Supporting Rural Areas: A Clinic-led Outreach HIV Care Model and its Associated HIV Cascade of Care Outcomes, Saskatchewan, Canada, 2018-2020.

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INTRODUCTION

- Saskatchewan (SK) has had the highest incidence of HIV nationally for over a decade, with Indigenous people being overrepresented in the SK HIV epidemic.
- HIV, which was initially concentrated in urban centres, began to spread to rural and remote areas in Saskatchewan.
- Due to the concentration of health care services in urban centers, access to diagnostic testing and treatment can be delayed for those residing in rural areas.
- We describe a unique rural care model that delivers patient-centred care to address gaps in HIV care in rural and Indigenous communities.

METHODS

- Existing documentation and key stakeholders engagement were used to describe the care model.
- Data was extracted for clients accessing care between January 1, 2018 and December 31, 2020 from the clinic's electronic medical record system.
- Demographics were described, including gender, age, and HCV co-infection as well as clinical care outcomes.
- The proportion of active clients on treatment and virally suppressed were defined as at least one antiretroviral (ARV) prescription in the calendar year and the last viral load within the calendar year being <200 copies/mL, respectively.

CARE MODEL

- The care model was initiated in 2016 to bring care to clients in a patient-centred approach aiming to reduce barriers to care.
- An Urban team, consisting of an Infectious Disease Physician, nurse practitioner and nurses, who travel out ~200-250km, on a monthly basis, to provide satellite clinics at regional local hospitals and community sites.

CARE MODEL (CONT'D)

- The model relies on local services including opioid substitution therapy and pharmacy. Phlebotomy services were introduced in 2020 by the outreach team due to limited local laboratory services.
- The urban team is engaged with local public health nurses to support the ongoing case management of clients and ensure retention in care.
- Due the COVID-19 pandemic, in-person clinics were temporarily suspended and replaced by virtual and telehealth care between April and September of 2020.
- A hybrid model of in-person and virtual care continues today.
- The clinics strive to deliver culturally safe and trauma informed care.

RESULTS

Table 1. Characteristics of clients living with HIV who were in care between 2018-2020 (n=48)

	N	%
Males	26	54%
Avg. Age	45 years (SE ± 2.07)	
Residence in First Nation Community	33	69%
Hepatitis C co-infection	34	71%
History of Injection Drug Use* (n=43)	31	72%

*Among those with recorded risk factor information

Figure 1. HIV Cascade of Care for the outreach clinics, 2018-2020

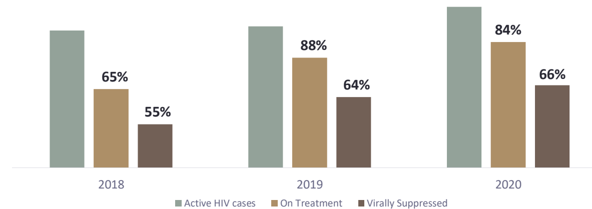
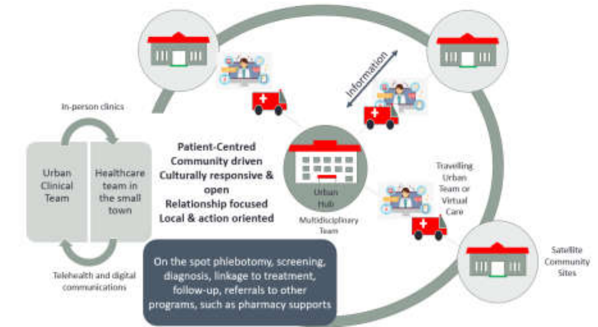


Figure 2. Clinic-lead outreach HIV care model illustration



CURRENT STATE/CHALLENGES

- Dedicated staff at partner sites and within the urban team are key to the success of the program. Long standing staff help foster trust.
- Patient specific challenges such as the lack of basic securities (i.e. homelessness, food security, poverty, etc.) are common and impact clients' overall health and involvement in care.
- A hybrid model (in-person and virtual care) appears to be improving patient engagement, giving patients further flexibility in accessing care.

CONCLUSIONS

- Despite the disruptions of COVID-19, this remote clinic outreach model achieved improvements in the cascade outcomes.
- The improvements reflect progress in establishing relationships, building trust with clients and the utility of virtual care to maintain patient care during a pandemic.

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