Nurse Navigators: linkage to care from an ED HIV screening program

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BACKGROUND

The UMC Emergency Department opt-out HIV screening program was established on 12/1/2018.

A one-month pilot at the beginning of the screening program had a linkage rate to a provider outside the hospital of 38%. Of note, 86.5% (n=7) of identified HIV patients were out of care (OOC) and only 12.5% (n=1) were newly diagnosed in the pilot. The subsequent 6 months had a linkage rate of 68% (n=47).

The linkage goal of the program was 80% or better. With the large proportion of OOC patients identified, UMC Wellness Center designed a Nurse Navigator (NN) program to increase the linkage rates.

PURPOSE

The NN program is designed to capture newly diagnosed and out of care patients that present to the hospital and provide navigation into care.

THE PROGRAM

NURSE NAVIGATORS

Educate	Educate patients and staff
Contact & Connect	Early patient contact
Ensure ART	Access while inpatient and for discharge planning
Transition care	Assist with barriers to HIV care

Other key feature: Single phone line access for NN contact
10 hours a day, 7 days a week
Daily hospital rounds

RESULTS

Linkage to care: successful transition of a patient from UMC to another care provider (outpatient HIV clinic, alternate care facilities such as skilled nursing home, acute rehabilitation, inpatient mental health, et cetera).

Program comparison:
- Six-month period after the pilot program of the HIV ED opt-out screening initiative (January 2019 to June 2019)
- First six-months of the NN program (December 2019 to May 2020)

Results:
- Improved total linkage with the NN program (Odds Ratio of 1.44)
- More improvement noted in linkage of newly diagnosed cases (Odds Ratio of 3.21)
- OOC cases had slight improvement (Odds Ratio of 1.05)

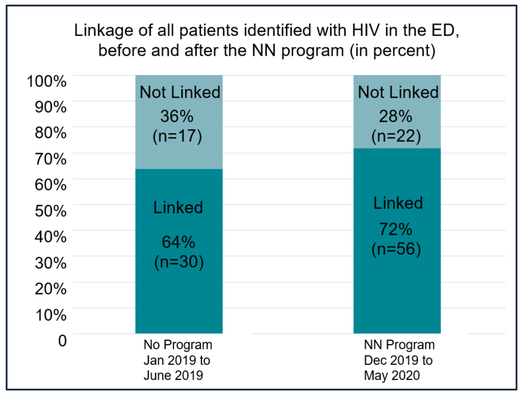

Figure 1. Comparison of linkage rates for all patients identified with HIV with and without NN program

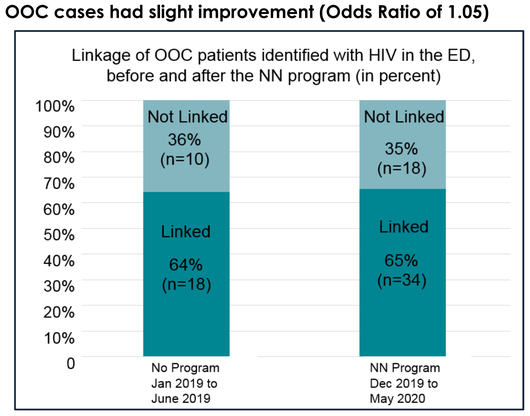

Figure 2. Comparison of linkage rates for identified out of care patients with HIV with and without NN program

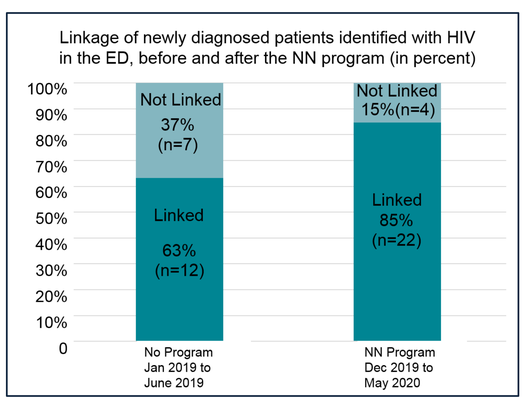

Figure 3. Comparison of linkage rates for identified newly diagnosed patients with HIV with and without NN program

CHALLENGES

- Medically complex
- Mental health
- Substance use

- Turnaroud time for lab result
- ED staff turnover requiring recurrent training

- Stigma
- Personal beliefs on HIV
- Unstable housing
- Transportation

- Coronavirus pandemic
- Communication with transfers to other facilities

RECOMMENDATIONS

Improve referral process to NN Program	• Increase visibility of program to hospital staff • Continuous education of ED and hospital staff • Focus on HIV Continuum of Care and program results
Daily rounding with ID/HIV Physician	• Rapid Start/review of HIV Medications • Patient Plan of Care/Team approach • Appropriate social, mental health and substance abuse referrals
Address Barriers to Care/Patient Education	• Increase patient knowledge of available services • Increase knowledge and understanding of disease • Decrease stigma

CONCLUSION

The introduction of the NN Program to the ED and the hospital has shown promise in improving linkage to care for newly diagnosed and out of care patients living with HIV.

FURTHER WORK

While newly diagnosed linkage rates increased from 63% to 85%, there was a more modest increase in out of care linkage rates from 64% to 65% as a result of this program. There is still much work to be done to address the needs of out of care patients who are challenged with multiple chronic medical and social challenges. In addition, the impact of the Coronavirus pandemic during this study period has yet to be determined, as some services were unavailable and many patients did not seek care during this time.

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