Poster Number: P031

Quantifying re-engagement of people in HIV care after 12 months of non-attendance in outpatient clinic

Christina Nigrelli, Anne Patterson, Kiera Adegbite, Clare Boggon, Helen Webb, Bernard Kelly, Lisa Hamzah.
St George's University Hospitals NHS Foundation Trust, London, UK

BACKGROUND

Reduced adverse clinical outcomes and decreased onward transmission among people with HIV is achieved through consistent engagement in care. Re-engaging those not in care is increasingly highlighted as a priority to maintain the United Nations 90:90:90 goal.

In November 2017, our clinic formalised a pathway for those not in care (NIC) or at risk of being NIC (AR) following a BHIVA best practise statement [1]. The aim was to discuss all those NIC or AR at a multidisciplinary meeting (MDT) involving clinicians, dedicated HIV health advisors, clinical nurse specialists (CNS) and psychology to improve outcomes for these individuals. This process had not been evaluated since inception.

Figure 1: Pathway for patients who do not attend an appointment or have no future appointment booked

Reception
Attempt to call/text patient over 3 week period to rebook appointment
If no response:
- Send standard follow up letter and put on health advisor recall for 2 weeks
- If no consent for letters, put straight on health advisor recall

Health advisors
- Check whether follow up appointment has been made
- Check contact details and call/text from clinic mobile
- Check Shared Care Record; not transferred care or died
- Is there any other way to contact patient e.g. support worker?
- If no response: discuss in next MDT

Possible MDT outcomes
- CNS or psychology to contact
- Letter even if no consent / signed for appointment letter
- Home visit
- GP letter or telephone contact to state concerns
- Review in MDT 3-6 months
- Safeguarding referral
- Leave to attend

AIMS

Within a single clinic cohort in the UK of people with HIV:
1. To describe those not in care (NIC), re-engaged in care (RIC) or at risk of NIC (AR)
2. To determine the impact of a standardised management pathway for these individuals

METHODS

Electronic and paper records were reviewed for all individuals with HIV aged over 18 years discussed in the MDT between 01/01/17 and 31/12/22. Outcomes were defined as follows:

Not In Care (NIC)
Not attended for an appointment or routine blood tests for >12 months

Re-engaged In Care (RIC)
Period over 12 months NIC and has re-engaged in care

At Risk of Not In Care (AR)
Seen within 12 months but due to missed appointments or other factors, identified as at risk of becoming NIC

Demographic and HIV data including age, sex, ethnicity, HIV risk, index multiple deprivation decile (IMDD), CD4 count, HIV viral load (VL) and time in HIV care were summarised and compared according to variable distribution.

RESULTS

From a mean cohort 1763 people with HIV attending clinic between 01/01/17 and 31/12/22
- 264 were discussed in the MDT.
- 172 (65%) had a period of NIC of whom 80 (47%) subsequently re-engaged and remain in care to date, of whom 69% had an undetectable viral load at last measurement.
- 6 (3.5%) of those NIC never engaged from time of referral to clinic.
- 92 (35%) were identified AR but remain in care.
- Of the 264 individuals, median (IQR) time since HIV diagnosis was 6.7 (2.7-9.8) years with good CD4 cell counts, 72% with a VL<200 copies/ml, average index multiple deprivation decile 4th most deprived. Overall, 20 (8%) died.

DEMOGRAPHICS

Demographics and HIV parameters did not differ significantly between those not in care and re-engaged in care (p>0.05 for all). Those at risk of not in care were more likely to be MSM.

