The role of primary care professionals in reaching the undiagnosed and re-engaging those lost to care

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HIV GP Champion Lewisham

Introduction and Background

Dr Grace Bottoni
- GP training in Lewisham
- Rotation in HIV clinic
- GP HIV Clinical Fellowship at GP Federation

- One Health Lewisham (OHL) is a GP federation of 32 GP practices in Lewisham
- Lewisham has a particularly high prevalence of HIV (8 per 1000) with a tendency for late diagnosis (40% of patients living with HIV (PLWH) are diagnosed late)
- In **June 2019**, OHL was contracted to a Social Impact Bond (SIB) called **Zero HIV Project**, commissioned by the Elton John AIDS Foundation
- **Outcome-based payments** were the primary mechanism of funding
  These were made **against two specific outcomes:**

  1. Identifying new diagnoses of HIV in primary care or;

  2. Re-engaging PLWH who were lost to follow up (LTFU)

ONE HEALTH LEWISHAM
The Integrated Community Provider

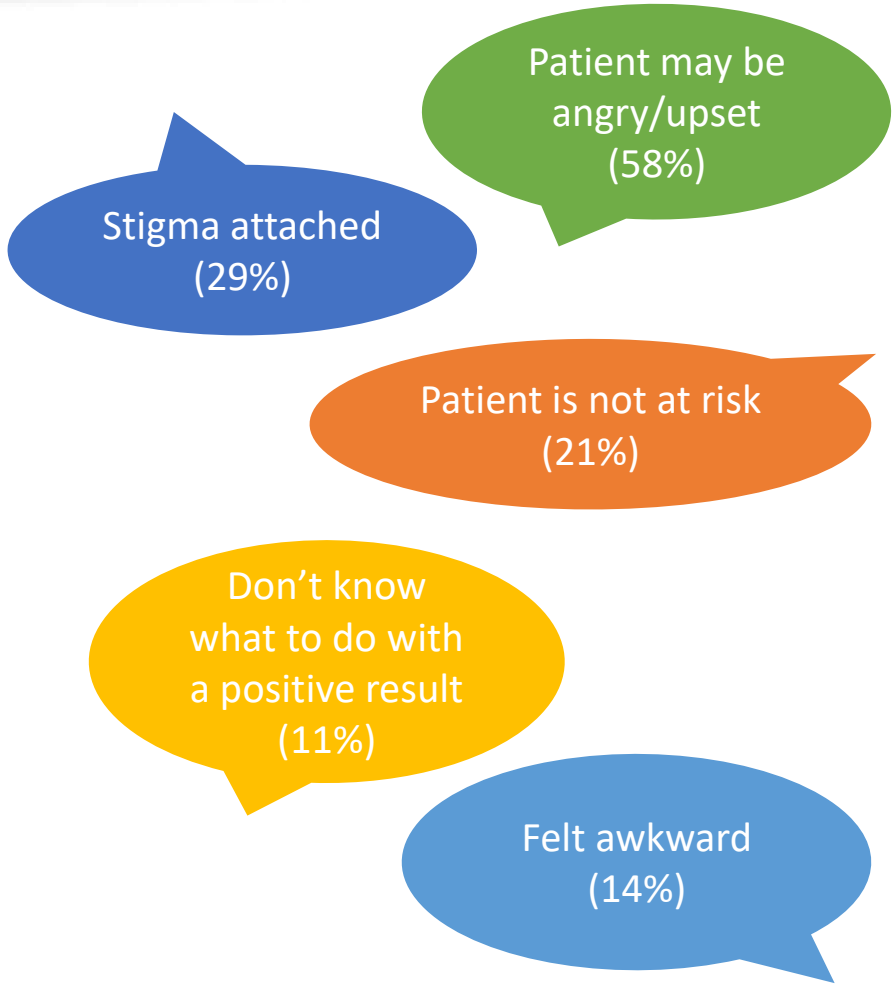
ELTON JOHN AIDS FOUNDATION

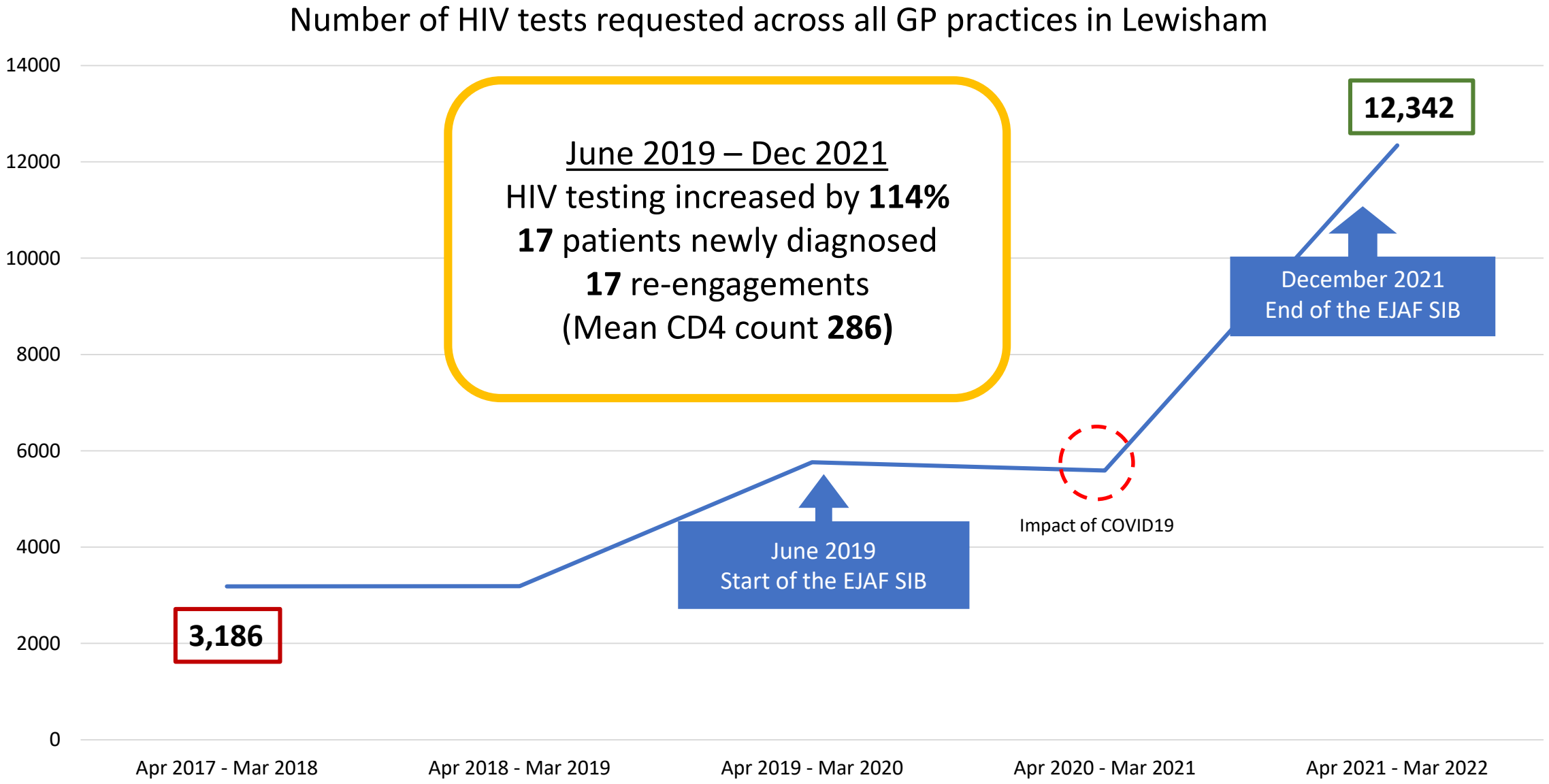
Why weren’t we testing in Lewisham?

In a survey conducted in 2019 (32 respondents incl GPs, trainees, practice staff, nurses, HCAs) we found:

- **44% had requested an HIV test in the last week**
- **19% had requested an HIV test in the last 3 months**
- **55% were extremely comfortable suggesting an HIV test to their patients**

