4%) clients whose CD4 count decreased to the AIDS range.

Table 15

CD4 at referral	CD4 at post				Total at Referral
	≤ 200	201-500	501-800	≥ 801	
≤ 200	9	10	0	0	19 (19.3%)
201-350	4	12	8	0	24 (24.3%)
351-500	0	10	10	1	21 (21.3%)
501-800	0	4	14	8	26 (27%)
≥ 801	0	0	1	7	8 (8%)
Total Post	13 (13.3%)	36 (36.7%)	33 (33.7%)	16 (16%)	98 (100%)

A statistical analysis was conducted to determine if there were any significant differences in the CD4 count over time. The mean CD4 count increased over time from 447 to 537. This difference was statistically significant ($p < .01$, $t = 4.87$). The increase in CD4 cannot be said to be caused by participation in the PN program, and the improvement may have happened even if they were not enrolled with PN. However, for these clients at this time their CD4 has statistically increased showing an improved health outcome. This indicates that in collaboration with the health care and case management teams, the PN services have supported clients to achieve an improved CD4 count.

Results and Discussion

Group Services Provided

Groups held, location & attendance

Information on groups held was reported starting in the September to November 2011 period. The data available on groups is provided in Table 16 below. New group locations were added based on opportunities and requests from clients or providers. Clients who attend groups include those referred from the STOP Outreach Team, St. Paul's HIV Program as well as clients who self-refer to PLBC.

Table 16

Group Data	Apr 2011- June 2011	July 2011- Aug 2011	Sept 2011- Nov 2011	Dec 2011-Feb 2012	Mar 2012- May 2012
Number groups held					
• IDC	22	8	9	10	11
• 10C	--	--	3	10	12
• YouthCo	--	--	--	--	6
• PLBC	22	8	--	12	12

“Their knowledge comes from firsthand experience. They are role models who promote health and wellness...”

Results and Discussion

Client Satisfaction

1. Individual drop-in service client survey

Clients were very satisfied with the services they received giving mean ratings of 4.4 to 4.5 out of 5 (88%-90%). When rating their “visit today” 83% said it was “excellent” or “very good.” The help they received about any questions or concerns was rated by 88% of clients as “excellent” or “very good.” Qualitative responses showed that the most common reply to suggestions for improvement was that no changes are needed.

Table 17. Drop-in Navigation Support Survey Results (N = 18)

Question	Excellent	Very Good	Good	Fair	Mean
How was your visit today?	13 (72%)	2 (11%)	2 (11%)	1 (6%)	4.5
If you had any questions or concerns, how would you rate the help you received?	11 (61%)	5 (27%)	1 (6%)	1 (6%)	4.4

Table 18. Suggestions on Improvement

Suggestion Category	N
No changes needed (e.g., keep up the good work, they are great and understand us better)	6
Extend the weekend hours for drop-in services	2
Hold drop-in in a larger office	2
Add more navigators	1
Add some low level music	1

Client Story – “Ethan”

“Ethan” was referred to a Peer Navigator through the IDC. He was not on medication, had a very low CD4 count, high VL, and was unwilling to try ART. He was also dealing with addiction issues and was about ready to disengage from care. A Navigator worked with him to gain his confidence through daily visits to IDC and low threshold ART readiness education. A training program was established where daily phone calls were made to remind Ethan to take his “training” medication to test ART readiness and adherence. He agreed to go on ART and is attending a self-management group.

Results and Discussion

Nine clients of the PN program were interviewed by phone or in person over a six week period. All had been engaged with PN at some point during the past year and agreed to provide feedback on their experiences for the purposes of program evaluation. Of those interviewed, five had met with a PN immediately after testing positive and four met with a PN within the first year of testing positive.

The areas in which clients reported receiving assistance from a PN included:

- Support/counseling – crisis management (e.g. self esteem and acceptance, disclosure to family, friends and potential partners, family planning);
- Multiple strategies of support (e.g. on the phone, in person, listening and comforting, extending support to clients' partners, acting as role model, accompaniments to support groups);
- HIV Education (e.g. accurate and accessible information about HIV, medication, health and wellness planning, employment issues, strategies for self-management).

