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Patient Navigation Facilitates Medical and Social Services Engagement Among HIV-Infected Individuals Leaving Jail and Returning to the Community

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Abstract

HIV-infected individuals leaving jails, facilities typically used to confine accused persons awaiting trial or to incarcerate persons for minor offenses, often face barriers to engagement with medical and social-support services. Patient navigation is a model that may ease these barriers by supporting individuals in negotiating fragmented and highly bureaucratic systems for services and care. While there is evidence linking navigation to a reduction in health disparities, little is known about the mechanisms by which the model works. We present findings of an ethnographic study of interactions between navigators and their clients: HIV-infected men and women recently released from jails in San Francisco, California. We conducted 29 field observations of navigators as they accompanied their clients to appointments, and 40 in-depth interviews with clients and navigators. Navigators worked on strengthening clients' abilities to engage with social-services and care systems. Building this strength required navigators to gain clients' trust by leveraging their own similar life experiences or expressing social concordance. After establishing meaningful connections, navigators spent time with clients in their day-to-day environments serving as mentors while escorting clients to and through their appointments. Intensive time spent together, in combination with a shared background of incarceration, HIV, and drug use, was a critical mechanism of this model. This study illustrates that socially concordant navigators are well positioned to facilitate successful transition to care and social-services engagement among a vulnerable population.

Introduction

Sustained engagement with health care and long-term adherence to a medication regimen is essential to reducing the morbidity and mortality of people living with HIV. And yet, in the United States, the 2011 'care cascade,' a visual model used to identify gaps in services for people living with HIV across the continuum of care, illustrates a powerful reality that the majority of those diagnosed with HIV are not receiving sufficient health care.[1] Recent research demonstrates that optimal health outcomes for HIV-infected individuals require care milestones to be met, including linkage, retention, medication adherence, and viral suppression. Between these milestones are gaps that limit linkage to and retention in care. These gaps have been attributed to financial barriers, organizational barriers, distrust of the medical establishment,[2,3] ongoing substance use, mental illness, and homelessness.[4–7]

For people living with HIV and cycling through the criminal justice system, engagement in care and adherence to a treatment regimen are further complicated.[8] Estimates are that 1 in 7 people living with HIV will pass through a correctional facility.[9] Jail facilities are used to confine accused persons awaiting trial and are also used to incarcerate persons for up to 2 years, usually for minor offenses. About 17%[8,10,11] of the 8.6 million people passing through jails, in particular, are infected with HIV; of these, 55% reported a recent substance-use disorder, and 64% reported having a mental illness diagnosis.[12] Treatment of these typically debilitating issues in a jail setting is challenging due to the time interval of detainment, otherwise known as a ''short stay;'' an average short stay is up to 2 weeks.[13] Initiation or re-initiation of anti-retroviral therapy

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(ART) may occur as a result of being detained in jail. Pant Pai and colleagues[14] reported on treatment patterns among a sample of 512 HIV-infected inmates who had a history of multiple incarcerations within the San Francisco county jail system over a 9-year period. They found 15% of inmates were in a ''continuous'' pattern (i.e., they continuously took ART while in jail, after release, and in between periods of incarceration).[14] These results support those of other studies, illustrating that it is highly unlikely that men and women in jail will continue to take ART once they are released into the community.[15,16] Nevertheless, the results from the Pant Pai article are encouraging because they demonstrate that it is possible to sustain a treatment regimen within a context of multiple incarcerations.

Patient navigation may be an effective model of HIV care coordination[17] that can facilitate greater continuity in care and treatment, particularly for men and women released from the criminal justice system. To date, there is no standard definition of patient navigation; instead the duties and diversity associated with navigator programs appear to reflect the availability of resources to fund such a program and the associated illness of interest. Clinic-based navigators are likely to have access to patients' health status and medical information. They are also likely to interact with the medical care team and may work on issues related to navigating treatment options, treatment adherence, and specialty care appointments. These navigators may be trained as nurses or social workers and are expected to provide a level of support that is commensurate with their educational background, whereas community-based navigators are likely to have responsibilities related to navigating a wide variety of services in addition to medical care. For example, community-based navigators may accompany patients to medical visits, but have no interaction with the medical team. They are unlikely to have access to the patients' medical information and/or they may not be responsible for supporting treatment adherence. Finally, *peer* patient navigators, located in either a clinic or community-based setting, are members of the community they are serving and have explicitly been hired because of these overlapping experiences, not necessarily because they are trained to support care engagement.

