

# The Care Continuum across clinics in Atlanta: The need for targeted interventions

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# A Generalized Epidemic

Cluster = 1.34%  
prevalence

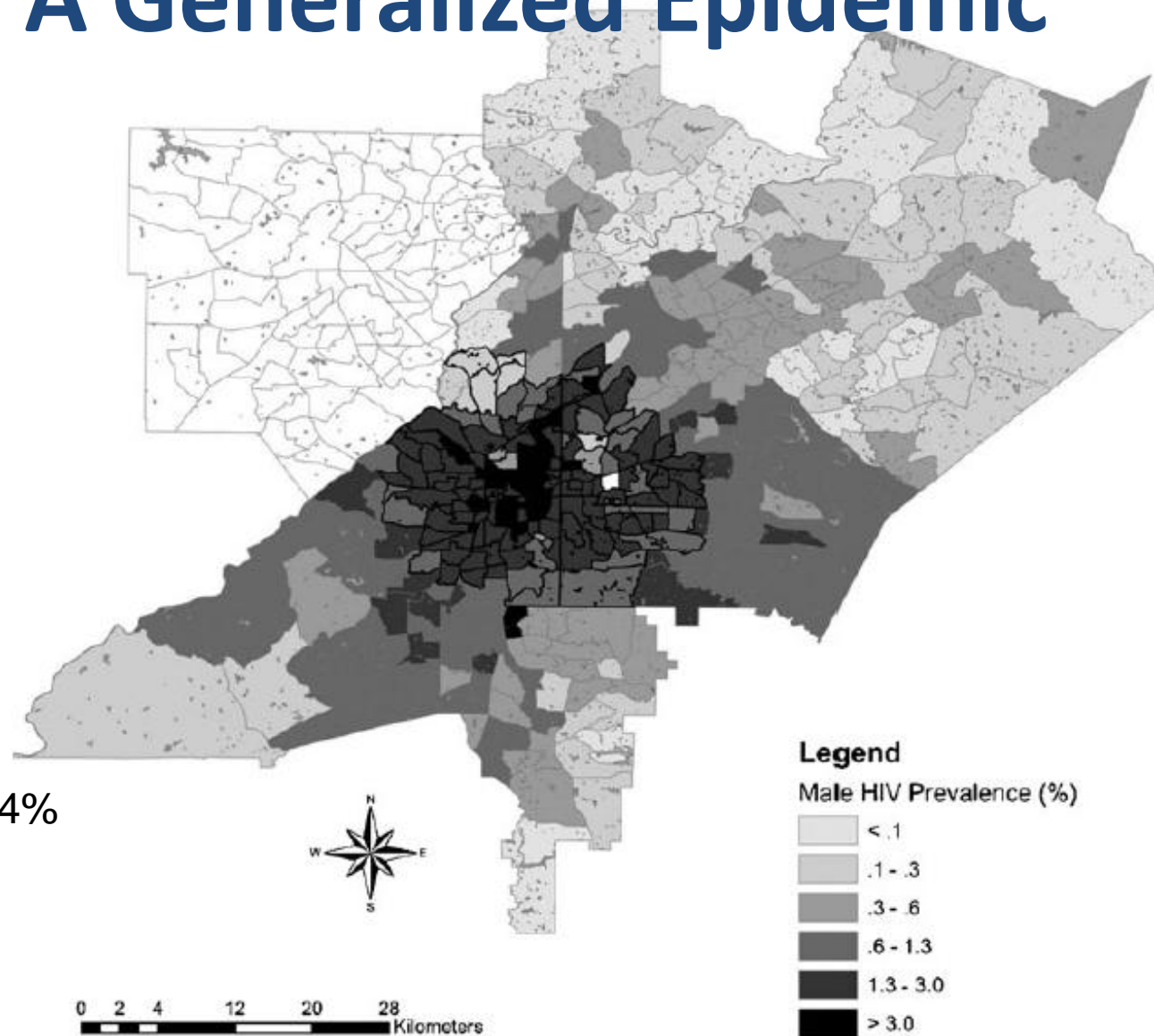
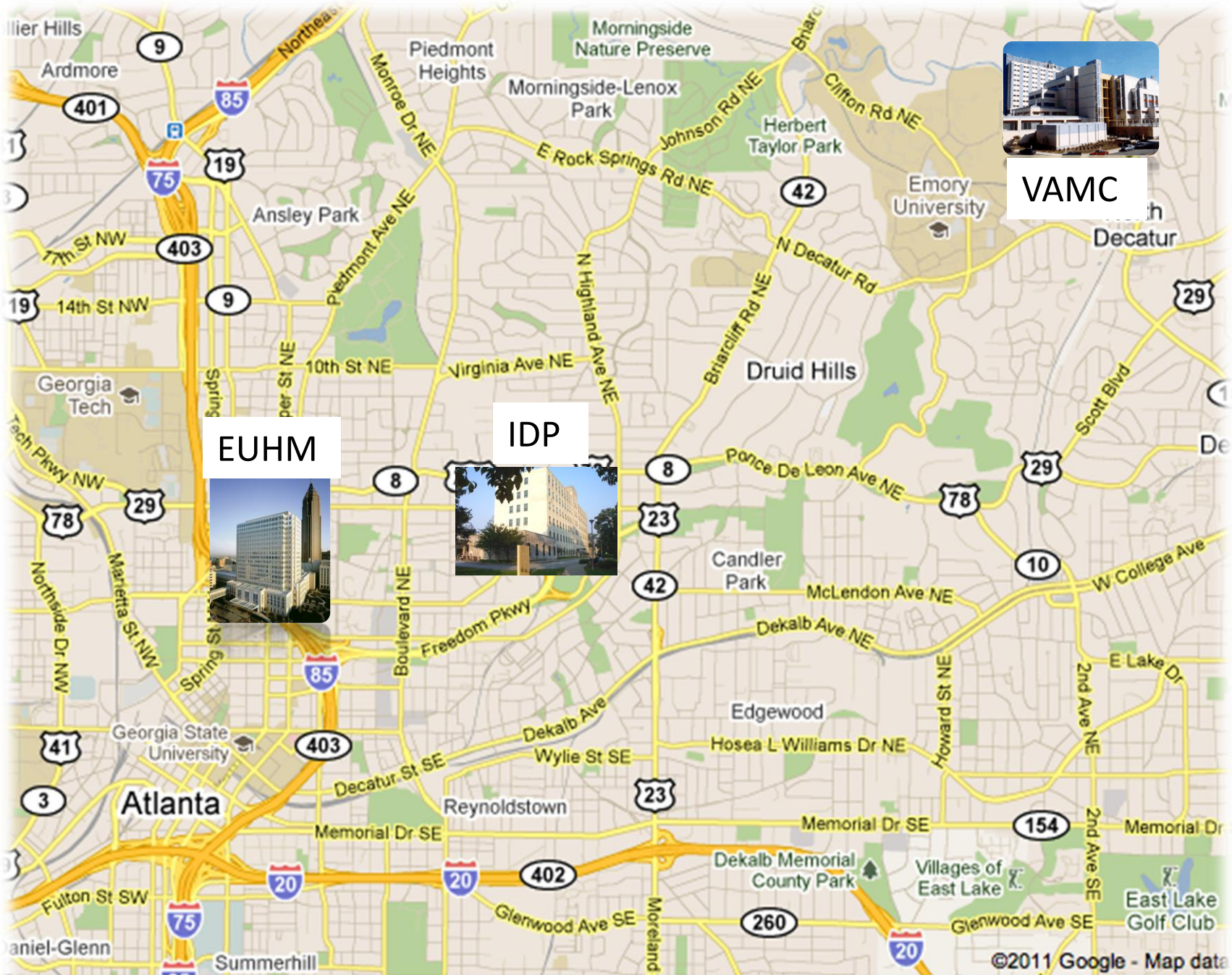


