Using a Multidisciplinary Evidence-Based Continuum Care Model to Reengage High-Risk Young Adults Living with HIV

Abstract Submission

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Abstract

**Background:** Young adults face unique barriers with adhering to the HIV Care Continuum such as lapses in health insurance, under-employment, unstable housing, and lack of transportation (Griffith et al., 2019; Zanoni & Mayer, 2014). This significant disparity prompted providers in an outpatient infectious disease clinic in an urban academic medical center in the Mid-Atlantic to create a program to transition high-risk young adults with HIV (YAHIV) to a standard-of-care adult clinic. Despite dedicated staff and individualized initiatives, these patients have lower virologic suppression (56%) when compared to YAHIV undergoing standard care (69%). Lack of viral suppression results from disengagement from the HIV Care Continuum, specifically in maintaining HIV care (Byrd et al., 2016; Griffith et al., 2019). These patients are more likely than adult patients to be lost-to-care, defined as no medical visit with an HIV provider in ≥ 6 months (HRSA, 2017).

**Purpose:** The research question was if initiating a multidisciplinary evidence-based continuum care model (CCM) would reengage lost-to-care high-risk YAHIV and improve patient outcomes.

**Method:** The CCM was developed by the project lead that incorporated the resources of the clinic and the findings from the literature review (See Appendix A). A pre- and post- quality improvement project was used to investigate the impact of the CCM on patient re-engagement. Participants were included if they were eligible for the clinic’s program for high-risk YAHIV (those who are 18-30 years old with ≥1 criteria: transfer from pediatric care, mental health diagnosis, substance use, or identified adherence barriers), and are lost-to-care (Griffith et al., 2019). Participants were excluded if they are on an alternate HIV management plan, switched providers, moved out-of-state, are incarcerated, are inpatient, or are deceased. The pre- and post-implementation data was analyzed with the Wilcoxon Signed Rank test to determine the impact.
of re-engagement on viral load levels. In addition, the CCM included a qualitative patient survey of barriers to care that will be presented as descriptive statistics for future quality improvement projects.

**Results:** Of the 66 high-risk young adults with HIV were found to be lost-to-care, 53.2% were successfully located (see Appendix B). 20 were successfully re-engaged. Results from the Wilcoxon Signed Rank Test determined that the median viral load increase post-CCM was not statistically significant ($p = 0.221$). The self-reported top barriers to care were a lack of transportation and lapse in health insurance. The most requested resource was transportation assistance.

**Conclusions:** The stakeholders determined that the CCM was effective in locating and re-engaging high-risk YAHIV and identifying their specific barriers to care. The survey revealed significant knowledge gaps that prevented the patients from using the clinic’s services. The project lead has since transitioned the CCM workflow and the interactive tracker spreadsheet to the patient navigator, who will be using it as the standard of care for re-engagement. Intake conversation, reminder calls, and office visits now include prompts for patients to update patient navigator about transportation, contact information, and health insurance.
References


Appendix A

Monthly data extraction of lost-to-care ACE patients will be audited through chart review:
1. Encounters
2. Care Everywhere/CRISP and
3. Media for ROI

Audit results will be discussed verbally at the weekly ACE meetings. The finalized list will be confirmed by the ACE team.

Initiate patient outreach, ≤3 attempts per patient

- **Successful**
  - Initiate communication script:
    - Survey top 3 barriers to care
    - Schedule next appointment
    - If available, provide resources for next appointment
  - Discuss survey results weekly at ACE meetings.
  - **Documentation:**
    - **Tracker Spreadsheet:** Track dates and times of outreach attempts, appointment adherence, encounter dates, baseline and subsequent viral load, appointment needs, and survey answers
    - **EPIC Note:** Record outreach attempts, appointment needs, and survey answers
  - Follow up conversation with patient 1 week after appointment date.

- **Unsuccessful >4 attempts**
  - **Location tracking:**
    1. Contact Emergency Contact
    2. Use Maryland Inmate Tracker
    3a. If **male** and/or ≥ 25 yo, contact Health Department
    3b. If **female** and/or < 25 yo, contact WICY coordinator
  - **Documentation:**
    - Record communication attempts in Tracker spreadsheet and EPIC note
    - Label patients as “Unable to Contact” on Tracker spreadsheet.

Last Modified: Mar 15, 2020
Appendix B

66 YAHIV identified as lost-to-care

62 underwent intervention

- 20 re-engaged
- 2 incarcerated
- 2 inpatient
- 29 sent for further tracking with HD or WIC-Y

Pre-intervention chart review (n=4)
- 1 does not have HIV
- 1 deceased
- 2 moved out of state

Removed from care after initiating intervention (n=9)
- 1 deceased
- 2 moved out of state
- 4 switched providers, but remained in state
- 2 removed self from care

Total removed from care (n=13)
- 2 deceased
- 4 moved out of state
- 4 switched providers, but remained in state
- 2 removed self from care
- 1 does not have HIV