Patient navigation in the world of HIV is relatively novel and currently understudied. In 2007, Bradford published the first article reporting on the use of patient navigators in the field of HIV care.[18] The professional duties of a navigator are not well specified, yet the use of navigators in HIV care settings is on the rise. Navigator programs emerging in the recent ''care cascade climate'' are most often designed to facilitate patient retention in care and to link out-of-care patients with services; however, the efficacy of such interventions remains largely unknown.

While there is evidence linking patient navigation to a reduction in health disparities in the field of cancer research,[19–21] little is known about the mechanisms by which the model works to achieve these changes. To explore these mechanisms, we undertook an ethnographic study to explore the complex strategies, roles, and responsibilities of the patient navigator in aiding the establishment of long-term engagement with social services and health care. Jail detainees are targeted with services such as release plans, but little research has systematically observed how recently released detainees make their way back into community services, including medical care, while being aided by a navigator.

Methods

Intervention study and setting:

This article describes the findings of a qualitative research supplement to a larger project—a 5-year, randomized, controlled trial that tested the effectiveness of a patient navigator-enhanced case management intervention for HIV-infected individuals leaving the San Francisco County jail system. A locally established, community-based organization—the San Francisco Pre-Trial Diversion Project—provided the intervention, which included in-jail HIV-prevention counseling and 1 year of post-release intensive case management enhanced with patient navigation. The standard-of-care comparison group received as-needed, post-release case management provided by the Forensic AIDS Project, a program of the San Francisco Department of Public Health.

The goals of the intervention included: reducing sex- and drug-related HIV transmission risk, increasing HIV medication adherence (if clients were on ARV treatment), reducing hazardous drug and alcohol use, and reducing reincarceration. Accordingly, case managers attempted to connect participants with appropriate community services (e.g., medical care, housing, food, ADAP, SSI) to increase the likelihood that they would be stabilized in the long term. Patient navigators worked closely with clients in the field to ensure successful engagement with services and continuity of care. Case managers conducted psychosocial assessments and provided prevention education; in addition, they developed, with client input, a discharge/ongoing-care plan. Navigators assisted in the implementation of the discharge/care plan by escorting clients to appointments, and they provided ''coaching'' on how to connect and interact with programs in

Table 1. Tasks of Case Managers and Patient-Navigators

Task	*Case manager*	*Patient navigator*
Conduct in-jail intake and provide prevention education session	X	
Monitor status of client's legal case	X	
Visit client in jail	X	
Meet client at jail upon release	X	X
Develop post-release care plan	X	
Ongoing monitoring of care plan	X	X
Formal reassessment of client	X	
Accompany client to appointments in the community		X
Accompany client to court appearances	X	X
Meet with client (post-release)	X	X
Confer with client's other providers or speak with client's family or support system (with client consent)	X	X
Refer client to other providers (with client consent)	X	
Provide outreach to client who is lost to follow-up		X
Visit client in treatment facilities/ hospitals	X	X
Document all client contact in NCM Client Database	X	X

the system. Table 1 outlines the tasks undertaken by case managers and navigators.

Hiring patient-navigators

Colleagues working in the criminal justice system referred the intervention provider to patient-navigator candidates. Navigators were hired because they were ''peers'' of their future clients (i.e., they were HIV-infected and had a history of incarceration and drug misuse). They also had a history of consistent engagement with social services and medical care and possessed good organizational and communications skills. All navigators had been abstinent from drugs and alcohol and had not been in jail for 1 year before being hired. Many of the patient-navigators had not previously held jobs or had been out of the work force for many years. Navigators attended trainings on a number of relevant topics such as professional behavior, confidentiality, time management, and communication skills. In addition, they received ongoing support to apply what they learned in trainings as well as clinical supervision.

Although the original design of the study was to create enduring navigator/patient dyads, this was ultimately not possible because of limits on the income navigators could earn to remain qualified for social-welfare benefits. Thus, navigators were not assigned to one particular client with whom they might work closely over a long time. Instead, navigators assisted any client needing services during a given workday. Each navigator worked 10–12 h per week, usually across two workdays. On each workday, at least two navigators were on duty. Navigators were hired specifically because they had criminal histories, so they were unable to obtain the security clearances necessary to provide services inside a jail. For this reason, case managers provided all in-jail services, including post-release planning and HIV-related counseling, and they made referrals to community services (see Table 1 for a list of services delivered by both types of provider). Once a client was released, the case manager worked with patient-navigators to monitor adherence to care plans and provide clinical supervision. All patient-navigators involved in the intervention were enrolled in this ethnographic study.

Ethnography overview

We used ethnographic research methods over a 10-month study period (December 2010 through October 2011) to understand how the patient-navigator model worked in everyday practice. Through firsthand, unobtrusive observation and insight, the study ethnographer was able to characterize the processes by which an intervention was delivered. These observations were complemented with in-depth, open-ended interviews of both clients and navigators. Study procedures were reviewed and approved by the Committee for Human Research at University of California, San Francisco.