FIGURE 3. Overlay of prevalent HIV cases among males in a four-county area.



EUHM



IDP



VAMC



# Emory HIV patients

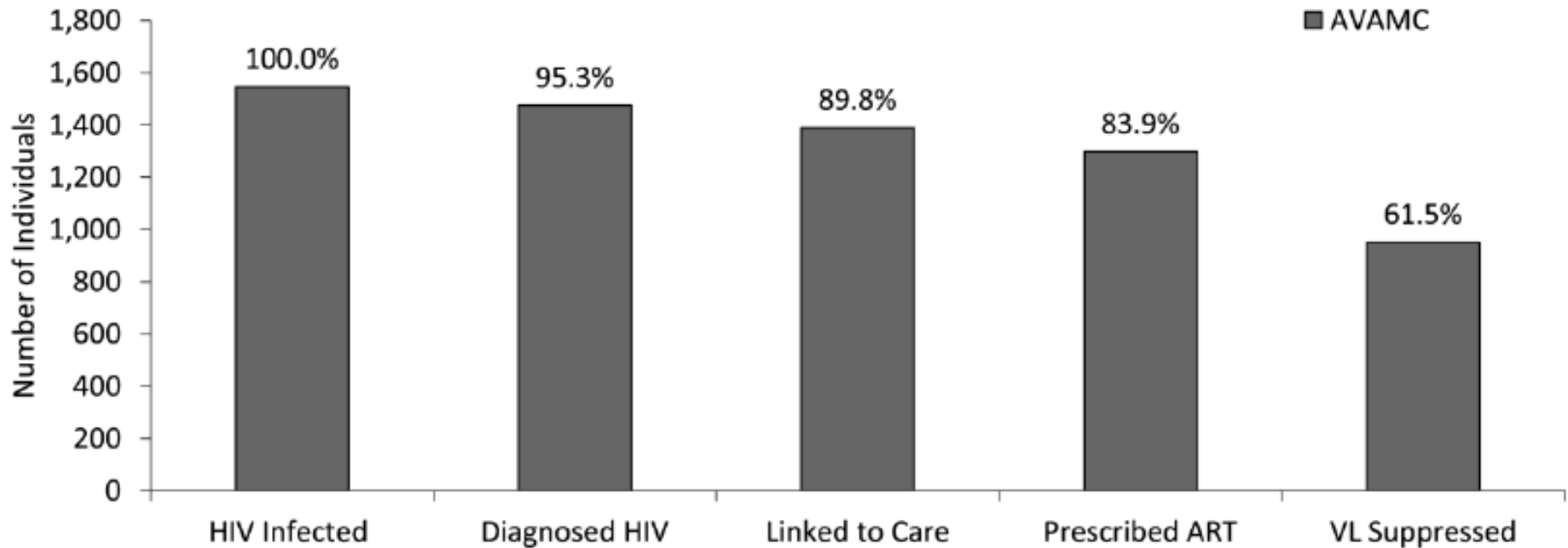
	IDP	EUHM	VAMC
<b>Total active patients</b>	5208	1548	1490
<b>Male/Female (%)</b>	71/29	81/18	98/2
<b>White/Black (%)</b>	15/82	32/67	19/63
<b>≥45 yrs</b>	29%	43%	71%
<b>&lt;44 yrs</b>	71%	52%	29%
<b>&lt;100% FPL</b>	61%	28%	
<b>101-200% FPL</b>	28%	21%	
<b>Medicaid/Medicare</b>	49%	37%	N/A
<b>Self Pay/RW</b>	47%	9%	N/A