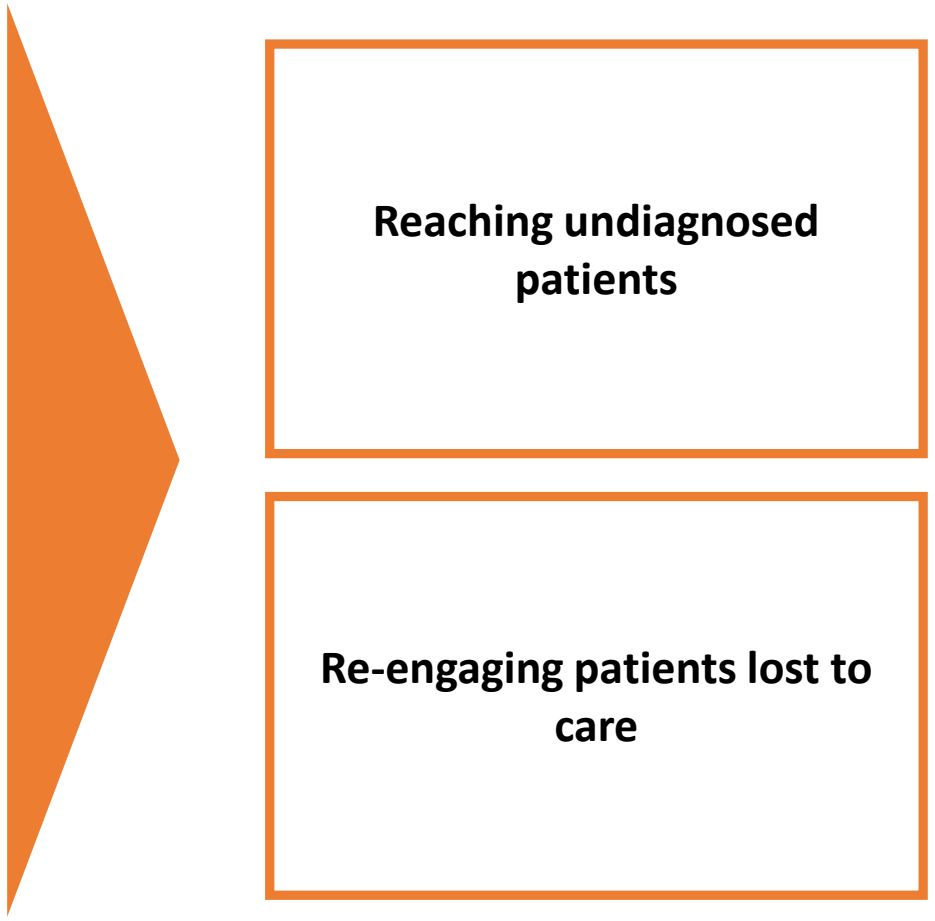
Some of the reasons why health care professional is uncomfortable to request an HIV test included:




Number of HIV tests requested across all GP practices in Lewisham
14000
12000
10000
8000
6000
4000
2000
0
June 2019 – Dec 2021
HIV testing increased by 114%
17 patients newly diagnosed
17 re-engagements
(Mean CD4 count 286)
12,342
December 2021
End of the EJAF SIB
June 2019
Start of the EJAF SIB
Impact of COVID19
3,186
Apr 2017 - Mar 2018
Apr 2018 - Mar 2019
Apr 2019 - Mar 2020
Apr 2020 - Mar 2021
Apr 2021 - Mar 2022

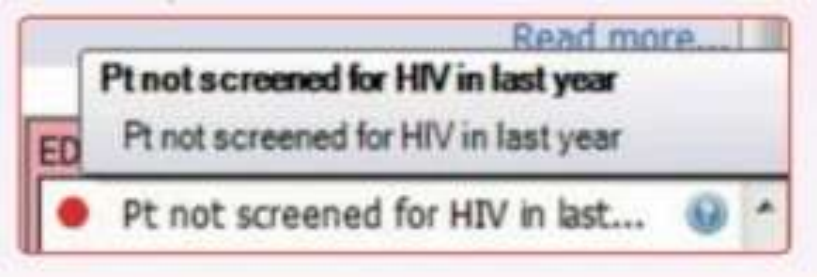
How did we achieve these outcomes?

1. Education for patients and healthcare professionals
2. Financial incentives for GP practices
3. Local leadership and support
4. Encouraging collaboration across local primary and secondary care teams
5. Audit of LTFU and action plan



Education

- The SIB was promoted across the borough
- Computer based reminders alerted clinicians to request an HIV test
- Organised lunch time teaching for GPs, nurses and health care assistants with local HIV consultant
- Posters were placed in all GP surgeries for patients



Financial incentives

Provided to practices who:

