How often do people attend for HIV care?

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INTRODUCTION

In the UK, a hierarchical method is used to classify people accessing HIV care by clinical complexity, based upon the previous 4 quarters of attendance (1) (figure 1). Clinical guidelines (2) recommend how frequently people attending HIV services should be monitored based upon clinical complexity, with ‘Stable’ patients recommended to attend only 1-2 times per year.

We used national HIV cohort data to examine attendance patterns and factors associated with more frequent consultation.

METHODS & COHORT CHARACTERISTICS

We used quarterly attendance-based data on adults (aged 15+) attending specialist HIV clinics in 2016. Clinics submitting all 4 quarters of data were included and attendances linked across quarters and people classified by clinical complexity (figure 2).

Consultation frequency was analysed by clinical and patient characteristics using multivariable regression.

RESULTS: CONSULTATION FREQUENCY, CHARACTERISTICS & PREDICTORS

65,109 adults (77% of all people) were included in the study and accounted for a total of 229,557 consultations in 2016, split between face-to-face, telephone and email (figure 3).

Median consultations: 3 (IQR [2-4]) per year
- 15% attended once (9,721);
- 29% attended twice (19,084);
- 20% attended three times (12,854);
- 36% attended four times or more (23,450).

Median annual consultations were the same regardless of gender, route of exposure, region of birth (UK vs non-UK) or age (<50 vs 50+) (figure 4).

Median consultations were greater for those categorised as New: both for those diagnosed and starting treatment in the past 12 months (4 [2-9]) and 5 [3-7] respectively.

Characteristics of frequent attendees
1,302 (2%) people attended 12 or more consultations during 2016 (figure 5).

Compared to those attending less frequently, they were (figure 6):
- twice as likely to be complex or new;
- three times as likely to have an unsuppressed VL or low CD4 count (CD4 <200 cells/mm³).

DISCUSSION

- Around two-thirds of people attended three times or fewer during 2016. Those who were newly diagnosed or newly starting treatment attended more frequently (median of 4 and 5 attendances in 2016 respectively).
- People who began the year with an unsuppressed VL or a CD4 count <200 cells/mm³ were likely to have an increased number of attendances.
- Demographic and geographical characteristics had a very minor impact on attendance frequency. Clinical conditions being a more important factor, implying that access to care and patterns of attendance are equitable across England.
- People who attend very frequently (≥12 times per year) were more than twice as likely to have a complex health condition. Other work (3) has shown that persistent viraemia, hepatitis C and tuberculosis lead to the greatest increases in attendance frequency among complex patients.

LIMITATIONS

- Despite a large cohort, 23% of people in HIV care in 2016 were not included due to incomplete data. There may be differences in patterns of attendance for these individuals therefore these analyses should be repeated for the entire population once data is available.
- Complexity relies on the available data in HARS where only a short list of complex health conditions are able to be captured. Future studies will link to data from the Positive Voices survey to investigate psychosocial factors.

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REFERENCES


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