# Specific Aims

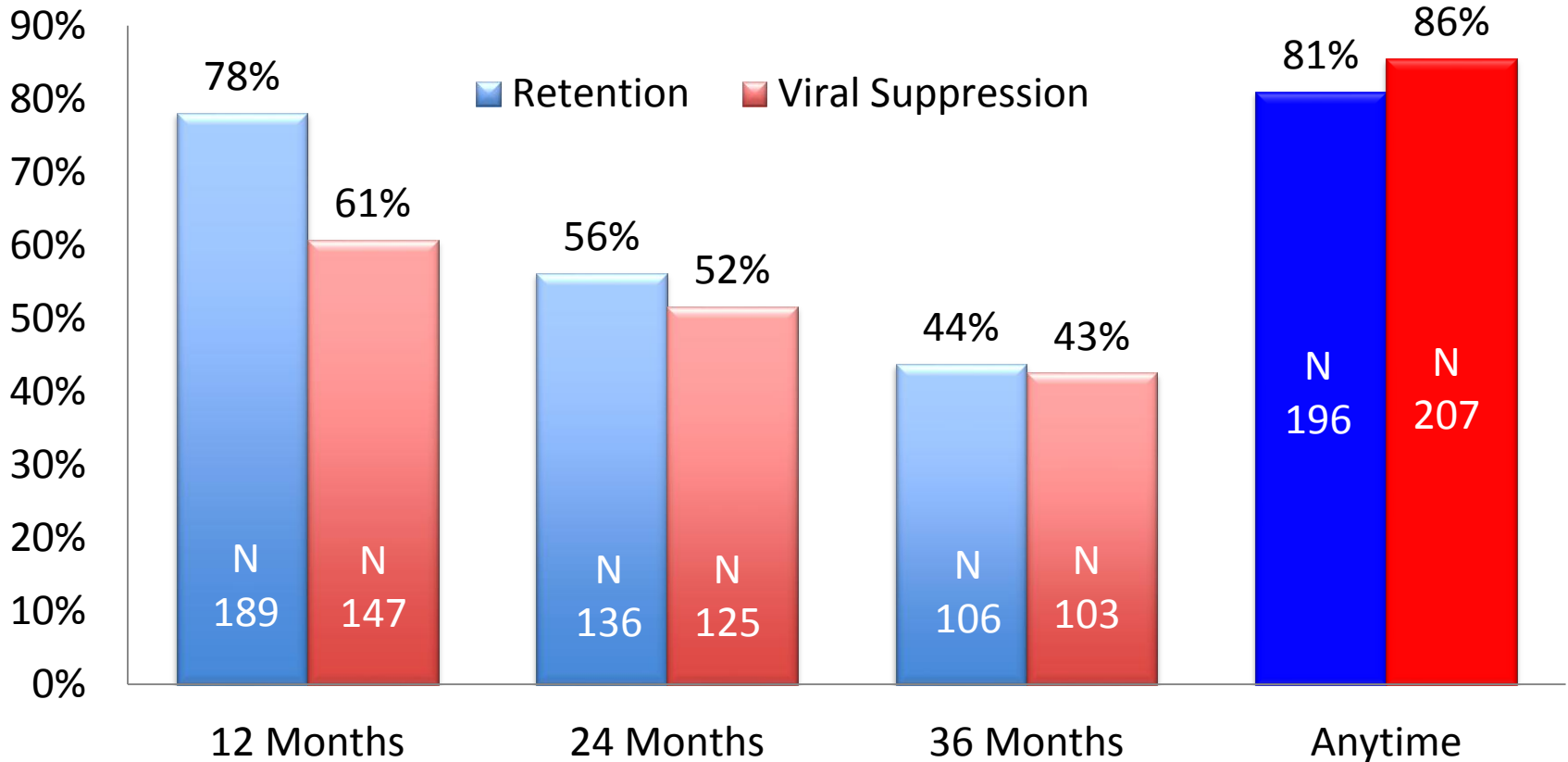
- Build the continuum of care for each Emory-affiliated site and compare data across systems
- Evaluate longitudinal retention in care versus “snapshot” retention and identify percentage of patients in churn
- Assess traditional but also non-traditional risk factors in those linked but not retained and assess the community viral load of this population