Field observations

An ethnographer conducted a total of 29 field observations of 15 unique clients over 10 months (average two observations per client, 2.5 h for each observation). The ethnographer—hired because of his familiarity with local social services as well as jail-to-community transition issues and trained in ethnographic methods—conducted direct observations and accompanied patient-navigators and their clients to service appointments. The ethnographer spent approximately 75 h in the field and produced detailed observational field notes.

In-depth interviews

We conducted baseline and follow-up in-depth interviews with all of the patient-navigators (baseline, $n=5$; follow-up, $n=4$) and in-depth, open-ended interviews of clients ($n=31$). Many of the clients interviewed were also study participants during the ethnographic field observations, so we had multiple data points with which to contextualize and triangulate data. After an initial comparison of the field notes and client interviews, we conducted follow-up interviews with navigators to verify and enhance our understanding of findings that emerged in this preliminary analysis.

We developed interview guides for patient-navigators and clients after analyzing a subset of the field notes from the first five ethnographic observations. Interview topics included life histories of incarceration, drug use, sexual behavior, and HIV care, and details regarding the navigator/patient relationship and its potential impact on engagement with services. For instance, we asked a version of these questions to both navigators and clients ''I want to ask about some of the successes and failures in your work. Can you think of one of your best clients and tell me about your interaction(s)? What makes it click for you and that client? How do you know if you're successful or not?'' Follow-up interviews with patient-navigators focused on emerging themes from the baseline interviews and field notes. Navigators and clients were paid $40 for participating in the in-depth interviews. All interviews were audio-recorded and transcribed. All patient-navigators were eligible to participate. Clients were eligible if they had two or more service contacts with a patient navigator (e.g., a navigator attended one medical appointment and spent time with the client developing a plan to attend drug-use cessation classes) and if they were enrolled during study assessments conducted 2, 6, and 12 months after release from jail. Clients were selected by convenience sample; if they met the study criteria, they were approached and asked to participate.

Data analysis

Ethnographic research allowed us to use ''inductive methodology'' to understand how patient navigation works, rather than test a hypothesis. Accordingly, our analytic approach was based in grounded theory, which seeks to develop knowledge based on information and insights provided by the people who experience a particular phenomenon.[22] We used contextualizing and categorizing strategies to analyze the data.[22,23] Each transcript was assigned a primary analyst in charge of systematically reviewing the interview and drafting a contextualized interview summary. Following this step, the primary analyst categorized or applied coding categories to segmented text within the interview. A secondary analyst reviewed the contextualizing summary and verified the coded interview. Twenty codes eventually emerged for the navigator data set, and 24 for the client data set. For this analysis, we closely read all text associated with the following codes: ''peer connection,'' ''navigator as role model,'' ''service engagement,'' ''navigator strategies,'' and ''service history.''

We read these excerpts to understand the strategies, roles, and responsibilities of patient-navigators as they worked with clients to improve engagement with services.

Results

We have organized our findings into two sections. In the first, we provide an in-depth portrait of the typical day-to-day activities of navigators as they worked with clients. We present data from the ethnographic field notes to best exemplify the interactions between the navigators and clients. This section provides a detailed description to set the stage for the presentation of our main finding: building ''peer connections'' with clients was crucial to facilitating their engagement with the services system. Navigators and clients both reported that this connection was integral to active and effective participation in various social and medical services. We argue that these connections were initially fortified by social concordance and then deepened as the navigator and client shared experiences of accessing complex, unfriendly systems that are replete with requirements and conditions that even the most resilient and resourceful of persons would feel challenged by.

We enrolled 31 clients and 5 navigators in our study (Table 2). Some clients and 1 navigator did not provide information on incidents of incarceration. The demographics of the participants enrolled in the qualitative group were similar to those of the overall study population, with the exception of slightly higher percentages of African-Americans and Latinos enrolled in the ethnographic study.

Each participant that is quoted multiple times has been assigned a pseudonym. All other quotes represent unique participants.

Day-to-day tasks of patient-navigators

One of the main responsibilities of patient-navigators was to escort post-release clients to medical, court, and social-welfare benefits appointments. Successfully engaging with community services after release from jail was challenging for clients to manage on their own, particularly if they did not have a social network to rely on for physical, logistical, financial, and psychological support. A client said: *''… every time you go to jail…it puts you behind on a lot of shit. Doctor's appointments, money that you are supposed to receive, everything stops for you when you go to jail. And when you come out, all of a sudden you're behind.''* One of the goals of navigation was to rebuild these social-services relationships in order to facilitate ''getting ahead''—or, more accurately, ''catching up.''

