



How patient navigators view the use of financial incentives to influence study involvement, substance use, and HIV treatment



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ABSTRACT

Background and aims: While patient navigation has been shown to be an effective approach for linking persons to HIV care, and contingency management is effective at improving substance use-related outcomes, Project HOPE combined these two interventions in a novel way to engage HIV-positive patients with HIV and substance use treatment. The aims of this paper are to examine patient navigator views regarding how contingency management interacted with and affected their navigation process.

Design: Semi-structured qualitative interviews.

Participants: 22 patient navigators from the original 10 Project HOPE study sites.

Measurements: Individual, semi-structured interviews lasting approximately 60 min addressed the patient navigator's professional background, descriptions of the participant population, substance use disorder versus HIV treatment entry and engagement issues, and the use of contingency management within the navigation service delivery protocol.

Findings: Patient navigators believed that financial incentives helped motivate participant attendance at navigation sessions, particularly early in study involvement, which helped them to establish rapport and develop relationships with participants. Patient navigators often noted that financial incentives positively influenced targeted HIV health-related behaviors, such as attending medical appointments, which provided a rapid pay-off with an escalating sum. Contingency management was more complex when used by the patient navigators for substance use-related behaviors, particularly when incentives revolved around negative urine screening. Patient navigators noted that not all participants responded the same way to the contingency management and that the incentives were particularly helpful when participants were financially strained with limited resources or when internal motivation was lacking.

Conclusions: Overall patient navigators found the inclusion of contingency management to be helpful and affective at influencing participant behaviors, particularly concerning navigation session attendance and HIV healthcare-related participation. However, issues and concerns surrounding the inclusion of contingency management for drug-related behaviors as delivered in Project HOPE were noted.

Clinical Trials Registration: [NCT01612169](https://clinicaltrials.gov/ct2/show/study/NCT01612169)

1. Introduction

Patient navigation is a patient-centered approach to care coordination that provides individuals with assistance to overcome barriers to receiving and adhering to health care. Patient navigation has

been effective in linking persons to HIV care (Craw et al., 2008; Gardner et al., 2005). Some people with untreated HIV concurrently have substance use disorders and may need additional assistance in accessing substance use treatment as well as HIV treatment (Bell et al., 2010; Gardner et al., 2016; Uhlmann et al., 2010).

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Contingency management is a system of delivering financial incentives to increase the frequency of desirable behaviors. It is effective in improving substance use-related outcomes, including promotion of abstinence (Lussier, Heil, Mongeon, Badger, & Higgins, 2006) and attendance at counseling sessions (Fitzsimons, Tuten, Borsuk, Lookatch, & Hanks, 2015; Sigmon & Stitzer, 2005). Among substance-using populations, the use of financial incentives has increased health-related behaviors, such as returning for medical test results (Malotte, Hollingshead, & Rhodes, 1999), completion of hepatitis B vaccine series (M. L. Stitzer, Polk, Bowles, & Kosten, 2010; Weaver et al., 2014), and promoting HIV-testing among disadvantaged populations (Saxena, Hall, & Prendergast, 2016). While incentives have been shown to be effective at increasing behaviors related to specific, short term outcomes, even with challenging populations such as HIV-infected patients with active substance use, they appear to be less successful over the long-term at increasing outcomes such as virologic suppression or adherence to a complex series of health behaviors, as are required for chronic disease management, especially once the incentives are removed (Bassett, Wilson, Taaffe, & Freedberg, 2015).

1.1. Hospital visit as opportunity for prevention and engagement for HIV-infected drug users (Project HOPE)

Project HOPE compared patient navigation with or without financial incentives to increase viral suppression among 801 HIV-positive patients with any opioid, stimulant, or heavy alcohol use within the past 12 months, recruited from 11 hospitals across the United States. Both patient navigation groups were hypothesized to be superior to a treatment as usual group. Viral suppression (≤ 200 copies/mL) relative to viral load non-suppression or death at the 12-month follow-up was the primary study outcome. Secondary outcomes included HIV health care engagement (e.g., HIV care provider visits, medication adherence), drug treatment entry, urine drug screens, and patient navigation intervention participation.