# Atlanta VAMC



# Longitudinal Outcomes-EUHM

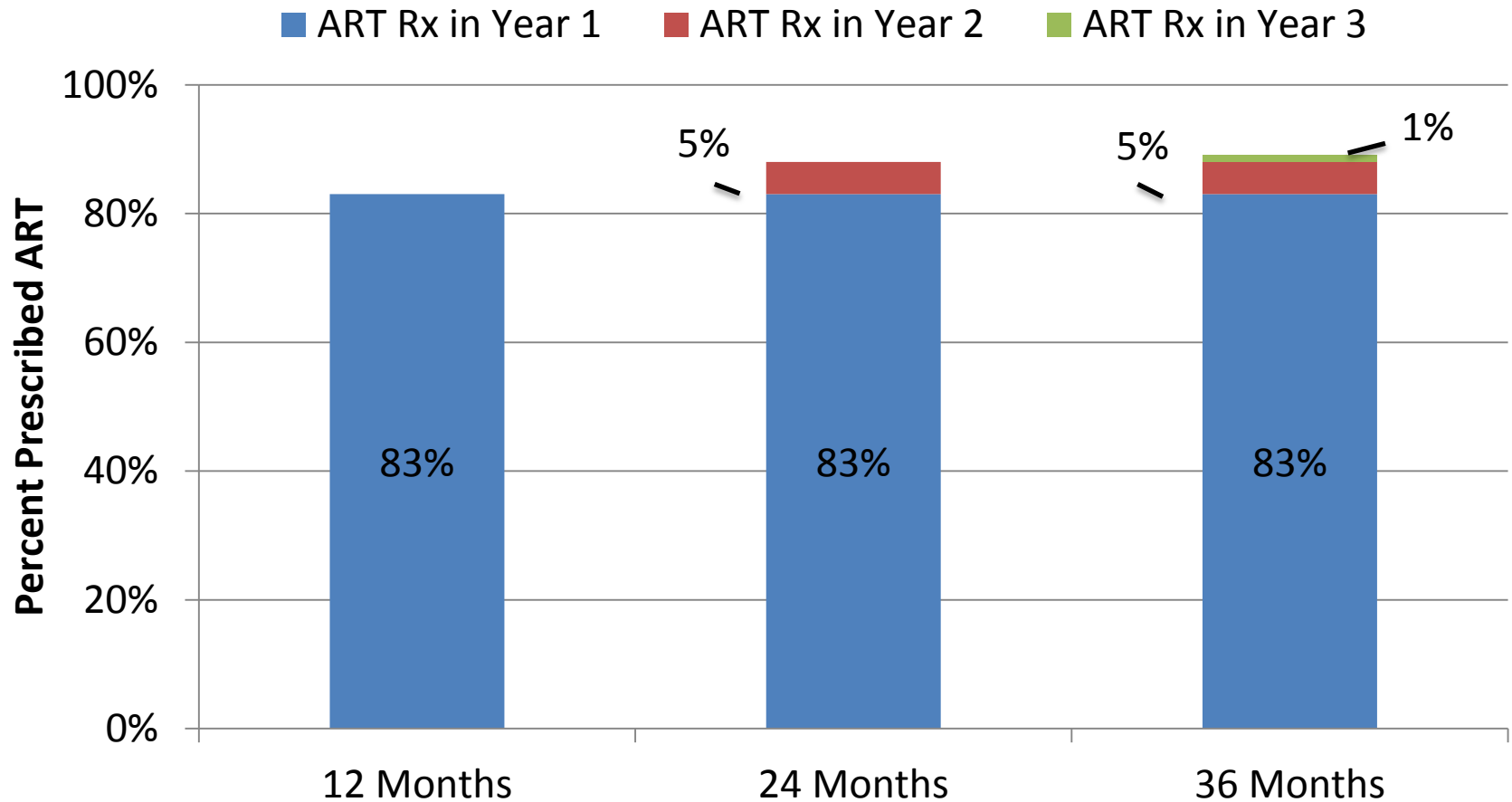


N=242 new patients 2009-2010

**Retention** = 2 clinician visits separated by at least 90 days within each prior 12 month block

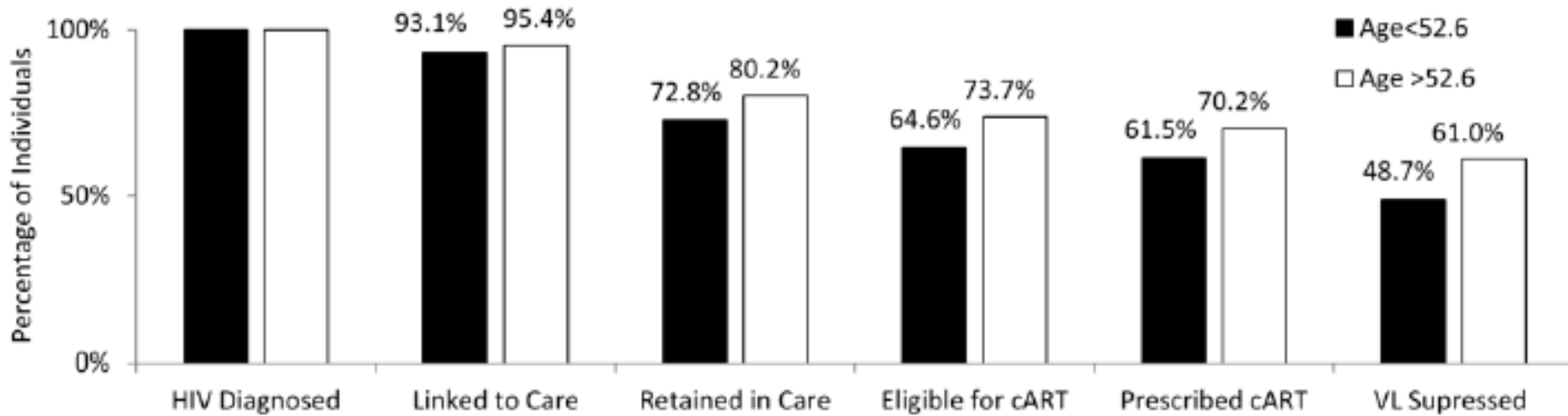
**Viral Suppression** = Most recent VL within prior 12 months <1000 copies/mL ;  
if patient had no VL within that time period, considered to have viremia

