Navigating HIV Positive Clients to Care in an Urban Hospital

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Introduction

The communities that surround Sinai Health System rank as some of the poorest communities in the city of Chicago. Sinai is located on the Westside of Chicago and the areas surrounding it have some of the highest HIV incidence and prevalence rates and unmet need. The Chicago Department of Public Health released a report on the HIV/AIDS prevalence rate by community area showing that North (*where Sinai is located*) and South Lawndale, have HIV rates of 540.1-838.9/100,000, the Lower Westside has rates of 228.8-540.0/100,000, and East and West Garfield Park has rates of 839.1-1351.1/100,000. The Chicago Area HIV Integrated Services Council (also known as the Chicago metropolitan area's Ryan White Planning Council) designated the area that Sinai is located in as one of 4 clusters of high risk populations in Chicago (based on an HIV incidence of greater than 69.1/100,000/ annually). The high risk populations, based on primary mode of HIV transmission, identified by the Council in Sinai's surrounding zip codes are black, white, and Hispanic MSM's (including persons under 25 years of age), and black heterosexuals (in particular female under 25 years of age). As a result, Sinai has targeted community testing and interventions in these populations.

The National HIV/AIDS Strategy includes the goal of increasing access to care and improve health outcomes of people living with HIV and AIDS. The cascade, known as the Gardner Cascade, reveals that many people who are living with HIV are unaware of their status, are not successfully linked to care or stay engaged with care. At a time when ART is widely available and very efficacious, less than one third of people who are living with HIV are virologically suppressed. Sinai Health System has been providing HIV care for the last 16 years and has had ongoing issues with linkage and retention in care, similar to the findings in other institutions. Patient navigation has been a successful method to produce positive health outcomes in care models for cancer, HIV, diabetes and other chronic illnesses ii,iii,iv. Patient navigators support and offer guidance to person with HIV, help to overcome barriers and facilitate timely, quality care provided in a culturally sensitive manner. V They provide social support, assist in identifying barriers to care assist with making appointments and help determine which services are most needed. Vi Patient navigator and case manager roles are quite similar, but patient navigators prepare the patient for care and may accompany patients to first appointments while the case manager works more closely once the patient is engaged in care. We hired a patient navigator to help link newly diagnosed HIV positive patients into care and link patients who were known to be HIV positive, but not in care into regular HIV primary care. The results of the first 10 months are included here.

Methods

Mt. Sinai is a 350-bed, inner city, level one, trauma center and is the largest Medicaid Hospital in Illinois which has offered HIV testing through the emergency department for over 10 years and in 2011 began offering routine testing throughout the hospital. In November 2011, a Patient Navigator was hired to assist HIV positive patients with being linked to care at Sinai or another agency of their choice. Patients testing positive for HIV during the HIV Focus routine testing project (October 2011 – October 2012) at Mount Sinai Hospital or during an outreach activity were split into two groups: those who consented to work with a patient navigator (n=93) and those who refused navigation (n=56). Inclusion criteria were those patients that were HIV-infected individuals who were not fully engaged in primary HIV care or whom had fallen out of care. Outcomes for these two groups were compared for the following indicators of success related to linkage to care: initial laboratory tests performed (CD4 and viral load), first appointment made/kept, second appointment made/kept, and time from diagnosis to first appointment. Testing and laboratory data were retrieved from Sinai's patient record database, Meditech. Appointment information was determined from the infectious disease clinic's patient database, NextGen. The patient navigator's log and case notes in the medical record which documents her work with patients was used to determine which patients she had direct contact with and the activities performed on behalf of the patient. The tracking form for the navigator is below.