Patient navigation in Project HOPE consisted of up to 11 sessions over a 6-month intervention period. Under the ideal scenario, more frequent meetings would occur in the early post-hospital discharge period with diminishing frequency over time. However, if participants were doing well, the full 11 sessions were not necessarily required and conversely, for those with whom contact was temporarily lost and re-established during the intervention, more frequent sessions could be scheduled later in the 6-month intervention period. The harm-reduction-grounded patient navigation intervention incorporated motivational interviewing techniques along with strengths-based case management (Metsch et al., 2016). Participants randomized to navigation with incentives received the same 11 navigation session intervention with the addition of a contingency management program that provided financial incentives of escalating value for 7 pre-determined target behaviors, including: 1) attendance at navigation sessions; 2) completion of paperwork prerequisite to care (e.g., health insurance forms); 3) attendance at scheduled HIV care visits; 4) possession of a current HIV medication prescription (as a proxy for medication adherence); 5) attending substance use disorder treatment; 6) providing negative breathalyzer readings and drug negative urine specimens for opiates, oxycodone, methadone, cocaine, amphetamine, and methamphetamine; and 7) meeting viral suppression criteria. A total of \$1160 in possible earnings was available over the 6-month intervention (M. Stitzer et al., 2017), with health-related targets garnering half of the financial incentives, and patient navigation meeting attendance and substance use-related goals each accounting for one-quarter of the possible earnings. Project HOPE found that there were no differences between groups in viral load at 12 months follow-up (6 months after completion of the interventions); however, at 6 months participants in the patient navigation group with incentives were more likely to be virally suppressed and to have engaged in HIV care than participants in the treatment as usual condition (Metsch et al., 2016). Additional

secondary analyses that compared behavioral outcomes for patients receiving navigation with and without financial incentives have shown that those with incentives attended substantially more navigation sessions (M. Stitzer et al., 2017), and had more HIV care sessions and more validated medication prescription checks than those without incentives (M. L. Stitzer et al., 2018).

The current sub-study, conducted as part of the NIDA Clinical Trials Network, is an exploratory qualitative investigation of patient navigator views regarding the inclusion of contingency management in a navigation intervention with this high-need, seriously ill population. The advantages and disadvantages of combining these very different interventions were explored from the perspective of the patient navigators, who both provided the strengths-based intervention and implemented the contingency management program with their participants, including tracking of target behaviors and dispersal of incentive payments. The purpose of this paper is to examine navigator views as to how contingency management interacted with and affected the patient navigation process.

2. Methods

2.1. Data source

The 22 patient navigators from the 10 original Project HOPE study sites completed individual, in-person semi-structured interviews between April and September 2013. An additional site was added midway through the parent trial to increase recruitment but was not included in this qualitative subsample. Most interviews were conducted in the second year of Project HOPE recruitment to ensure that patient navigators had ample experiences delivering the contingency management intervention. However, length of time in the role and experiences delivering patient navigation services were diverse across the sample, with some having functioned in that capacity for over a year and others newer to the role having served in a different capacity (e.g., research assistant) in the study prior to becoming a patient navigator. All patient navigators completed an informed consent process. They were not paid directly for their sub-study participation, as their interviews were completed during normal business hours. This project was approved by the Johns Hopkins Medicine's Institutional Review Board.

2.2. Participants

The sub-study sample included all patient navigators working at the 10 sites at the time the interviews were conducted, with the exception of 4 navigators who were still new to the role (with limited experience or still in-training). Nineteen of the participants were full-time patient navigators with the remaining 3 splitting their time between administrative/research roles and patient navigation. Several participants were former Project HOPE research assistants who transitioned into navigator positions as they opened up. The sample included 16 females and 6 males, and the racial/ethnic composition was 64% African American, 9% Indian/Asian, 18% non-Hispanic white, and 9% Hispanic white. The training backgrounds of the patient navigators varied widely, ranging from some college education combined with prior outreach worker experience, through master's-level clinical degrees. Among the patient navigators, 10 possessed either some college or bachelor's degrees (often not in clinical or health-related fields) and 12 held master's degrees (2 in counseling, 3 in public health, 6 in social work, and 1 with a masters in a non-health field). Three patient navigators specifically mentioned possessing either outreach worker, health education, or addiction certifications.

2.3. Semi-structured interviews

All interviews were conducted by the lead author and lasted approximately 60 min, addressing the professional background of the

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