# High Rates of ART Prescribing

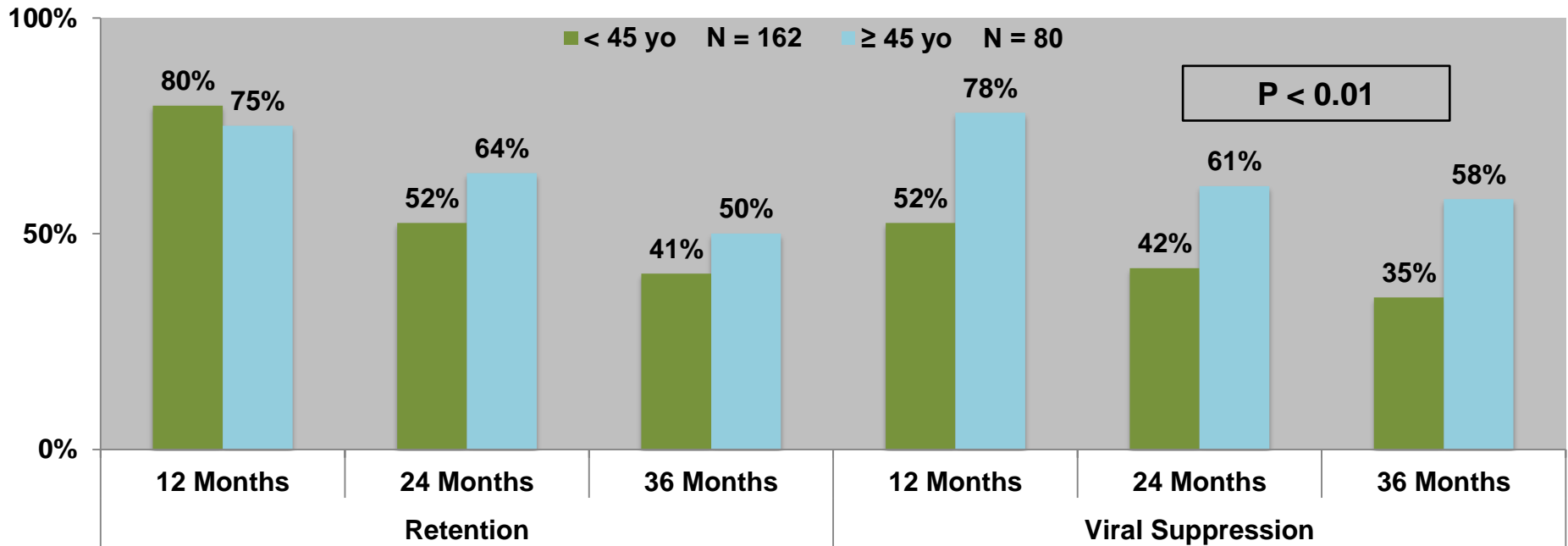