“They offer friendship and support to patients in need, are easy to relate to and are non-judgmental. I would be lost [if I hadn’t met PN].”

Clients reported positive changes in a number of areas of their lives since receiving support from a PN.

These changes include improved:

- emotional support to enable acceptance of HIV status, decreased feelings of depression/suicide, increased self esteem and confidence;
- knowledge of HIV self management and care in areas such as medication management (ART) as well as aging with HIV;
- social connections to family, friends and other positive people;
- overall health and wellness.

Client responses indicate that the PN services are perceived as a key component of the care they receive in the clinic. In addition to the themes listed above, clients also reported that the PN facilitated the use of other resources such as “bridging the gap” between client and clinician, as well as connecting clients to community resources and agencies.

Suggestions for improving the PN program in IDC included expanding access to services (e.g. increasing the number of navigators, space, hours, and providing services outside of the downtown core). It was also recommended that the navigators have a private space for one-on-one sessions, and that PN support become an ongoing, permanent component of IDC services.

Partner Organization Staff Satisfaction

Peer Navigator, STOP Team, IDC Collaboration

A focus group was conducted with PN, STOP Outreach Team, and IDC staff to discuss satisfaction with their collaborations and new ways of working together. Overall, all three teams were highly satisfied with the PN program and the collaborative work being done.

When asked, “What have been the positive changes for patients/clients in terms of the care and support they receive due to the new staff members and ways of working together?”, responses relating to PN programming centered on three themes. Four staff thought the PN were great at helping patients navigate the system of care, allowing them to learn about other services and become empowered to self-manage their health. Three staff noted that the networking between PN, IDC, STOP Team and other services allows for a quicker response, more complete continuum of care leading to better outcomes for clients. Two staff mentioned that PN are able to fill gaps in the healthcare system.

Staff were asked what challenges have arisen due to the new collaborative models of care across teams and what could be changed to improve collaboration. Two areas of concerns were noted: communication between the three teams, and language barriers in interacting with clients. The main communication concern was the inability to connect with staff members in a timely fashion due to changing schedules across the three teams. In general, the consensus was that the PN are easy for clients to contact and reach in a timely manner. With respect to the language that services are provided in, it has proven difficult to support clients with English as a second language due to the limited options for interpretation support. PN also emphasized that it is important to be sensitive to the cultural context in addition to overcoming language barriers. For these reasons, a navigator with Mandarin and Cantonese language skills was recently hired to increase client accessibility to different languages. Currently, the PN program has access to Arabic, Hebrew, Swedish, German and French speaking navigators and also has access to Spanish speaking HIV+ volunteers who can help with translation services as needed.

Many positive changes have occurred through working with other teams. Those mentioned include how easy it is to link clients to PN because they participate in rounds with other teams and help bring the community into the medical system. Flexibility is key and it has allowed clients to be connected immediately, for example, when doing outreach work on the street.

When asked what the main challenges are that have arisen out of this interdisciplinary collaboration, defining roles was the main topic. Sometimes duplicate work is done but the PN think this is hard to avoid as clients often elect to use many different services at the same time. The definition of roles and responsibilities for each team could be reviewed and improved. Overall, teams noted that this is currently a good system: “there is no territoriality or possessiveness over clients and the work is being shared.”

Partner Organization Staff Satisfaction

IDC Clinic Survey

Twenty-eight IDC providers were contacted by email to provide feedback on the PN Program on the following questions:

- Awareness of the PN Program at IDC over the past year
- Contact with a PN (referred patients, talked to PN about patients)
- Impact on clients who have been supported by a PN
- Ideas on how to improve the PN program at IDC

Sixteen team members including two dietitians, three physicians, four nurses, three pharmacists, and four social workers responded to this query offering their feedback and suggestions for improvement. The themes from respondents are summarized below:

Awareness of the PN Program

All respondents were aware of the PN program. PN were seen as valuable team members and an “important component of patient-centered care.” Respondents discussed their observations of PN work, which included the ability to build rapport with patients, provide linkages to community services, enhance opportunities for support and education during “waiting times,” work in a non-judgmental way with clients, work well with limited clinic space, and being flexible and accessible to clients – meeting clients on their own terms.