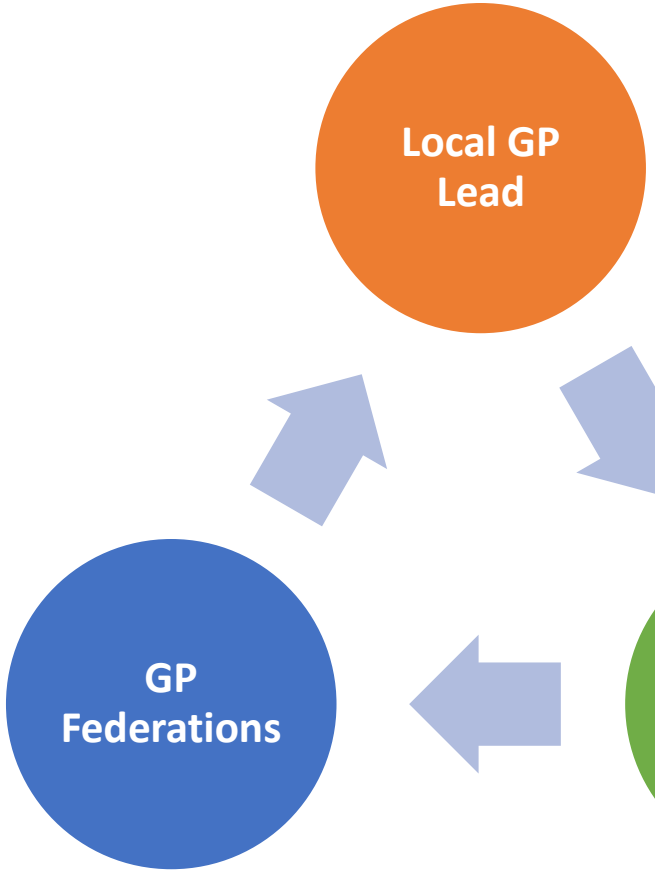
- Increased their HIV testing
- Identified a new patient living with HIV
- Re-engaged a patient living with HIV back into care

GP surgeries were tracked against these outcomes on a monthly basis

Example dashboard:

GP practice	Monthly lower threshold	April 2021	May 2021	June 2021	Total	Total positives/ re-engaged
Amazing Vale	22	56	49	44	149	0
Troubled surgery	14	4	10	13	27	1
Trying Surgery	9	161	142	177	480	0
Down Road GP	22	4	11	9	24	0
Middle Road GP	12	11	10	16	37	0

Local leadership and support



- Understands local pressures and services
- Build relationships with stakeholders
- Carry out audit

- Supported initially by EJAF
- Key to sharing learnings and ideas throughout SEL
- Generate momentum within General Practice

- Supported with general administration and data analytics
- Enabled coordination and engagement across GP practices

Re-engagement audit

1. Search ran on all GP practices for patients with an HIV diagnosis (1586 patients)
2. Details of identified patients were sent to HARS team who provided the month and year of last clinic date
3. For all potentially LTFU patients, GP notes were reviewed to identify which HIV clinic the patients were under the care of
4. The date of the last HIV clinic letter was used as an indication of when the patient was last seen
5. The patient's respective HIV teams were contacted to confirm if the patient was engaged, if they had moved abroad or if they were known to be LTFU
6. In some circumstances, there was no indication that the patient was under any HIV clinic, in which case these patients were contacted individually for more information

Who re-engaged?

Between: June 2019 – December 2021

- Approximately **701 patients** were thought to be LTFU
- **17 patients** were re-engaged into care
- Average **CD4 count** of those who re-engaged was **252**

Sex	Percentage (number of patients)
Male	29% (5)
Female	**71%** (12)
Age	
30-40 yrs	12% (2)
40-50 yrs	**47%** (8)
50-60 yrs	29% (5)
60+ yrs	12% (2)
Ethnicity	
Black African	**58%** (10)
Black Caribbean	24% (4)
White other	12% (2)
White and Black African	6% (1)

Who re-engaged?