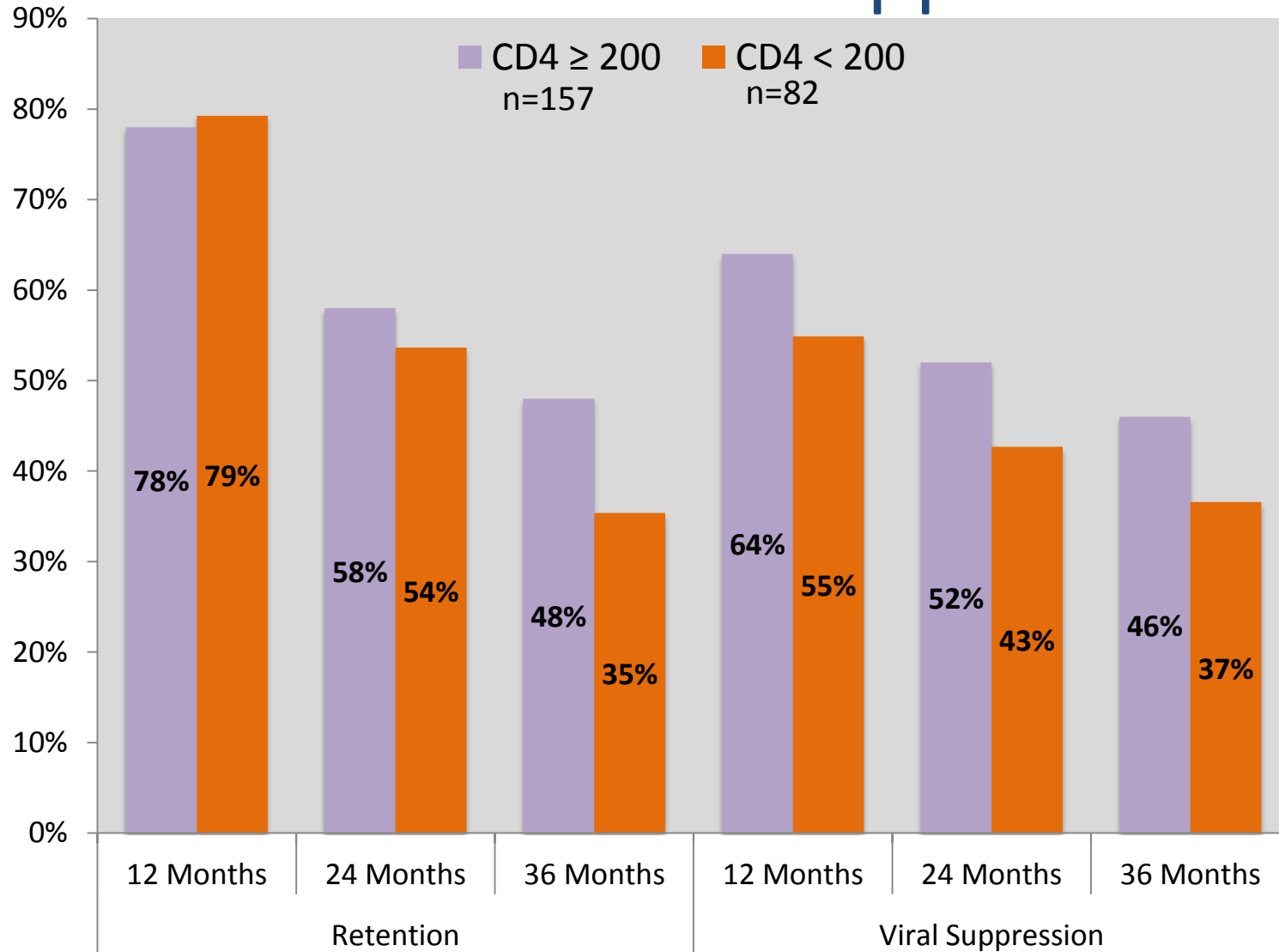
# Impact of Age (VA and EUHM)



