Overcoming Barriers to Re-engage People with HIV who are Out of Care

University of Virginia Ryan White HIV/AIDS Program Clinic,
Division of Infectious Diseases & International Health, UVA Health

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Everlyne Sawyer and Veronica Ross have no relevant financial relationships with ineligible companies to disclose.

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UVA Ryan White HIV/AIDS Program (RWHAP) Clinic

- Funded by RWHAP Parts C and D
- Subrecipient of RWHAP Part B, Virginia Department of Health

- Embedded in University of Virginia Health System- Academic Medical Center

- Services Available:
  - HIV Medical Care
  - Primary Care
  - Psychiatric Mental Health Care
  - Psychological Mental Health Care
  - Obstetrics Medical Care
  - Anal PAP & High Resolution Anoscopy (HRA) Services
  - Community Health Workers
  - Medical Case Managers
  - Non Medical Case Managers
  - Nutrition Services and Counseling
  - Substance Abuse Counseling
  - Pharmacy Services on site
  - Comprehensive HIV/AIDS Resources and Linkages for Individuals Experiencing Incarceration (CHARLII)

UVA RWHAP Clinic Team

- **Medical Care Providers:**
  - 17 Physicians (5 Infectious Diseases (ID) Attendings, 6 ID Fellows, 6 Internal Medicine Residents (HIV Primary Care Track))
  - 3 Advanced Practice Practitioners (2 Nurse Practitioners, 1 Physicians Assistant)
- **Behavioral Health Providers**: 1 Psychiatrist, 2 Psychologists, 1 Substance Abuse Counselor
- **OBGYN & Anal Pap Medical Care**: We have 1 WICY Nurse Practitioner, 1 WICY RN Coordinator, 1 Anal Pap RN Coordinator
- **Nutrition Services & Counseling:** 1 Registered Dietician
- **Case Management:**
  - 6 Non Medical Case Managers
  - 5 Medical Case Managers
  - 1 CHARLII Case Manager
  - 3 Community Health Workers