Experience during contacts with PNs

In describing their contact with PN, respondents gave numerous and diverse examples of how PNs had assisted IDC patients. All of the respondents indicated that they refer or introduce patients to the PNs. Nurses who provide orientation to new patients include the PN office in their orientation to the clinic. If the patient consents to more explicit collaborative work with professional staff, they may consult about challenging situations, act as translators or provide ESL resources for patients. Other collaborative work with professional staff includes facilitating group work and activities (e.g. community kitchen), assisting staff in finding patients who have not been in to the clinic, and being involved in post-test counselling after a positive result (in the case of point of care test being done on site). They were also described as being helpful to staff with regard to cultural sensitivity.

Observations about impact on client care

Generally, respondents reported that PNs have helped increase patient engagement in care and that they increase active participation in health promotion activities and harm reduction. Nurse respondents in particular noted that they had seen positive changes in functioning, health knowledge and emotional well being. From one RN:

“I have also noticed that it helps the patients feel connected to a community that the patients are not familiar with and may not have had before. It provides them a sense of belonging, especially with those with little/or no social support.”

Partner Organization Staff Satisfaction

Social connection/support

A social worker discussed the benefits of PN to patients living with depression and anxiety disorders. She notes the isolation and social disconnection that these patients typically experience and has seen the benefits of their supportive relationships with PN. Not only do these connections facilitate engagement in medical care, but they also help patients improve social skills and relate to people in ways that will improve their quality of life overall.

Connection to community resources

All of the nurse, dietician and social worker respondents discussed the ways in which PN connected patients to community resources. For example, many HIV-positive patients are in need of decent and affordable housing but may not have the knowledge, skills, or confidence to seek assistance. PN are knowledgeable about the resources and can therefore share information, but they also provide role modeling, support and confidence building that can enhance the patient's ability to pursue better options.

According to respondents, PN may have more success than professional staff in engaging patients in groups, meetings, community services—in part because they offer accompaniment and they serve as role models. [“For my clients, I have noticed better engagement in activities that support their own health and well being.”] This engagement “has helped improve their overall functioning and well-being and allowed them to access a greater range of community supports and services.”

Adherence to treatment

A pharmacist found the PN were able to help a patient discuss side effects in their interview and thought that this kind of experience helps promote adherence. The added perspective of a PN helped the patient understand that he was not alone in this experience, and that things would likely improve over time. Another team member consulted with PN who knew a patient well. They worked together to solve a problem related to her ART access and improved the likelihood that the patient would continue taking her medication.

Client Story – “Rob”

Rob was referred by Acute Care after receiving his diagnosis in the ER. He has Hep B and prognosis was not good. While in Acute Care, Rob took all curriculum topics, including “Talking to your Physician” which came in handy for him as he wanted to develop patient self advocacy skills while staying in Acute Care. He was untrusting of care, very private and had no contact with family or friends. Through daily visits and relationship building a Peer Navigator was able to bring him out of his shell and help him with his HIV identity. Rob received assistance with his discharge planning from Acute and transfer to a Primary Care Clinic. He attended a group session and now attends Positive Living on his own. Strong self-management skills developed and re-engagement with his family has begun. We were able to find him social housing through our own contacts. VL has dropped. CD4 is up. Kidney transplant was considered but has since been dropped as he is improving in all areas.

Conclusions

The PN program has reported on its operations over the past 14 months. The evaluation results demonstrate that clients have benefited from their participation in the program and from the close partnership/integration between PN and the clients' teams of health care providers. Further, the PN have assessed clients as having increased knowledge and confidence of how to self-manage HIV care.

During this period, the evaluation results have shown that the program has been successful in creating and building partnerships with PHC/IDC/10C and VCH/STOP Team staff as well as community agencies. As they gained more experience in assessing the needs of clients referred, the navigation staff adjusted the services offered to add new relevant components such as holding self-care groups in multiple locations, accompanying clients to appointments and to new services and drop-in services at IDC.