Table 1: Demographics and HIV parameters of those not in care, re-engaged in care and at risk of being not in care

Variable	Summary statistic	Not in care N=92	Re-engaged in care N=80	At risk of not in care N=92
Age (years)	Mean [SD]	43.0 (11.2)	44.2 (12.4)	42.3 (14.6)
Sex (male)	N [%]	53 (57.1)	46 (57.5)	63 (68.5)
Ethnicity				
White/Other	N [%]	31 (33.7)	17 (21.3)	30 (32.6)
Black/Other	N [%]	54 (58.7)	58 (72.5)	54 (58.7)
Other	N [%]	7 (7.61)	5 (6.25)	8 (8.70)
Risk HIV acquisition				
Heterosexual sex	N [%]	52 (56.5)	42 (52.5)	37 (40.2)
Men who have sex with men (MSM)	N [%]	22 (23.9)	17 (21.3)	36 (39.1)
Vertical transmission	N [%]	9 (9.78)	16 (20.0)	16 (17.4)
Not documented/other	N [%]	9 (9.78)	5 (6.25)	3 (3.26)
Index multiple deprivation decile	Median [IQR]	4 (2.5, 6)	4 (3, 6)	4 (3, 7)
Time since HIV diagnosis (years)	Median [IQR]	3.2 (0.5, 6.6)	9.3 (6.1, 10.2)	7.8 (4.2, 10.1)
Last documented CD4 (cells/µL)	Median [IQR]	476 (294, 648)	425.5 (243.5, 578)	510 (291, 669)
Last documented HIV VL <200 copies/ml	N [%]	66 (71.7)	55 (68.8)	69 (75.0)
Died since 2017	N [%]	3 (3.26)	6 (7.50)	11 (12.0)

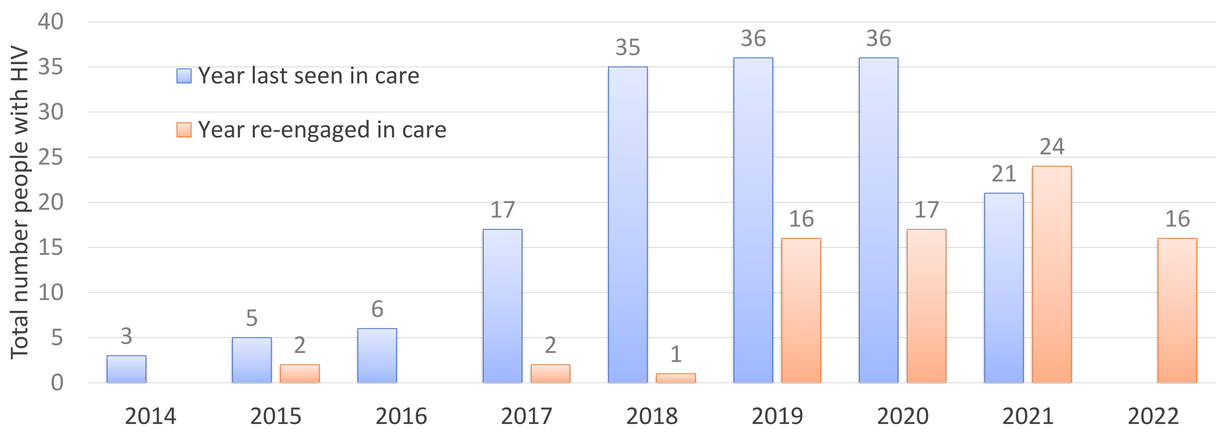
RE-ENGAGEMENT IN CARE

For the 47% of individuals RIC, time to re-engagement was median (IQR) 1.2 (1.2-2.2) years and 69% maintained an undetectable viral load at last follow up.

IMPACT OF STANDARDISED PATHWAY

Following the introduction of the standardised management pathway in 2017, both total number of people discussed in the MDT increased from 2017 and re-engagement in care increased from 2019. In 2021 more people with HIV were re-engaged than lost in care.