Mangal et al, 2013

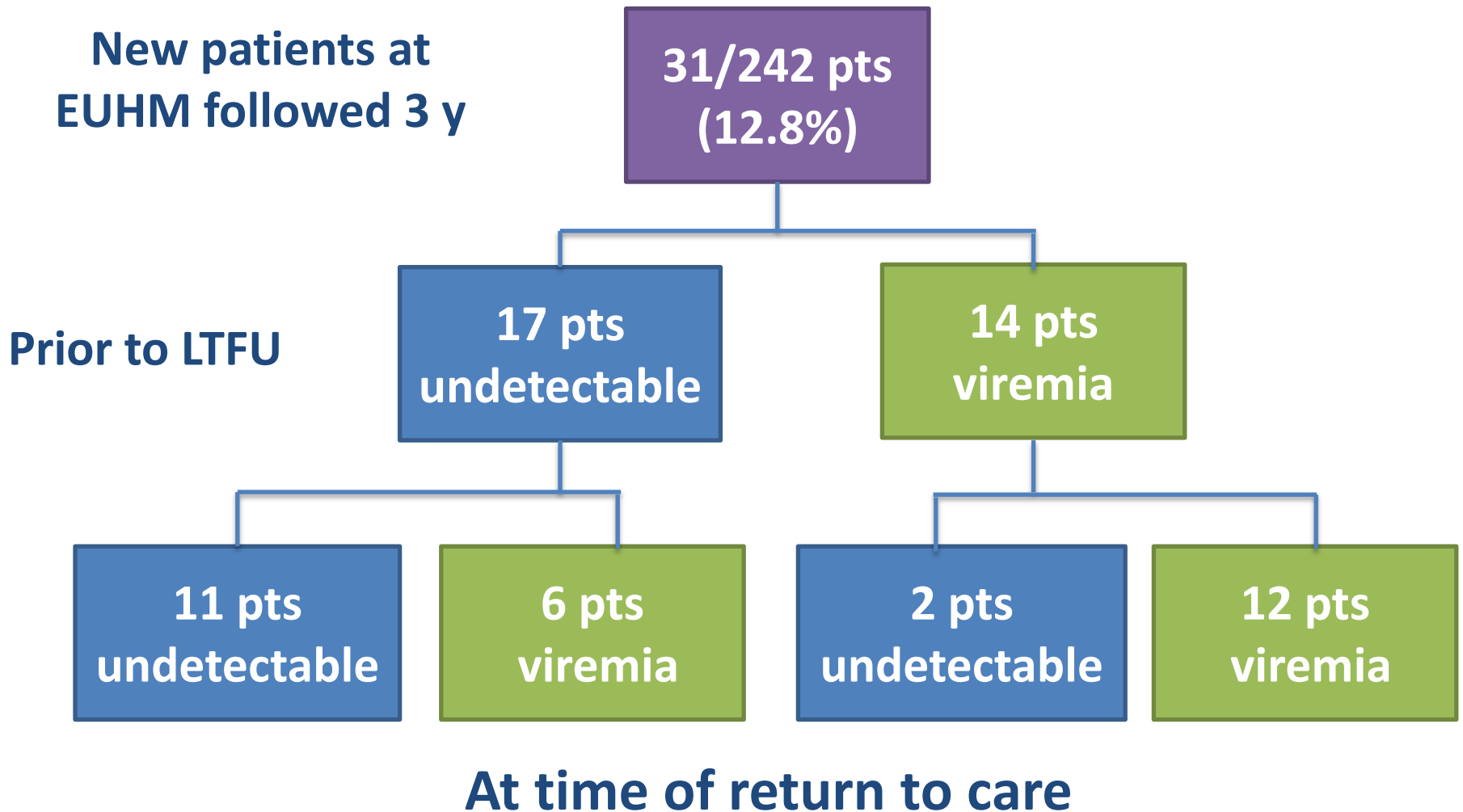


# Presenting CD4 count with no effect on Retention nor Suppression



# A look at churn

Gap in care > 365 days and returned to same clinic



# Lessons learned so far...

- Longitudinal data teaches additional lessons about the care continuum and the public health implications
- Obtaining data that is granular enough to provide this information is challenging
- Populations located even in very close proximity can show very different results that are likely not entirely explained by socio-economic factors

# Much more work to be done

- Collect data at our third site, IDP and longitudinal data at the VA
- Merge this data with records from the GA DPH to assess patients that shift sites of care
- Quantify the effect of churn at other clinics
  - Clinic viral load?
- Assess non-traditional risk factors among those not longitudinally retained including social capital, stigma measures, transportation etc.



**Targeted Interventions**

# The IDP Transition Center

	Pre TC	Post-TC	p value
% mos linked to care	81%	95%	<0.0001
% time virologic suppression	9%	42%	<0.0001
$\Delta$ CD4+ T cells (cells/ml)	-19/year	+36/year	<0.0001

- Positive factors

- Mental health care
- SA counseling
- **Social support**
- **TC Staff**
- Pt/Prov relationship

- Negative factors

- Substance abuse
- Mental health
- Homelessness
- **Transportation**
- Incarceration

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