

# Standardizing a Process for Identifying Out of Care Patients at an HIV Clinic Site

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## Background

Poor engagement and retention in care are associated with worse outcomes including decreased rates of viral suppression and increased morbidity and mortality among people living with HIV (PLWH). Patient navigation and Data to Care (D2C) strategies are evidence-based interventions that have been shown to improve HIV Care Continuum outcomes.

## Goal/ Objective

This quality improvement project aimed to develop and standardize a sustainable process for identifying patients who have been out of care (OOC) at two HIV clinical sites at Johns Hopkins and prioritizing patients for navigation or outreach services for reengagement in care.

## Methods

The process included identification of OOC patients using a combination of an EPIC clinic dashboard, and an HIV patient database. Patients were considered OOC if they had not been seen at the two clinic locations for any clinic visit between 01/01/2021 – 12/31/2021, but were previously seen by an HIV provider in the prior 36 months. Through chart review of Epic and Epic interfaces with outside medical institutions including Care Everywhere and CRISP by an OOC workgroup, patients were categorized as engaged in care, deceased, transferred care, moved out of state, or out of care. A protocol was developed to standardize list generation, chart review efforts, and outreach activities.

## Results

A total of 169 presumed OOC (POOC) patient records (mean 48±13.9 years old, 78% African American, 71% male) were reviewed to determine if the patient was engaged with HIV care or if their medical record required updating to reflect either a change in location or vital status (Table 1). From the review it was determined that the majority of patients were engaged in care with 31% (n=52) of the patients having re-engaged with a local practice, and 20% (n=34) transferring care to an HIV clinic within the state of Maryland (Table 3). Additionally, 11% (n=19) of the patients were determined to have died. Of the remaining 40 patients who were OOC, 7 had engaged with Bartlett navigation services, while 33 had no documented contact with any Bartlett clinic team member nor any of the HIV clinics identified through Epic interfaces.

## Conclusions

Development of a standardized process for identifying OOC patients allowed the clinic to update vital statistics within the electronic medical record system, delineate patients needing reengagement services and prioritize outreach efforts by identifying patients with no HIV care contact who required referral to the health department for home-based outreach or more intensive reengagement in care services.

## Clinical Implications

Given the time constraints on clinic personnel in HIV clinics with high patient loads, establishing a feasible, systematic and sustainable process to identify and provide outreach to OOC patients may improve clinic engagement and clinical outcomes. By creating reports and updating patient information including vital statistics and transfer of care, clinics can employ a data-driven and standardized process to proactively distinguish patients that are OOC and more readily intervene to promote engagement and retention in HIV care.

**Table 1. Characteristics of Presumed OOC (POOC) Review Patients and the 2021 Clinic Populations**

Characteristics	POOC N (%)	2021 Clinic Population N (%)
<b>Age</b>		
<b>18-29</b>	17 (10)	160 (5)
<b>30-49</b>	73 (43)	882 (29)
<b>50-69</b>	71 (42)	1742 (58)
<b>&gt;70</b>	8 (5)	214 (7)
<b>Sex at Birth</b>		
<b>Male</b>	120 (71)	1943 (65)
<b>Female</b>	49 (29)	1054 (35)
<b>Race</b>		
<b>Black/African-American</b>	131 (78)	2195 (73)
<b>White</b>	32 (19)	600 (20)
<b>Other</b>	5 (3)	202 (7)
<b>Ethnicity</b>		
<b>Hispanic</b>	5 (3)	113 (4)
<b>Non-Hispanic</b>	164 (97)	2884 (96)
<b>Last HIV Viral Load (copies/mL)</b>		
<b>No nucleic acid detected</b>	110 (65)	2326 (78)
<b>20-200</b>	26 (15)	454 (15)
<b>&gt;200</b>	32 (19)	203 (7)

**Table 2. Date of Last HIV Primary Care Visit for OOC Patients**

Last Engaged in Care	N (%)
<b>2020</b>	160 (95)
<b>2019</b>	7 (4)
<b>2018</b>	2 (1)

**Table 3. Out of Care Classification Outcomes**

Out of Care Classification Outcomes	N (%)
<b>In care</b>	52 (31)
<b>Moved out of state</b>	24 (14)
<b>Transferred care</b>	34 (20)
<b>Deceased</b>	19 (11)
<b>Out of care</b>	33 (20)
<b>Out of care - engaged with navigation</b>	7 (4)

**Table 4. Characteristics of Patients Determined to be Out of Care Post Review**

Characteristics	N (%)
<b>Age</b>	
<b>18-29</b>	4 (10)
<b>30-49</b>	18 (45)
<b>50-69</b>	16 (40)
<b>&gt;70</b>	2 (5)
<b>Sex at Birth</b>	
<b>Male</b>	32 (80)
<b>Female</b>	8 (20)
<b>Race</b>	
<b>Black or African-American</b>	33 (78)
<b>White</b>	4 (19)
<b>Other</b>	3 (3)
<b>Ethnicity</b>	
<b>Hispanic</b>	2 (5)
<b>Non-Hispanic</b>	38 (95)
<b>Last HIV Viral Load (copies/mL)</b>	
<b>No nucleic acid detected</b>	19 (48)
<b>20-200</b>	10 (25)
<b>&gt;200</b>	11 (28)

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