The Peer Navigators work closely with the IDC clinic and 10C Acute Care at St. Paul's Hospital. The most important part of this process was having clear communication between all parties involved to define roles and responsibilities. This included addressing issues of privacy and confidentiality, in terms of what information the PN are able to access about IDC/10C patients. Also important was ensuring the PN were visible to clients, accessible to the IDC/10C team, and had enough space to conduct their work. This led to the program receiving additional funding to hire more navigators to work at IDC and 10C at St. Paul's Hospital. There was also a designated space established in the IDC clinic for PN and they were incorporated into the 10C patient rounds.

Limitations

In terms of clinical indicators, CD4 count and viral load, there has been an improvement for clients between time of referral and time of reporting. For these individuals, there has been a significant improvement in their health. However, no causality can be inferred between participation in the PN program and improved health outcomes – these improvements may have happened even if clients were not receiving PN support. Rather, it can be said that in collaboration with the clinical care and case management teams, the PN services have been effective in supporting clients to achieve improved health outcomes.

Some indicators, such as client level of knowledge, confidence, and ART-readiness, were subjective measures reported by PN assessment of clients. With subjective measures there can be a potential bias leading to an overestimation of positive responses.

The PN success comes from the collaboration between Peer Navigators, physicians, social workers, and nurses at STOP and IDC/10C. As an interdisciplinary group, these professionals supported clients to become more knowledgeable and confident in self-managing their HIV and supported clients to achieve improved health outcomes. Thus, the PN program cannot be considered a stand-alone program, and needs to be part of an integrated team to be successful.