For a typical patient appointment, the supervising case manager would assign a navigator. The assigned navigator would receive relevant clinical and social services information about the client, along with a specific navigation-related task that was to be performed immediately before contact with the client. Because the pools of navigators and clients were relatively small, navigators did develop relationships with some clients, particularly those with acute or multiple-service needs. However, the design of the intervention was such that navigators were likely to meet a new client with each assignment. Accordingly, the navigator would meet the client at either the client's residence or the intervention site, which also served as a drop-in center, and would accompany the client to the referral site. In most cases, this involved taking a city bus or walking to the appointment. There were also instances when a client chose to meet a navigator at the appointment site, rather than be escorted there.

The availability of an escort proved to be essential in getting most patients to attend and complete their appointments. For example, the ethnographer noted that navigators helped clients cope with the physical effects of prescribed methadone and/or illicit drugs, making sure that clients got on and off a bus at the appropriate stop or remained alert enough to complete an appointment. A navigator named Hector accompanied a female client to a medical appointment at a hospital. The following excerpt from the ethnographer's field notes describes the appointment:

> *The study participant arrived a little after 12 PM. The participant is female, African-American, and appeared to be in her mid-40s. She was neatly dressed in a black leather jacket over a black-and-white animal print shirt, blue jeans, and white shoes. The first impression of her that popped into my head was that she might have been a former substance user. Her mannerisms reminded me of many substance users I had met and worked with in the past. I also noticed that her hands were a little swollen and had a slight reddish color to them. I have seen this many times with active substance users. Although she didn't openly talk about any past substance usage, she did mention to one of the navigators about having received a dose of methadone prior to arriving at [the drop-in center].…Because her appointment wasn't until 1:45, Hector brought a plate of food from upstairs and she began to eat. Making the clients comfortable and welcome seems to be extremely important to the staff. This is only my second visit as a tagalong, and on both visits, the staff was extremely attentive to the needs of the clients. They always asked if the client was hungry or thirsty and made them feel comfortable before they conducted any business with them.*
>
> *After the client finished eating, we headed out the door for the trip to the local hospital. During the walk, the three of us*

Table 2. Demographic Description of Participants

	Gender	*Ethnicity*	*Age*	*Self-reported incidents of incarceration*
Clients	81% M	49% African-American	3% 18–30 years	29% 1–10
($n=31$)	19% F	42% White	26% 31–40 years	16% 11–20
		6% Latino	71% 41–65 years	13% 21+
		3% More than one		42% missing data
Navigators	80% M	60% African-American	20% 18–30 years	20% 1–10
($n=5$)	20% F	20% White	80% 41–65 years	20% 11–20
		20% White/Filipino		40% 21+
				20% missing data

engaged in small talk. She talked about her family and told me that she is from [city name]. I told her that I was also born in [city name]. She seemed to relax and be more comfortable with me tagging along after that.…At Mission Street, we caught the #14 bus. The bus was full, with just a few seats unoccupied. The participant was able to find a seat while Hector and I stood in the aisle.…I noticed that the participant started nodding off soon after we were under way. I assumed that her dose of methadone was starting to kick in. Hector roused the client when we arrived at the hospital. I have no doubt in my mind that she would have slept through her stop and might have been late or missed her appointment entirely had he not been with her.

We arrived at the hospital about 1:25 PM and proceeded up to Ward X. The participant checked in at the reception desk and received a number. We sat and waited for her name to be called. The waiting area was fairly full and busy.…Her name was finally called about 2 PM. She left the reception area and followed a staff person into the ward. She returned to the waiting area about 5 minutes later. She apparently just had her vital signs taken and was told to return to the reception area and wait for her doctor to call her. She opened a book and started to read. I noticed the title of the book was ''Staying Sober—Guide to Relapse Prevention.'' She had the book open on her lap, but started nodding off again, so I don't think she actually read much of it while we waited. At one point, she vented a little frustration about having to wait so long and Hector provided a sympathetic ear. I felt having [Hector] present helped keep the client from getting too frustrated and possibly leaving the ward without seeing her doctor. At about 2:20, she was finally called back to see her doctor. Her appointment concluded about 3:05 PM. We left the hospital and rode the bus downtown. Hector thanked the client for successfully getting through the appointment and got off the bus.

There was some, but not a lot of, interaction between the navigator and the client. My sense is that they were familiar with each other, but weren't particularly close. There was some conversation between the two after the client's arrival to the agency, but not much. At one point, the client and Hector stepped outside for a smoke.…This was the second time I accompanied Hector. Once again, I was extremely impressed with his dedication and attentiveness. He was readily available and stayed with the participant throughout the appointment. While the participant was seeing her doctor, he told me that he felt the appointment was going well mainly due to the disposition of the participant. He said that some of his participants would become far too frustrated with the waiting and he would have difficulty getting them to stay.