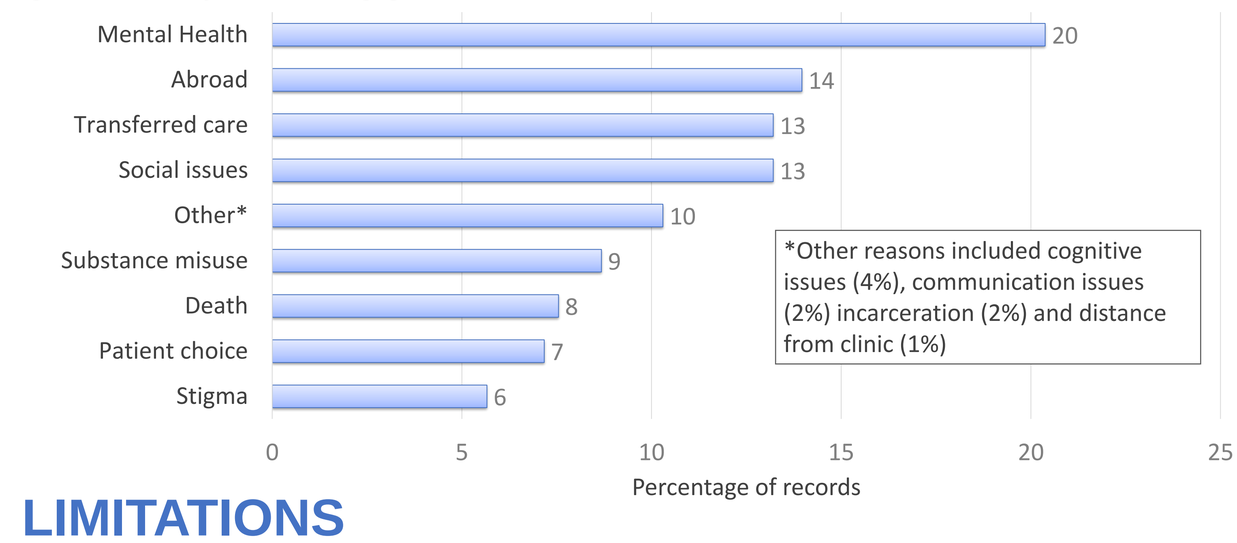
Figure 2: Total number of patients per year a) lost to follow up and b) re-engaged in care



REASONS FOR REDUCED ENGAGEMENT

212 (80%) of records indicated possible reasons for reduced engagement which was often multifactorial.

Figure 3: Reasons for reduced engagement in care



LIMITATIONS

- Lack of a uniform definition describing people with HIV not in care limit comparison with other data. While this study consider patients NIC after 12 months without attendance, others considered patients NIC after 6 months of non-attendance [2] which would increase our NIC population.
- We have likely underestimated our loss to follow up, particularly in the earlier years and aim to compare our figures with UKHSA data when available.

CONCLUSION

- Almost half of people with HIV not in care were re-engaged in care over a 6-year period and the majority maintain an undetectable viral load
- Psychosocial issues and moving abroad were the most common reasons for being not in care or at risk of not in care
- Mortality was high (8%) among this group of people with HIV
- Standardised pathways, a dedicated multidisciplinary team and supporting organisations are key for re-engaging people with HIV in care

References
[1] BHIVA. Prevention and management of loss to follow up in HIV outpatient services: good practice position Statement 2016. Available at: https://www.bhiva.org/other-best-practice-policies (accessed April 2023).
[2] Chi BH, Yiannoutsos CT, Westfall AO, Newman JE, Zhou J, Cesar C, Brinkhof MW, Mwango A, Balestre E, Carriquiry G, Sirisanthana T, Mukumbi H, Martin JN, Grimsrud A, Bacon M, Thiebaut R; International Epidemiologic Databases to Evaluate AIDS Collaboration. Universal definition of loss to follow-up in HIV treatment programs: a statistical analysis of 111 facilities in Africa, Asia, and Latin America. PLoS Med. 2011 Oct;8(10):e1001111. doi: 10.1371/journal.pmed.1001111. Epub 2011 Oct 25. PMID: 22039357; PMCID: PMC3201937.