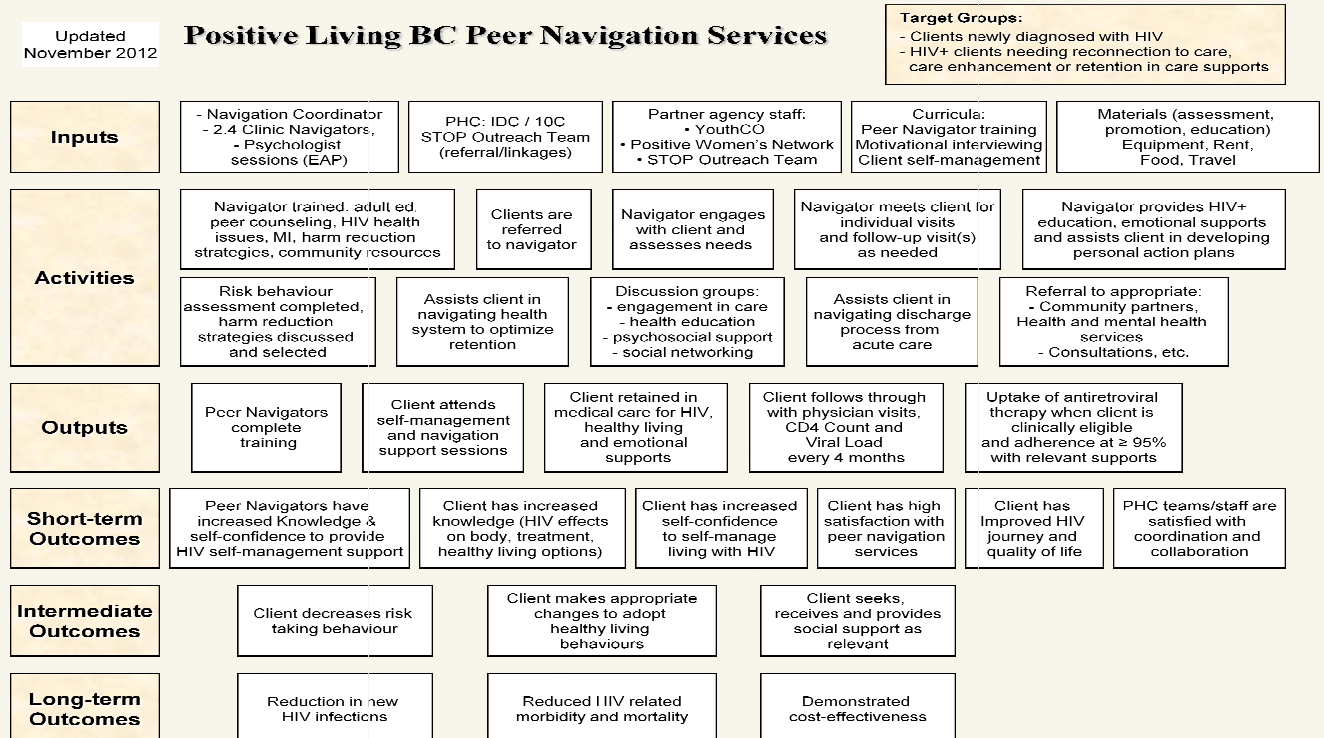
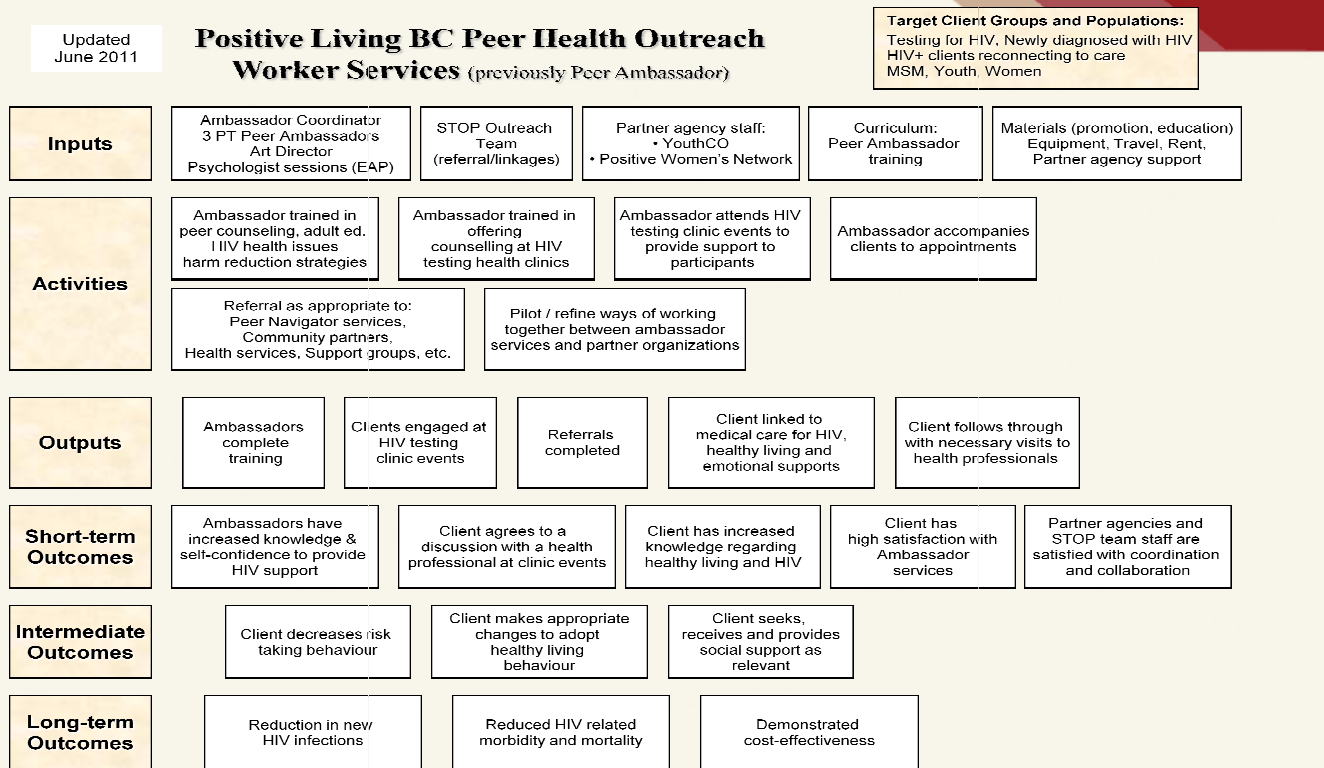
Recommendations

1. Expanding the number and range of practices/sites that benefit from the role of PN to ensure we are supporting the patients with the highest need and providing required resources for practices to increase their number of patients for whom they are providing HIV primary care.
2. Expand access to self management tools by translating them into other languages. Spanish & simplified Chinese were suggested based on current client needs.
3. Continue to provide information sessions to staff in partner organizations about ways of working with a PN and the PN role within an interdisciplinary team. Consider having the PN program introduced as part of orientation for new staff.
4. Review current evaluation data reporting requirements to streamline the number of indicators and data elements, selecting those most relevant for measuring key outcomes on an ongoing basis.