This excerpt highlights some of the challenges that navigators faced in escorting patients to appointments (i.e., patients feeling the effects of licit and possibly illicit drugs, frustration due to long waits, nervousness in working with strangers). The excerpt also details key strategies for managing these potential difficulties. Hector fed the client, making sure she was physically cared for. Another navigator explained the strategy as: ''First you eat, and then we'll talk. We talk better on a full stomach.'' Hector was also able to rouse the client at key points in the engagement process; as the ethnographer noted, she might not have made it to the appointment without his help. Last, the navigator may have mitigated the patient's frustration with the long wait times by attending the visit and enduring it with her, thereby ensuring that the appointment was completed.

In our field observations, we learned that the principal function of a navigator was to focus on problems, both real and potential. Not only did they assist with the basic task of getting to and completing an appointment, they also helped with special circumstances. For example, a navigator escorted a client to a court appointment and filled out a required form because the client had poor eyesight and was unable to do it himself. In another example, a navigator watched over a patient's companion dog outside the Social Security Administration building; otherwise, the appointment would have been missed because the dog was not allowed inside. In yet another example, a navigator escorted a male client from a residential drug-treatment facility to his home, which he had not been to in months, in order to retrieve a few personal items. They arrived to find that the patient's roommate had been lying dead in the home for 2 months. The navigator took control by calling the police and dealing with the medical examiner. The patient noted that the navigator *''didn't go crazy. He kept it together and helped me keep it together, you know. And we did what we needed to do.''*

The aforementioned navigators helped with basic tasks as well as with idiosyncratic events; meeting these needs is a fundamental requirement for transitioning clients back into the community. Consider the case of Barry, a male client who enrolled in the study after his first jail detainment, at age 52. He had moved with his partner to the San Francisco Bay area about 10 years earlier. Two years after their arrival, they ended their relationship, and Barry started selling methamphetamines and increasing his use of the drug. In 2010, he was arrested and served 4 months (of a 6-month sentence) in county jail. At the time of his involvement with this project, he was homeless, had recently been hospitalized twice for cellulitis in both legs, and was suffering from severe depression. Additionally, he was not on antiretroviral medications and had begun using methamphetamines again. Barry felt that he had gone *''from being a professional to being pretty much on my own with almost nothing.''* His income had been ''cut off'' when he was arrested, so at the time of his participation in the project, he faced not only a ''tough spot'' economically but also a need to put his life back together. In the field observation of an appointment Barry had at the Social Security Administration, the ethnographer noted that he ''broke down and cried during parts of his responses'' during the interview. In a fragile state, Barry appreciated the support that his navigator and others offered him:

[Navigators] know what you can often do and not do, and the challenges that you face. They understand how things that maybe seem to somebody else on a daily basis to be a breeze can become a very challenging thing to do. I mean, just for example, when I applied for GA, the fact that [the navigator] came in and walked me through that process made all the difference in the world. You know, I got through that whole process within a day—that and MediCal. We got that all done in one day, even less than a day, basically, and I don't think that I would've gotten that done within a week had I done it myself. Just because at that point in time I was really scared and nervous and unsure; everything seemed to be a challenge.

Another participant spoke of the discontinuities and disruptions that incarceration can cause. Pat, a 34-year-old male client, had been incarcerated four times for drug offenses during the 3 years prior to his involvement in the study. In an interview, he said, *''It's really hard by yourself to start all*

over again'' when leaving jail. Despite the tumultuousness of his recent life, Pat reported that he had maintained an ART regimen while living in the community and that, at the time of his interview, his viral load was undetectable; he also reported using methamphetamines.

In a field observation, the ethnographer accompanied Pat and his navigator, Michael, to a mandated court appearance. The ethnographer entered the extremely crowded courtroom just as the navigator was emerging from the judge's chambers. According to his field notes:

> *[Michael] motioned for me and [Pat] to follow him out of the room. Once in the hallway, he informed [Pat] that there was a bench warrant out on him. Evidently, he had failed to appear before the court the previous week, and a warrant was issued for his arrest. Michael was able to speak with the judge in his chambers and get him to stay the warrant, under the condition that [Pat would] appear before the court on Wednesday. We walked out of the center and [Pat] thanked Michael for his assistance.*

Later, in an in-depth interview with project staff, Pat offered the following comments on that particular experience in court:

> *It feels like, as much as you know everything, dealing with the court thing is a new thing. Like, it's a new thing how to do them. For example, go to court and talk to the judge. I have to make another court date because that date doesn't work. It's like, for me, I don't know how to do it.…They kind of call there and tell them, and they tell me, like, 'Okay, this is your court date,' that kind of thing. Like, I didn't have any idea. If I was by myself, I think I would be going round and around.… [Navigators] know, and they put things together.*