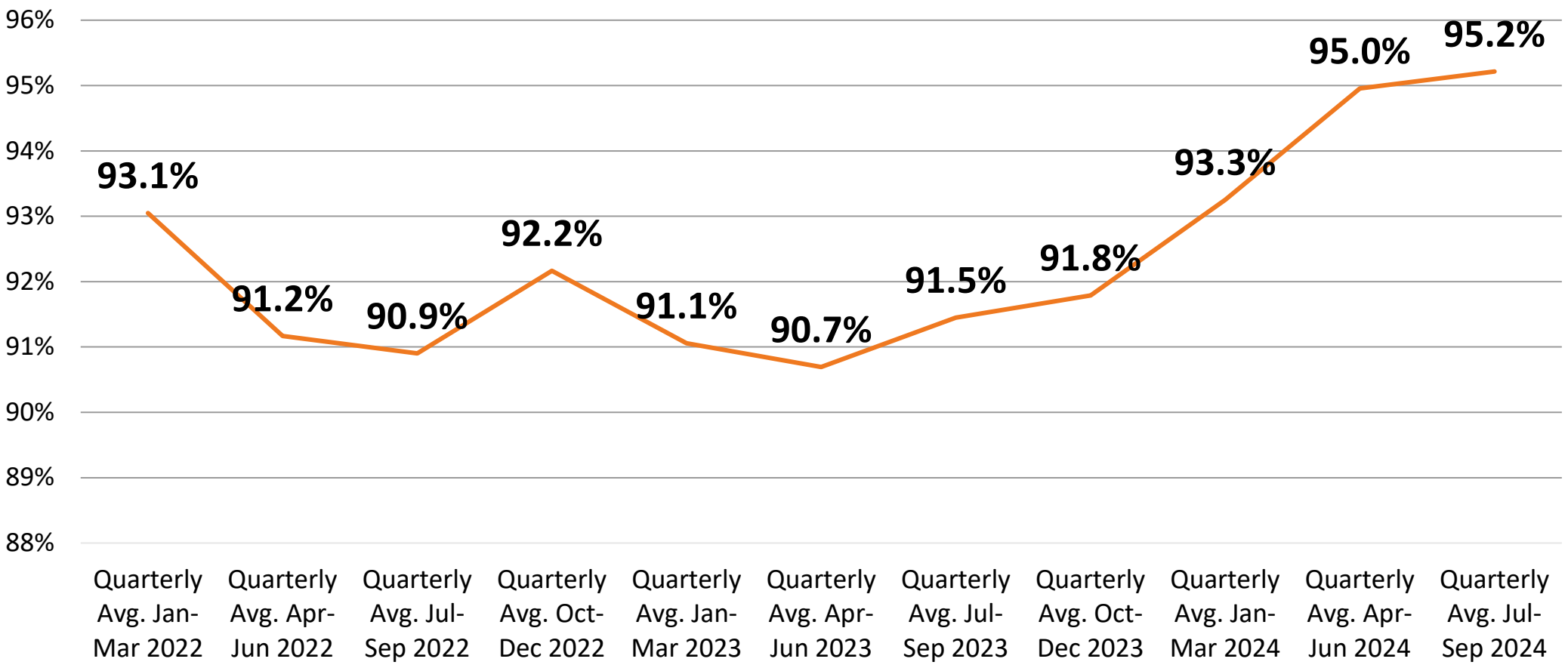
Current UVA RWHAP Patients

Current Patients = 974

• Gender	Race/Ethnicity	Age Group	Insurance
72% Male 26% Female 2% Transgender	45% White (non-Hispanic) 43% Black or African American 7.4% Hispanic **Other Groups <5% combined** American Indian/Alaska Native Asian More than one race Not specified Other Pacific Islander	33% 25-44 50% 45-64 13% 65+ **Age Groups <5% combined** Under 2 2-12 13-24	33% Medicaid 23% Medicare 25% Private- employer 10% Uninsured 7% Private- individual 2% Other

- 40% with incomes less than 100% of the Federal Poverty Line
- Non-urban clinic, patients can travel long distances

UVA RWHAP Patients HIV Viral Suppression



RWHAP PART D WICY-
Patient Retention in Care Project

- For the project, we had ~300 WICY-eligible people with HIV
  - Data Coordinator- weekly report of WICY patients that “no showed” their visits
  - Program Director and dedicated mental health case manager- call patients directly to learn of the reasons for their “no show,” resolve the barrier to care right away (transportation, housing needs, food security, childcare services), and link patients to medical case management
  - Calls- done after hours
  - Used My Chart to reschedule patients

- **Barriers to Care discovered**
  - Housing instability/ Homelessness
  - Lack transportation
  - Mental Health issues
  - Substance use disorder.
  - Food Insecurity
  - Lack of Childcare

Change in Average No Show Rate During WICY No Show Project Compared with Control Time Period

	Control Period	Project Period		
	Oct '22 to Jul '23	Oct '23 to Jul '24	Absolute Change	Percent Change
WICY No Show Rate	22%	17%	-5%	**-23%**
Non-WICY No Show Rate	18%	15%	-3%	-17%
All Clients No Show Rate	19%	16%	-3%	-16%

Linkage & Retention of Patients Out of Care

Who is considered out of care?

- No medical appointment in 6 months; inactive if no medical service in one year

How do we re-engage patients who are out of care?

- Quarterly, Virginia Department of Health (VDH) runs a “Data to Care” report of clients that have not had a medical service in 15 months.
- Monthly, our Data Coordinator provides a UVA Careware report of patient that have not had a service in 6 months.
- Retention in Care Coordinator contacts patients to reengage them in care, by using phone numbers in Electronic Medical Record (EMR), Vine link, or using handwritten letters to the address on file.
- Case managers collaborate and share information and update our EMR system if a patient has relocated, transferred care, or passed away
- Patient chart review, including care everywhere.

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