

Results from a quality improvement initiative to improve antiretroviral therapy adherence at an HIV/AIDS health care facility that incorporates supervised injection services into an integrated HIV/AIDS health care program

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INTRODUCTION

The Dr. Peter Centre (DPC) is a not-for-profit health care facility in Vancouver, Canada that provides an integrated model of HIV/AIDS health care and support services to mitigate the risks faced by marginalized persons living with HIV/AIDS. Among the inherent risks these individuals face are unsafe illicit drug injection practices, homelessness, mental illness, food insecurity, unemployment, drug criminalization, and a reluctance of health professionals to provide health care due to negative attitudes towards this population.

In 2010, the DPC joined the STOP HIV/AIDS Structured Learning Collaborative, a quality improvement initiative aiming to improve care and treatment for better adherence and client outcomes. Aligned with this, the DPC aimed to increase ART adherence by 15% and develop a measure for client engagement that could be linked to health outcomes.

METHODS

The DPC applied a quality improvement framework to test, measure and apply interventions in the areas of adherence (as measured by medication administration records), virological results and self-reports using a customized validated survey to ascertain client-provider engagement and satisfaction.

As this at-risk population experiences barriers to traditional adherence strategies, the DPC uses an integrated model with multiple entry points (see graphic in the center column) to engage individuals in their health care with a specific goal of improved adherence to HIV treatment and overall improved health.



Engagement in Care at the Dr. Peter Centre

INTERVENTIONS

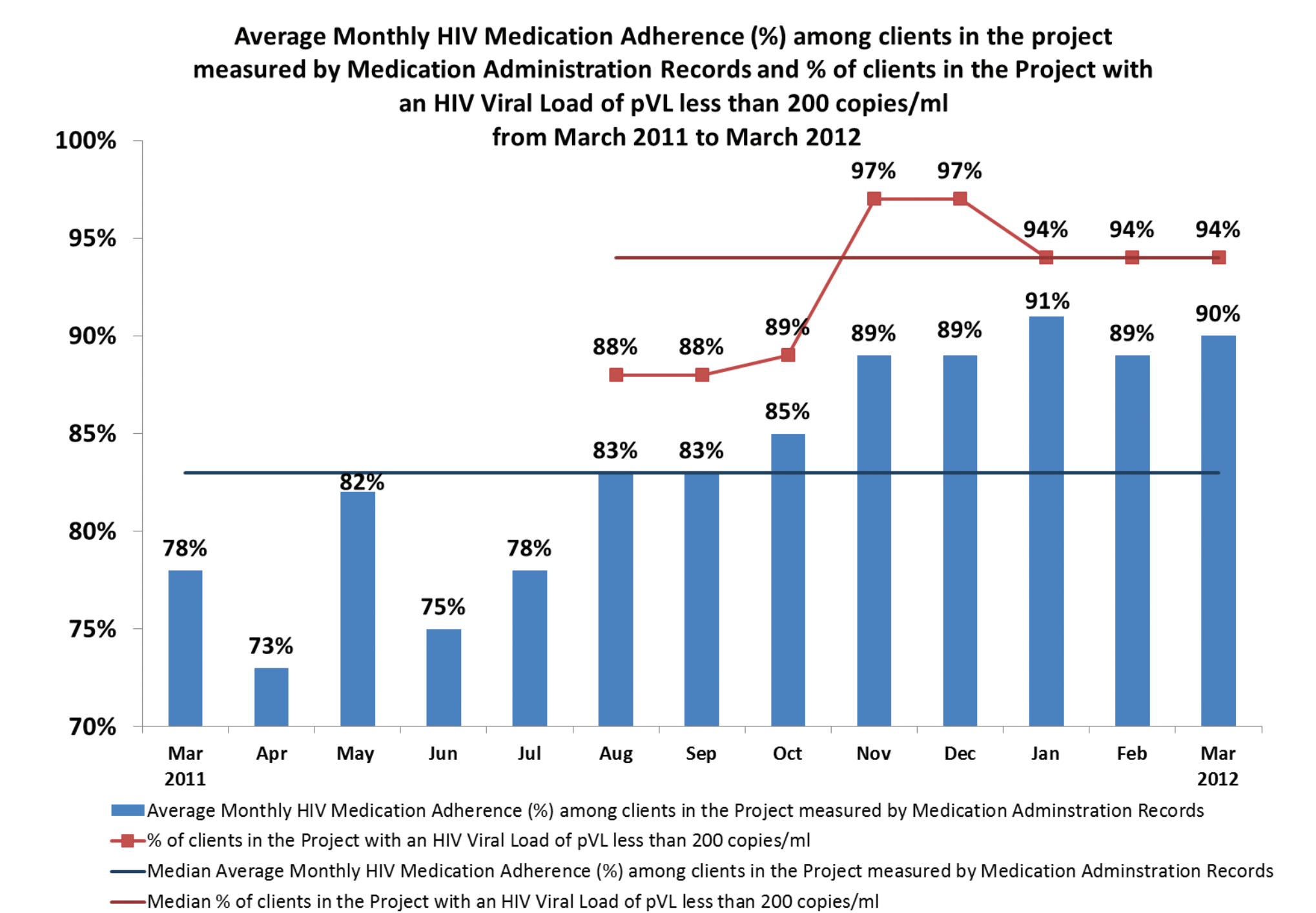
For its population of focus (POF), the DPC selected clients who were known to be reluctant to medication adherence and treatment procedures. Interventions were developed that utilized current engagement strategies, emphasizing medication adherence and treatment procedures (e.g., blood collection). The challenge with designing more assertive interventions for these individuals is ensuring that there is no perceived barrier to service, and they continue to engage in care.

