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

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Background

- 60.7% of new HIV diagnoses in 2017 in MD were among young adults aged 20-39 years old (MDH, 2018).
- Unique barriers young adults face are lapses in health insurance, under-employment, unstable housing, and lack of transportation (Griffith et al., 2019; Zanoni & Mayer, 2014).
- A review of literature found a lack of evidence-based re-engagement interventions and concluded that these specific interventions would be the most cost-effective use of resources (Higa, Crepaz, & Mullin, 2016; Krebs et al., 2018; Shah et al., 2016).

Purpose

Does initiating a multidisciplinary evidence-based continuum care model re-engage lost-to-care high-risk young adults living with HIV (YAHIV) and improve patient management outcomes?

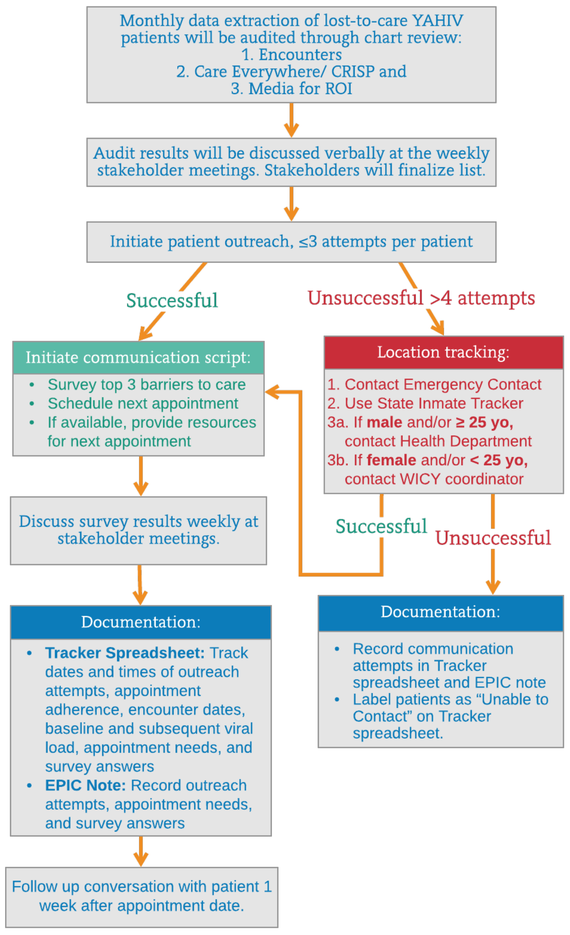
Methods

Design: a pre- and post-intervention quality improvement project
Setting: Infectious disease outpatient clinic located in an urban academic medical center in the Mid-Atlantic
Sample: 66 lost-to-care YAHIV

Table 1. Leading Demographics of Participants Who Underwent Intervention (N = 62)

Sexual Orientation	MSM: 56% (Heterosexual: 30%)
Gender Identity	Male: 55% (Female: 14%)
Race	African American: 55% (Caucasian: 8.1%, Hispanic: 4.8%)
Highest Education Level	High school degree/ GED: 95.2%
Employment Status	None: 56.5%
Mental Health Diagnosis	Yes: 74.2%
STI History	Yes: 77.4%
Current Illicit Substance Use	Yes: 59.7%
Current Alcohol Use	Yes: 69.4%
HIV Acquisition (≥1 possible)	Consensual Sex: 74.2% (Perinatal: 14.5%, Rape: 3.2%, Sex Worker: 3.2%, IVDU: 3.2%, Incarceration: 1.6%)

Intervention



Aims & Evaluation

Aim 1: Develop an evidence-based multidisciplinary re-engagement Continuum Care Model (CCM) to be utilized as a quality improvement project.
Measure: Stakeholders' approval
Analysis: Descriptive statistics

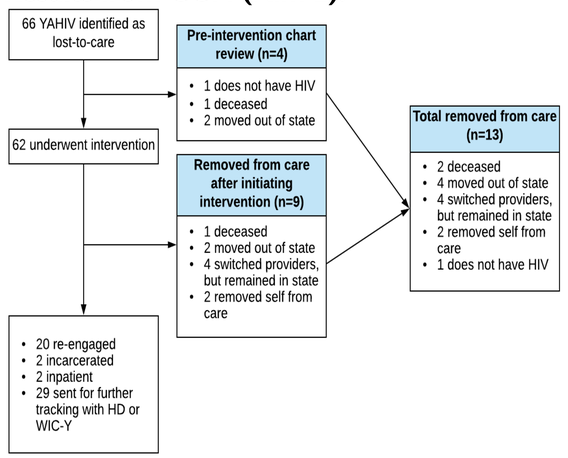
Aim 2: Identify the YAHIVs who are lost-to-care via chart audit, and use the CCM to locate all the patients, and re-engage most of those eligible for care.
Measure: Quantitative data of results
Analysis: Wilcoxon Signed Rank test of Δ in viral loads after re-engagement

Aim 3: Administer a qualitative survey for patients to self-identify barriers to care.
Measure: Patient-reported barriers
Analysis: Descriptive statistics

Results

Results from Aim 1: 100% stakeholder approval

Results from CCM (Aim 2):



Results from Wilcoxon Signed Rank Test (Aim 2): The median viral load increased by 5,161. This is not statistically significant as the p-value = 0.221

Results from survey (Aim 3):

Barriers to Care (Multiple responses), n (%)	(N = 14)
Lacks transportation	6 (12.5%)
Lapse in insurance	5 (10.4%)
Recent move	4 (8.3%)
Change in work hours	4 (8.3%)
Didn't receive reminder messages/ Forgot appointment	4 (8.3%)
Mental health issues	4 (8.3%)
Lack of knowledge on the social worker's role	3 (6.3%)
Financial barriers	3 (6.3%)
Lack of medication adherence	3 (6.3%)
Didn't have time to schedule appointments	2 (4.2%)
Active substance use	2 (4.2%)
New medical issues	2 (4.2%)
New job without time off	2 (4.2%)
Change in contact information	1 (2.1%)
Couldn't schedule appointment d/t clinic staff	1 (2.1%)
Active alcohol use	1 (2.1%)
Unemployment	1 (2.1%)
Total Responses	**48**

Top Barriers to Care:
1. Lacks transportation (13%)
2. Lapse in health insurance (10%)
3. Mental health issues, Didn't receive reminder messages/ forgot appointment time, change in work hours, or recent move (8%)

Table 2. Future Appointment Needs, Descending Order

Resource Requested	# of Patients
Transportation Assistance (Bus tokens, Lyft)	8
None	5
Appointment Reminder	3
Medication Reminder	1
Mood check-in by Patient Navigator	1
Later Appointment Times	1

Discussion

Limitations
- Project lead's lack of familiarity with the patients, the care team, and clinic culture
- Impromptu absence of the program's patient navigator, social worker, & scheduler

Strengths
- Stakeholders' commitment to their patients
- Project lead fully integrated into team
- Survey answers provided real-time feedback of the patients' needs

Next Steps

Sustainability
- Procedures transitioned to new patient navigator, & CCM is now standard of care.
- EPIC lists of lost-to-care patients
- Intake conversation, reminder calls, and office visits now include prompts for patients to update patient navigator about transportation, contact information, and health insurance.

Translation into Practice
- Qualitative surveys should be administered regularly for patients to self-identify their barriers to care
- Teach-Back Method to confirm that patients understand the role of the social worker, patient navigator, and ancillary support staff

Conclusions

- CCM was effective in 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.

References

Separate reference list is available.