Patient-navigators build connections and serve as role models

Patient-navigators reported that, in order for them to work effectively and facilitate engagement with services, it was essential to establish a trusting relationship with clients. A navigator said, if *''they feel a connection…they will start opening up.''* The building of rapport (i.e., this connection) was achieved mainly by sharing experiences. In client interactions, navigators often referred to their own histories of drug/alcohol use, HIV, and incarceration. Tim, a 60-year-old navigator who has been incarcerated over 80 times, explained:

> *The experiences, skills, and assets that I have [are] that I have been in ''the life.'' I know what it is to understand the shame and the guilt.…If we can share some of our personal experiences with [clients], it makes them feel more comfortable and trusting.…As navigators being HIV-positive and in the lifestyle, once they know that, it tears down a lot of barriers. It's not just meeting someone that they know nothing about.*

The implication is that interactions between HIV-infected, post-release clients and *non-peer* service providers can be challenging because the clients lack trust and both parties misunderstand each other. It is, Tim said, the similar life experiences of both navigator and client—and an ability on the part of the navigator to place these experiences at the center of their interactions with services—that can allow trust to be established and barriers overcome.

In addition to recognizing a similarity in life experiences, patient-navigators reported that withholding judgment was also integral to building an effective relationship. According to Tim:

> *A person has to have compassion, not to judge. That's the first thing. You can't judge a person, because you got it and they haven't got that, or [you're] working towards to better yourself and they're not.*

Hector, the navigator introduced earlier, confirmed Tim's point and said that a ''compassionate relationship'' can help disenfranchised clients engage more effectively with service providers.

> *… I speak when it's necessary. I listen when it's necessary. I show compassion, and I explain how to make it easier for us to get through [a] particular interview. And [clients] feel comfortable with that. And they feel confident knowing that I'm not going to belittle them or make them feel inadequate.*

The importance of a ''peer connection'' was supported in the stories told by clients during interviews. A female client said: ''*[The navigator] let me in on a little bit about her personal life, and that means a lot because I feel like I have a closeness with her, that I could tell her personal things about me.''* Another male client, who had been incarcerated 7 times since 1982, reported feeling that he could ''really relate'' to his navigator because the navigator had ''been through it.'' The client explained:

> *I don't know if I can listen to somebody that hasn't been through what I'm going through or isn't HIV-positive. You can't study doing drugs, and you can't study going to jail. That's something that you have to experience in order to be able to talk about it. Whenever I talk to the navigators, anybody, those are my first questions— ''Are you positive?'' ''Yes.'' ''Have you been to jail?'' ''Yes.'' ''Have you done drugs before?'' ''Yes.'' ''Was it meth?'' ''Yes.'' Wow. With the navigators, I'm like, ''Damn, I can really relate to you.''*

> *It really does matter, and it was really surprising that Navigator was like that because I haven't been anywhere where it's like that, where I can relate to the person. It's just better that way because I can't listen to advice from somebody that isn't—that really, truly doesn't know.…You know you've been bad your whole life, and you know everything that you've done has led up to this, and you can't actually get advice from somebody that hasn't been through it.*

This client cannot, as he said, listen to advice from someone who ''truly doesn't know.'' Other clients spoke similarly of the value that shared life experiences bring to their interaction with services. A male client who had been incarcerated 3 times in the last 15 years said:

> *See, L. [a case manager not affiliated with this project] has never been on drugs or alcohol. She doesn't know. She knows from books. It's not the same. You got to be in that for real.…You got to be in this shit and go through it.…You see it in the way they talk to you. Don't talk down; don't try to make them feel small, like it's big You and little Me. Just talk to somebody, like it's your friend.*

For this client, having life experiences similar to his provider's was conducive to building a relationship grounded in equality and respect, a relationship he desired and intimated was central to positive engagement with services. For this client and others, their relationship with a patient navigator was different and potentially more meaningful than previous

experiences with service providers who had not *''be[en] in that for real.''*

According to clients, these connections are important because they help create a situation in which the client is more likely to listen to and act on the advice given. Shared experiences are a ''short cut'' to a client acting in accordance with what a navigator suggests or requires. As one male client noted, the life experiences of navigators can lead them to be *''very perceptive to your feelings and what you're going through.''* Barry, introduced above, expanded on the importance of this connection and described how it could impact a social-services encounter:

> *… [the navigator is] very grounded. You know he's not, like, highfalutin or trying to be something that he's not. I mean, he is what he is, [and] we often come down to the same kinds of conclusions, I think, about a lot of things and about different people. And he has a sense, like, when people are too hard or too harsh on you, or when people need to let up, that has helped me …*

Barry pointed to how a client might come to understand that he/she shares a common set of values and assumptions (i.e., a common sense) with a navigator, which can help facilitate successful participation in a services appointment. For Barry, the navigator was almost an extension of himself, an empowered surrogate.