Recommendations 5 – 8 are specific to IDC Clinic:

5. Expand PN office space – respondents to the IDC clinic survey suggested that having a larger space would allow for more patient privacy.
6. PN should be part of the IDC quality improvement committee.
7. PN should post advertisements for support groups in the PLBC office waiting room and throughout the clinic to increase patient awareness.
8. The program should bring some of the resources from PLBC office to the IDC – e.g. housing listing.

Appendix A: Logic Models



Appendix B: Peer Navigator Training Syllabus

Core Training Topics:

1) Getting to know each other

- a) Who we are
- b) What we bring
- c) What we expect from the training

2) Overview of Positive Living BC

- a) History
- b) Structure
- c) Mission Statement, Vision and Core Values of PLBC
- d) Health Promotion Department
- e) Determinates of Health
- f) Self-management

3) Overview of The Peer Navigation Project

- a) How we got here
- b) Who are the players?
- c) What are Peer Navigators?
- d) Goals and Objectives
- e) Successes and Challenges
- a) Attending Groups and Group Facilitation

4) Being part of an Interdisciplinary Team

- a) Clinic Navigators
 - i. IDC/10C
 - ii. What is self management?
- b) Outreach Navigators
 - I. STOP Team
 - II. Events
 - III. Testing procedures
 - IV. Why is stabilization important?
- c) Other Agencies/Clinics
- d) Working within a Continuity of Care Framework
 - i) Privacy
 - ii) Key policies

5) What it means to be a Peer

- a) Meaningful Involvement of People Living with or affected by HIV/AIDS (MIPA)
- b) Code of ethics
- c) Readiness to be a peer
- d) Boundaries
- e) Triggers