Interventions included:

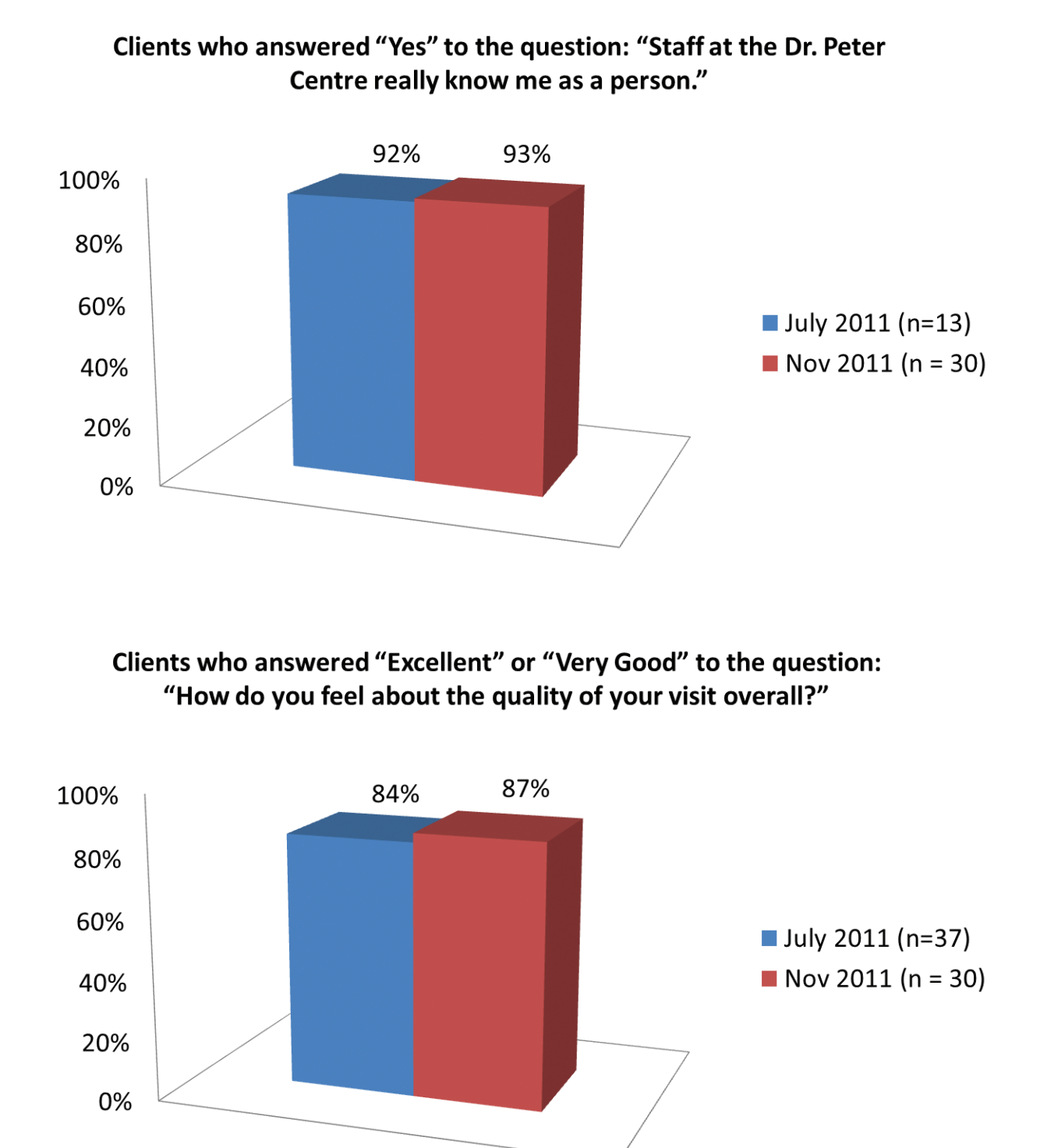
- Improved systematic collection of data related to medication administration and monitoring and laboratory results.
- Client self-assessment surveys which provided self-reports on adherence, engagement and satisfaction. In addition to being another adherence measure, the self-reported adherence became a potential vehicle for clinician-client dialogue on HIV treatment and overall health.
- Design of customized self-management support strategies and focused care plans.
- Improved collaborative care strategy that recognizes the combined value of self-care and formal care provision.

RESULTS

After one year, ART adherence increased by 15%, and the number of clients with undetectable viral loads (pVL less than 200 copies/ml) increased by 7% (n = 44).



Surveys were administered twice, demonstrating positive client-provider engagement scores of 92% and 93% at two different intervals. Client satisfaction increased from 84% to 87%.



DISCUSSION

The DPC achieved its aim of increasing ART adherence by 15%. Positive and consistent results in the areas of client engagement and satisfaction suggest that the increased emphasis on adherence did not create a therapeutic barrier between clients and staff and services at the DPC. While the DPC did develop some proxy measures for engagement, a specific tool to measure client engagement in health care was not achieved.

CONCLUSIONS

Engagement and ART adherence support strategies within an integrated model can improve ART adherence and health outcomes for marginalized persons living with HIV/AIDS.