By leveraging their life experiences, navigators were able to develop trusting relationships with clients as their equals; in doing so, they created a ''bridge'' between clients and the services system. Along this line, navigators reported another, more complex task in their work. It was necessary, they felt, to help clients reorient their relationships with the services system, reducing their fear and apprehension and building more trust and openness. As Tim, a navigator, reported: *''The fears—I can sense the[ir] fears with health care providers; [sometimes clients] are not willing to expose or give any kind of information.''* A male client further explained:

> *It is the way [a service provider comes] off as a person. You don't make [clients] feel like they're shit and you are better than them and you know what's best for them. It's the way you talk to people, the way you treat them.*

In trying to convey how navigators and clients were equals due to their similar life experiences, a navigator tellingly reported that: *''[I was] once using the system like they're doing, just to get another hit.''* This indicates that disenfranchised, post-jail, HIV-infected individuals may be profoundly distrustful of, and even antagonistic toward, ''the system,'' which includes health-care services and social-welfare programs. For this reason, if client relationships with service providers are founded on alienation, then reorienting these relationships becomes necessary for the establishment of long-term care. Hector, the navigator, explained:

> *The major part of being a navigator is helping the next individual understand that these people in these agencies that we deal with and the resources that are out there are put in place to help us live our lives to the fullest.*

If the objective is to create an understanding that the services system is in place to help clients live life to the ''fullest,'' then navigators are struggling against the perception of many that the services system is something opposite, that it is somehow oppressive or disengaging—or even ''inhumane,'' as one navigator termed it after helping a client through a 5-hour appointment at the Social Security Administration.

Many clients came to regard their navigator as a *role model*. A male client, who had been incarcerated 7 times since 2000, reported:

> *With navigator[s], these people have been through what I'm going through. The 3 navigators that I've gotten were [HIV-]positive. The 3 navigators I've gotten have been to jail. The 3 navigators I've gotten—they all 3 have done drugs before. So I can relate to them, and I could actually look up to them and see that this is where being clean and being good can get me.*

By identifying similar life experiences, this client linked his own process of transformation to those of his navigators. The navigators came to represent an end point or goal (i.e., they embodied a process of transformation and long-term engagement with services). This profile of the navigator-as-role-model was described simply by another male client who had been incarcerated more than 40 times since the early 1980s: *''He [a navigator with at least as many incarcerations] did a drastic turnaround. It shows that it can be done.''*

With adequate support, men and women can move out of a jail setting and successfully reintegrate into healthy communities. The peer navigators in this study, for all intents and purposes, worked as reintegration specialists. Their clients required substantial input on how to negotiate schedules to appear in court, fill out bureaucratic forms, and visit medical clinics. Navigators worked to get people to and from their important appointments. This shepherding process created opportunities to demonstrate or model prosocial behaviors, and it provided patients with support during a time of possible instability.

Discussion

Through our ethnographic work, we identified mechanisms by which the patient-navigator model works to improve health outcomes for a particularly vulnerable population of men and women living with HIV. One of the reasons why the model seemed to function well for both clients and navigators was that their shared life experiences fostered easy-to-build relationships and trust. When this sense of shared experience was established, clients (by their own accounts) were willing to accept the advice offered by their navigators as well as allow them to act in their interests. This union of efforts helped alleviate the isolation and alienation often experienced by clients. Navigators were sensitive to what life was like for their clients because they themselves had walked the paths of incarceration and drug use and HIV infection. With this insider knowledge, they could anticipate clients' needs in a way that other types of health-care providers may not be able to. Another critical mechanism of patient navigation is that, in this study, the navigators worked well beyond clinic and services-agency settings and had full license to spend time with clients in their worlds (i.e., their neighborhoods and homes).

The patient-navigator model is intended to facilitate a client's ability to confidently and fluently navigate the care system. Achieving this goal requires an understanding of the barriers to and facilitators of system navigation. For example, one such barrier is transportation, typically defined as either not having it or not having funds to pay for it. The solution

has previously been to provide a cab ride or bus tokens. But in our study, because of its ethnographic nature and close proximity to the everyday experiences of clients, we found that even if they had access to transportation, they often lacked confidence and/or the knowledge of *how to navigate* it. More specifically, some clients lacked familiarity with the bus routes that led to health-care or social-services sites, or they encountered minor mishaps that derailed the successful completion of their appointment. Having a navigator accompany a client from home to the location of a service (e.g., a particular room in a courthouse, a specific clinic within a hospital complex) can potentially foster greater independence on the part of the client. On the other hand, clients receiving methadone may not be in a position to fully operate independently if the dose compromises their ability to get from point A to point B as illustrated in the opening field note.

