

DOES A HOSPITAL-TO-COMMUNITY MULTI-DISCIPLINARY INTERVENTION IMPROVE OUTCOMES IN PEOPLE LIVING WITH HIV (PLWH) IN SASKATOON?

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As we gather here today, we acknowledge the land on which we gather is the traditional territory of the Attawandaron, Anishinaabeg, Haudenosaunee, and Lunaapeewak peoples who have longstanding relationships to the land, water and region of southwestern Ontario. We pay our respect to the First Nations ancestors of this place and reaffirm our relationship with one another.



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- In 2017, amidst an emerging syndemic^{1,2} (HIV, HCV co-infection, substance use) a cohort of PLWH had frequent acute-care utilization, were leaving early and/or against medical advice with poorer clinical outcomes
- Contributing factors:
 - Upstream, historical structural inequities^{1,2,3}
 - **Local system-level gaps** ie: in-hospital harm reduction policies, person-centered culturally safe care, tailored and flexible outreach supports and outpatient services
- Local stakeholders designed a complex 'wrap-around' hospital-to-community intervention **HIV/AIDS Rapid Response Team – HART:**

Intake done in-hospital

- PLWH with complex social and medical needs
- PLWH vulnerable to poor clinical and social outcomes
- Hospital policies failing patients
- Patient-led priorities

HART organization goals

- 3mth hospital-to-community service
- Medical/Substance use providers and supports, integrated HIV services
- Flexible/mobile Social supports and outreach: transport, housing, income, peer support, spiritual needs, low-barrier services
- To improve HIV-related outcomes and hospital utilization

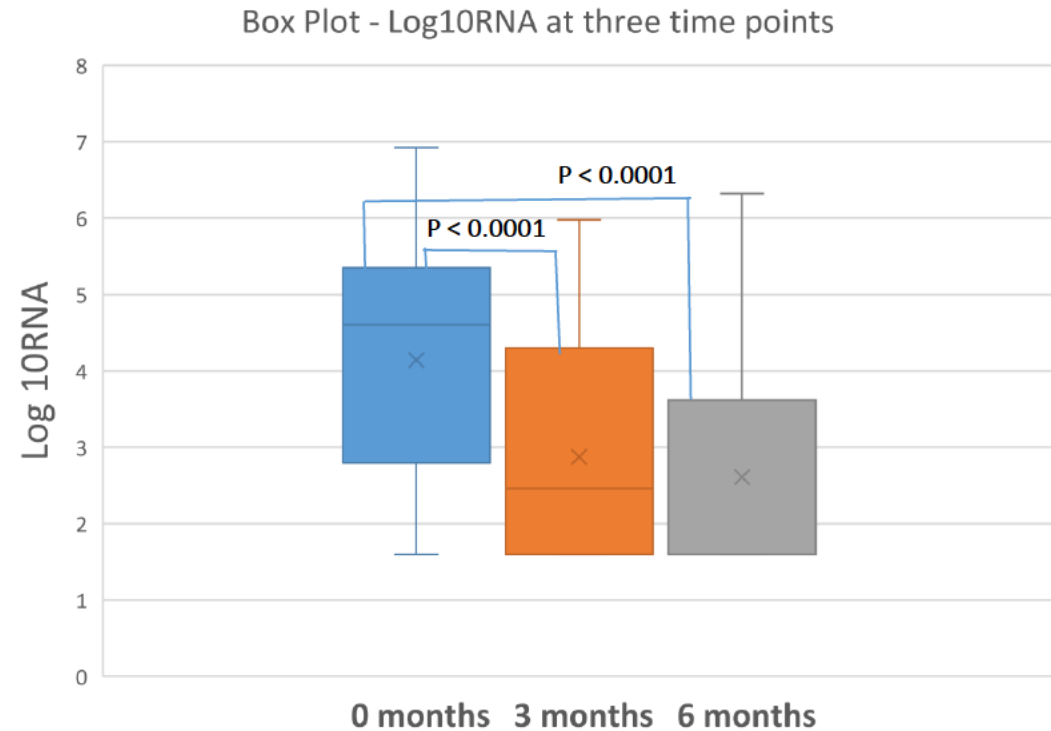
HART care philosophy

- Trauma & Violence Informed care
- Culturally safe care
- Person-centered care
- Harm reduction

- **Study Objective:** To determine if HART improves HIV-specific outcomes in PLWH
 - Primary outcome: viral load
 - Secondary outcomes: housing status, ARV treatment, self-reported health, community and income supports, mortality
 - Process outcomes: duration of the intervention, #primary specialist appts, referral source, OST prescriptions
- **Design:** single group pretest-posttest analysis at 0,3,6mths, using routinely collected HART data at these timepoints
- **Setting:** Saskatoon, SK
- **Study population:** adults living with HIV in Saskatoon *Inclusion:* All patients admitted to hospital, 18 years or older, HIV seropositive and who consented to HART *Exclusion:* <18years HIV seropositive, unable to consent or declined service.
- **Timeline:** April 1, 2017 – June 1, 2019
- Ethics approval by the REB, University of Saskatchewan

RESULTS:

- 133 patient charts were included:
 - Largely HCV co-infected 75.6%(CI:67.3-82.7)
 - Active substance use 72.5%(CI:64.0-79.95)
 - HIV mono-infected patients had significantly lower substance use than HCV-co-infected (47.8% p=0.003,)
- ***VL's were significantly reduced*** at 3 and 6mths (2.88 log₁₀ p<0.0001, 2.61 log₁₀, p<0.0001) with parametric (t-test) and non-parametric (Wilcoxon) tests
- More people were receiving ARV's at 3 and 6mths (34.1% p=0.000, 29.4% p=0.000)
- Fewer people were living with homelessness at 3 and 6mths (25.6% p=0.00, 19% p=0.0005)
- Income supports increased at 3 and 6mths (9% p=0.012, 18% p=0.011)
- Co-infection with HCV predicted a lower 3mth VL (126, 990 p=0.042)
- Clients completed the intervention in 50-150 days, the majority at 100 days
- Attrition was low at 3 month (N=116) – 2 lost to follow up, 5 deceased, 10 data entry errors



PRELIMINARY CONCLUSIONS...

- There is clinical and statistical evidence that HART does improve HIV-specific outcomes and that this improvement is sustained beyond the intervention period
- Intervention components seem well-matched to the needs of the target population, specifically relationship-driven model, organizational flexibility and in-hospital advocacy
- Focus-group discussions with key communities for giving back knowledge and determining recommendations are upcoming
- An analysis of hospitalization utilization data in HART patients vs controls is ongoing