Results

Most patients consented to use a patient navigator. Persons living with HIV who worked with a patient navigator were 2.6 times more likely to schedule an infectious disease appointment then those who did not. Of the 93 patients working with a navigator, 65 (66%) had appointments set up at the infectious disease clinic and of the 56 patients not working with a navigator, 27 (48%) had appointments set up. Of the appointments set up for the 65 patients navigated, 42 patients (65%) attended at least one appointment in 3 months, and 32 patients (75%) attended at least two appointments in the time period. Of the appointments set up for the 56 patients not navigated, 22 patients (39%) had at least one appointment in 3 months and 18 patients (82%) had at least two appointments in the time period. Twenty-seven patients (30%) navigated were lost to follow-up versus twenty-nine patients (52%) who were not navigated.
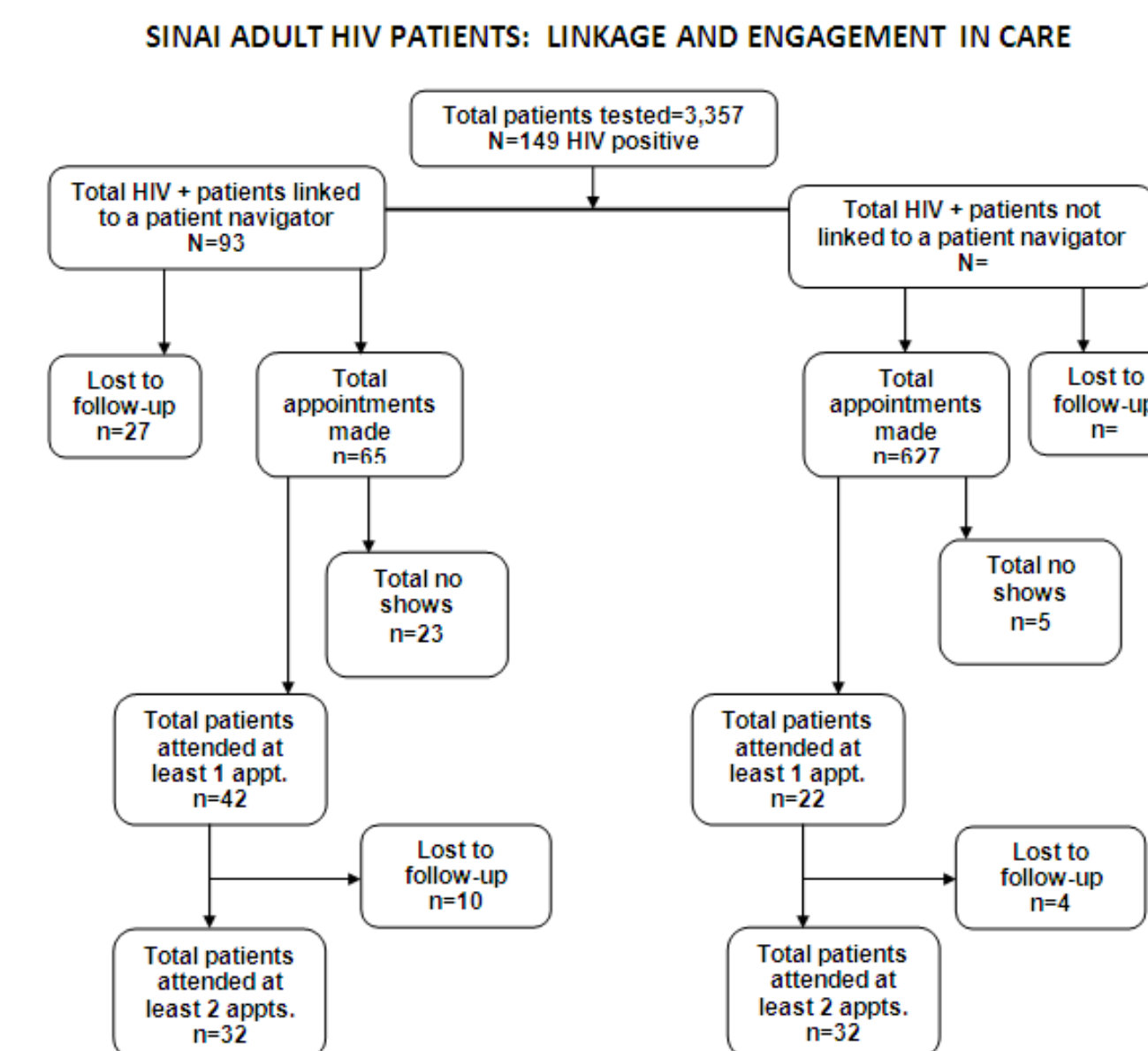

SINAI ADULT HIV PATIENTS: LINKAGE AND ENGAGEMENT IN CARE

Table 1. Characteristics of Patients Navigated and Not Navigated

Characteristics	Navigated		Not Navigated	
	Linked to Care (≥ 1 appointment in 3 months) N=42	No Appointment Set Up N=27	Linked to Care (≥ 1 appointment in 3 months) N=22	No Appointment Set Up N=29
% Female	19 (45.23%)	12 (44.44%)	9 (40.91%)	11 (37.93%)
% under 30 years old	29 (69.05%)	5 (18.52%)	3 (13.64%)	7 (24.14%)
% African American	36 (85.71%)	22 (81.48%)	15 (68.18%)	26 (89.66%)
% New Positives	14 (33.33)	2 (7.41%)	0	2 (6.90%)

Conclusions

Patient navigation was very successful in helping the patient make and keep their appointments and engage in care. Sinai's adult HIV programs will continue working on strategies to increase the number of patients who consent to work with a navigator by explaining the benefits outside of HIV care such as assistance in accessing housing, substance abuse treatment, food, and job training/employment; common barriers to care. Additionally, future analysis will include logistic regression to determine which patient characteristics were more likely to result in good medical outcomes such as appointment adherence, maintenance of medical coverage, adherence to antiretroviral therapy, and undetectable viral load to see how the role of the patient navigator may be emphasized more for certain populations. At Sinai, there is an opportunity to use this preliminary evidence of success to show the importance of the medical departments contacting the patient navigator prior to patient discharge.

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