Navigators in our study were often able to address client needs that might otherwise go unspoken or unmet in clinic settings. For example, peer navigators used a practical or intuitive strategy to engage with clients by first offering them food and/or drink. Navigators anticipated that their clients struggled with food security, and they wanted, at minimum and whenever possible, to meet this basic need. The act of feeding clients, and thereby giving them some level of physical comfort, was not only a supportive gesture but also one that grounded peer and client in a common human activity: eating together. Even if the peer navigator did not eat with the client, the simple act of offering food is unique within the usual social- or medical-service context. Indeed, this offer appeared to be a mechanism that built rapport between navigator and client.

In addition to addressing a client's immediate needs of hunger or thirst, another notable difference between the work of navigators and case managers was the amount of time navigators spent with clients as they attended appointments of all types. The health-care system in its current design rarely offers the opportunity for clinicians, nurses, case managers, or health educators to provide services beyond the walls of the clinic. Navigators, in contrast, were not limited to serving clients in a specific setting. In fact, their role was to *physically* 'meet clients where they were at.' Physical presence and accumulation of time spent together, in combination with shared backgrounds of incarceration, HIV infection, and drug use, may be the most important finding of our study.

Patient-navigators, who act as both a professional *and* as a peer, may be uniquely able to address the challenges faced by post-jail, HIV-infected individuals. By modeling effective communications during interactions with providers in various service systems, the navigators were also helping clients to intuitively build skills that could allow them to more successfully and independently navigate these systems. Indeed, patient-navigators may provide the best model for improving access to care for a particular type of vulnerable population because the navigators themselves had previously been in that same category.

Capitalizing on similarities or a shared identity is a topic of particular relevance in the study of health disparities. Research on the effects of racial and ethnic concordance/discordance between patient–physician dyads is extensive and results indicate that racial concordance may be associated with patient satisfaction, patients' trust and adherence to medications.[24,25] However, results from the cumulated research are mixed.[26,27] In 2008, Street Jr. et al[28] published an article shedding light on the mechanisms through which concordance leads to improved patient outcomes. They reported that the strength of patient–physician relationships occurred most often when patients perceived similarities in personal beliefs, values and, communication. The study was designed to reach beyond demographic similarities to investigate the role of modifiable aspects of the patient–physician relationship. We touch on this literature here because, like the research on concordance, we too capitalized on the use of socially concordant navigators. The ethnic backgrounds of our navigators and their clients were diverse (Table 2) and no effort was made to match dyads according to race or ethnicity. Our findings support the positive effect of social concordance; in our study concordance appeared to be the critical first step to establish trust between the client and navigator.

Our study design had limitations. Our intention to consistently assign navigators to a personal caseload of clients did not work out as planned due to issues related to limits on the income navigators could earn to remain qualified for social-welfare benefits; We are therefore unable to report on the outcomes of more intensive, stable dyads. We did not compare our model of patient-navigation with other models, such as one that employs patient-navigators who do not share any life experiences with the individuals they serve. Our conclusions are also limited to recently released jail detainees; results may be different for HIV-infected individuals who do not have jail experience. Even with these limitations, though, the data allowed us to identify important insights about the key mechanisms for a patient-navigation model that affects health outcomes for disenfranchised, vulnerable, HIV-infected men and women exiting jail settings. Finally, this was not an outcomes study; we were not able to determine the effectiveness of navigation services. We were, however, able to describe in rich detail how the model works for these high-need clients.

Navigators in this study worked with clients who had severe social deficits. It was through working with navigators that clients gained insights such as *''… this is where being clean and being good can get me.''* This study illustrates that navigators are well positioned to facilitate a successful transition to care and social-services engagement among a vulnerable population. We observed that the navigator/patient interactions provided meaningful support and that this support was fostered in a context where the client and navigator shared a history of drug addiction, criminal activity, arrest, and jail detention. Pairing a recently released client with someone from his/her community who has faced very similar life challenges is a compassionate response to the problem of recidivism. This type of intervention, which leverages the experiences of and skills developed by successful ex-offenders, has potential to break the cycle of reincarceration and suboptimal engagement with services. We recommend further research into the training and hiring needs associated with this type of navigation program, as well as future studies to determine whether this particular model of patient navigation can fill gaps across the continuum of care and thereby increase the number of clients who reach optimal engagement with medical and social services.

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