Frequent stable attenders – is HARS missing the true complexity in stable patients?

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Background

- HIV has become a chronic and manageable long term medical condition. Consequently, people living with HIV are growing older & accumulating comorbidities[1].
- The HIV and AIDS Reporting System (HARS) was introduced in England in 2013. HARS underpins HIV surveillance and facilitates commissioning of adult outpatient HIV services[2].
- HARS categorizes patients as[2]:
  - Category 1 – New (to clinic/treatment/both)
  - Category 2 – Stable (on treatment with HIV viral load <40c/ml), monitored every 6 months according to BHIVA guidelines
  - Category 3 – Complex (8 subcategories according to specified comorbidities)
- The current issue is that patient pathway mapping in HIV clinics has identified more regular attendance in outpatient clinics among those in category 2.
- Our pilot study in 2016 identified that most additional visits were due to mental health, new symptoms under investigation and recreational drug use.
- This is problematic because it suggests that HARS may be missing the more complex needs of these patients, thus underestimating the support that they require from HIV services.

Aim

- **To investigate reasons for increased clinic attendance among HARS category 2 Stable patients, attending more frequently than 6-monthly.**

Methods

- HARS category 2 patients were identified from the clinic database at a specialist HIV outpatient center.
- 200 of these patients who attended clinic within a 6 month interval between April 2017 and March 2018 were selected at random.
- They were divided into 2 groups:
  - **Group A:** attended 1, 2 or 3 months following previous appointment
  - **Group B:** attended 4 or 5 months following previous appointment
- Information was collected using paper notes and electronic data regarding demographics, background information around their HIV and reason(s) for increased attendance.
- This was input into an Excel spreadsheet for collation and subsequent analysis using Chi-squared tests.

Results

- Of the 200 HARS category 2 patients included, 163 were category A (1-3 months from last appointment) and 37 were category B (4-5 months from last appointment).
- *Table 1* shows demographic data and background information. *Figure 1* shows reasons for increased attendance as a percentage of each group. Note that often there were multiple contributing factors for each patient.

Demographics	Group A (n=163)	Group B (n=37)
Mean age [SD]	50 [11]	52 [12]
Male	146 (90%)	29 (78%)
MSM	133 (82%)	26 (70%)
Background		
Mean duration of HIV diagnosis in years [SD]	13 [8]	15 [8]
Mean CD4 in cells/mm^2 [range]	713 [124-1984]	657 [273-1058]
HIV VL <40c/ml (%)	152 (93%)	37 (100%)
Previous AIDS defining illness (%)	2 (1.2%)	0 (0%)
Mean number of appointments [range]	3.89 [1-9]	3.35 [2-6]

Table 1. Demographics and background information

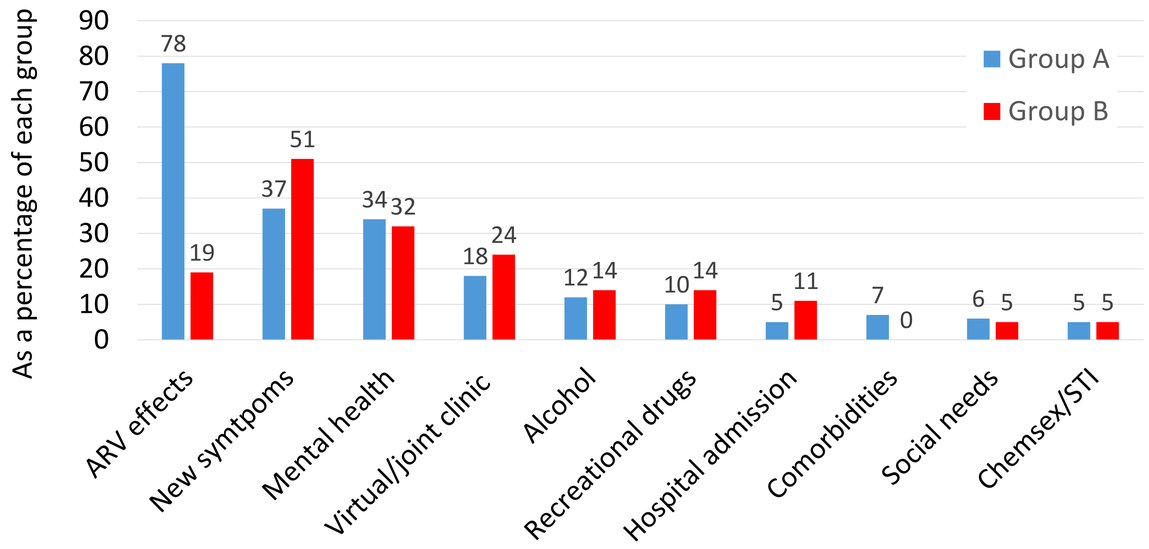

Figure 1. Reasons for increased attendance among HARS category 2 patients

- ARV related issues were significantly more common in patients in group A than in group B ($X^2 = 47.47$, $p < 0.01$).
- Where patients presented for more than one reason ARV issues and investigation of new symptoms were found to be related (X^2 5.614, $p < 0.05$). Mental health issues were also found to be related to alcohol (X^2 6.836, $p < 0.01$) and recreational drug use (X^2 5.604, $p < 0.05$).

Conclusions

- There were 10 key factors that contributed, in differing degrees, to increased attendance among HARS category 2 Stable patients. The most frequently reported were issues with ARVs such as side effects or simplification, investigation of new symptoms and mental health issues.
- Some of these factors were related given that some patients presented with multiple factors at each visit and with an average of 3-4 visits within the 12 month time frame of the study. ARV side effects and investigation of new symptoms were strongly associated, suggesting that many of the new symptoms reported by patients were actually related to HIV medication.
- Mental health was also a significant factor. This is unsurprising given that mental health conditions are higher among individuals with chronic diseases than they are in the general population[3,4]. Whilst HARS category 3 accounts for individuals under consultant psychiatric care, it does not include those with mental health issues who do not get such a referral. Evidently, those who do not get psychiatric support do still need increased support from HIV specialists.
- This matters both for patient quality of life and for wider public health. If complex needs such as mental health are not recognized and managed, adherence to treatment will suffer and increase the risk of transmission[3,4].
- With the increased needs of these patients we recommend consideration for a HARS Stable Plus category.

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