Appendix B: Peer Navigator Training Syllabus

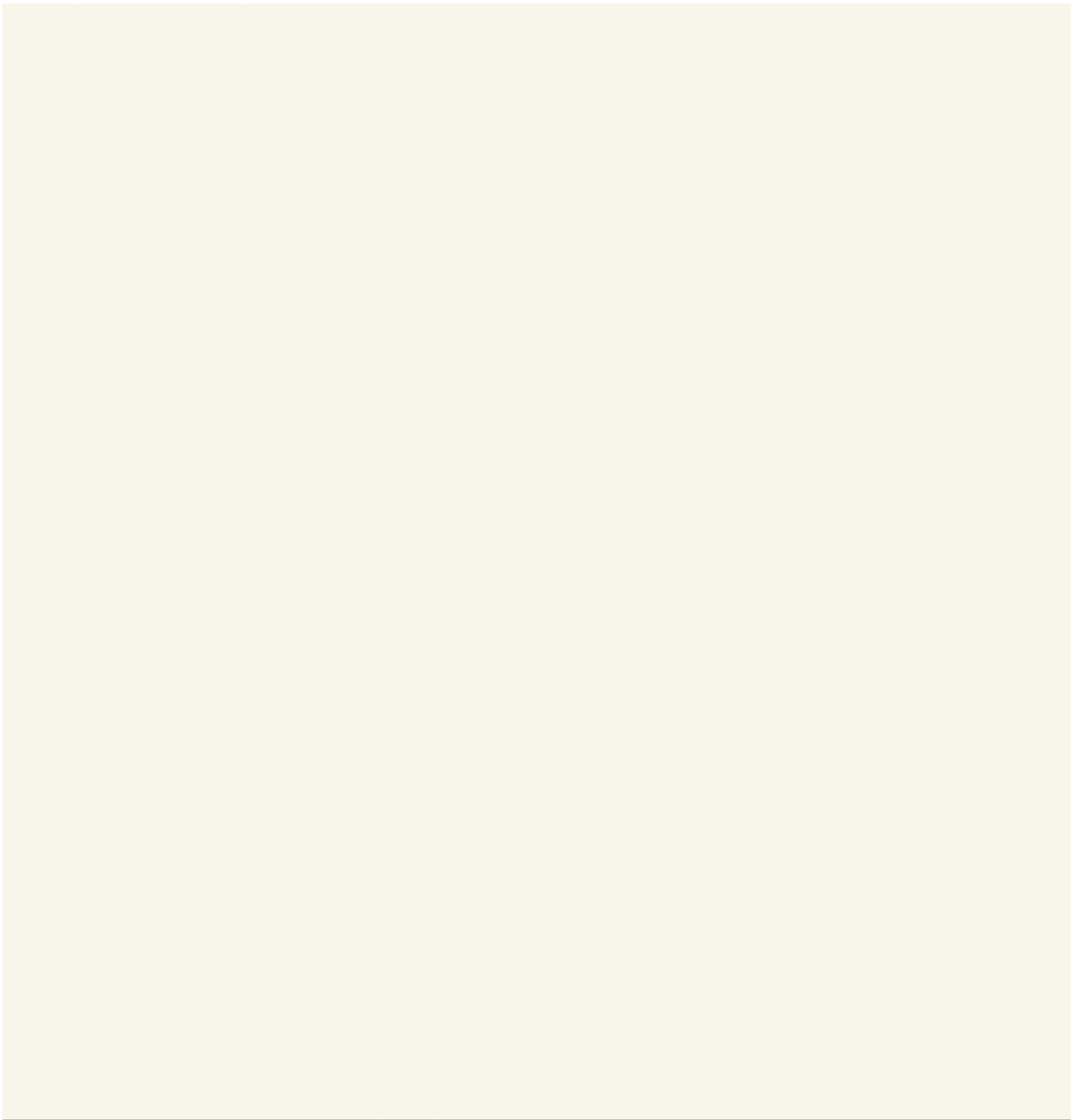
6) HIV Modules

Modules are divided into two parts. “Learning About It” and “Living With It”. In the “Learning About It” portions learners get the latest information on HIV. In the “Living With It” portions we give time to discuss what the session topic means to them in their everyday life. Peer Navigators are encouraged to learn through the lens of a newly diagnosed person as this information is what they will be teaching to their clients. With easy to understand presentations, Peer Navigators learn about and discuss:

1. First contact
2. HIV as an Episodic Disability
 - a) Compare and contrast the experience of living with HIV in the past and now
 - b) Define HIV as a lifelong, treatable “episodic disability”
3. Preventing Disease progression
 - a) Definitions
 - b) Learn the value of medications to prevent disease progression
4. The Life Cycle of the Virus
5. HIV and Treatment
 - a) When to start medication
 - b) Blood work
6. Side-effects of HIV and ART/factors that influence premature aging
7. Learn the transmission equation
 - a) Name the body fluids necessary to transmit HIV
 - b) Harm Reduction
8. Disclosure: telling others about your HIV and other legal considerations
 - a) Strategize ways in which to disclose your HIV status to others
 - b) Learn about your legal rights and responsibilities to disclose your HIV status
9. The value of self care when HIV-positive
 - a) Learn the value of good diet, nutrition and exercise to prevent progression to AIDS
 - b) Learn the value and cautions of complementary and alternative therapies
10. Patient Centred Care
 - a) The Doctor/Patient Relationship
 - b) Privacy and Continuity of Care

On-going Trainings

1. Computer skills
2. Shadowing other Navigators
3. Reflective listening with Bill Coleman
4. Developing Appreciative Inquiry/Strength-based conversations with Shelley Hourston
5. Transference and Counter Transference with Shelley Hourston
6. Being with someone when they receive catastrophic news with Paul Harris, BCCDC nurse
7. Empathy as a Tool with Bill Coleman (upcoming)
8. Harm Reduction for Addictions with VCH Harm Reduction Nurse
9. HIV Testing Options with STOP Team
10. Trans-theoretical Model of Behaviour Change
11. Tools for coping with challenges – positive tools for building and maintaining resilience with Shelley Hourston
12. Grief and Loss



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