Case 1

Profile:

- 36 year old
- Black African female
- LTFU for 2 years

Action:

- GP audit identified her as LTFU
- Her GP practice was alerted by the GP champion
- At her next GP appointment the GP discussed HIV medications. She mentions she has been taking her husbands
- Patient not attending her clinic anymore as she knows staff at the hospital. Worried if they find out she has HIV

Outcome:

- GP Referred her to another local clinic
- CD4 count 659
- Stable on medications and had another baby

Case 2

Profile:

- 54 year old
- South American female
- LTFU for 4 years

Action:

- Had been seeing her GP for recurrent mouth ulcers. Treated for oral thrush, then herpes stomatitis.
- Patient told GP she was engaged with clinic. No LTFU letter in the notes. Last clinic letter was from 5 years ago
- GP audit identified her as LTFU
- Her GP practice was alerted by the GP champion

Outcome:

- The GP made contact with the patient who agreed to re-engage
- CD4 count 14
- Now back on treatment

Other findings

Care provided by 13 different NHS Trusts making it difficult to co-ordinate follow-up

Limited up-to-date clinic letters in GP records meaning GPs unable to contact clinics

GPs were not made aware if the patient was LTFU which limited re-engagement conversations

Primary care collaboration

GP HIV Champions in South East London

- Sharing learning
  - Computerised alert
  - How to best approach certain stakeholders
  - What hasn't worked
- Sharing ideas
  - Developed a GP trainee session
  - Mass texting patients to invite them for an HIV test in HIV testing week
  - Awaiting approval from local Pathology services to provide a written reminder to test for HIV when a patient has a positive CT/GC result

Collaboration between primary and secondary care

- GP Champions set up a primary and secondary care LSL network that met quarterly
- Obstacles to effective patient pathways were identified and resolved
    - Changes to HIV teams clinic letters to GP to ensure messages were clear and evident
    - Shared GP surgeries and HIV consultants contact details to improve communication and facilitate reengagement of patients lost to follow up
- Worked together to re-engage patients through the audit

Case 1

Profile

- 58 year old
- Black Caribbean woman
- LTFU for 2 years, clinic unable to get hold of her

Action:

- HIV clinic sent LTFU letter to the GP
- GP sent letter to patient asking for up to date contact details
- New mobile number sent to the HIV clinic who managed to contact the patient

Outcome:

- Patient attended. CD4 count 329. GP is now aware of the patient's potential to disengage

Case 2

Profile:

- 42 year old
- Black African female
- LTFU for 5 years

Action:

- Had been seeing the GP with several issues – recurrent thrush, eye infections, low energy. Patient told the GP she was on HIV treatment.
- GP noticed recent LTFU letter from clinic.
- GP discussed this with the patient at her next appointment.

Outcome:

- Patient agreed to be referred to a more local clinic. CD4 count 126. Patient now on treatment

The role of primary care in re-engaging patients

Primary care reaches a wide audience

- 98% of the population sees their GP at least once every 3 years
- 75% of people with a late HIV diagnosis had seen their GP in the preceding 1-3 years

HIV is a chronic disease like any other

- GPs need the skills and support
- Establish communication with specialists

Tackling stigma starts in the community

- Encourage disclosure of their HIV status to their GP
- We need support patients to avoid disengagement with HIV care in the first place

We need a coordinated approach **involving primary care**

ELTON JOHN AIDS FOUNDATION

HIV PREVENTION ENGLAND

Practical guidance for Primary Care to optimise HIV testing and re-engagement of people living with HIV

Aim of the guidance

This guidance is for primary care professionals interested in increasing HIV testing and re-engagement of people living with HIV lost to follow-up in their practice. It is based on learning from the Elton John AIDS Foundation Zero HIV Social Impact Bond (SIB) Primary Care HIV testing and re-engagement, which was informed by BHIVA/BASHH/BIA HIV testing guidance[1], NICE Guidance (2016)[2] and previous Primary Care HIV testing initiatives such as the RHIVA study[3].

Top tips from the Elton John AIDS Foundation HIV GP Champion group

Changes require time and energy. You may consider implementing one of these changes at a time and work your way down the list!

1. Add HIV test as an opt out/offer everyone an HIV blood test

In all routine yearly bloods, NHS health checks and new patient registration. No counselling involved, just informing "we are including HIV in all our MOT/yearly tests" is enough. It can be helpful to attach an explanatory slip to the blood forms (see example in appendix 1).

2. Get your team on board

Ensure all primary care staff including reception and administrative staff are involved and aware of your HIV testing policies. Offer training and answer questions to help combat HIV stigma.

3. Set up electronic reminder alerting

Electronic reminder alerts for patients who've never had an HIV test or not for the last year can be very helpful (see EMIS alert in appendix 2).

4. Make sure your patients living with HIV are not lost to follow-up

Ensure they have at least one hospital review every year. Check that their HIV diagnosis is properly coded and their antiviral medication is recorded as "hospital prescription" on the GP system. This avoids risk of serious drug interactions. (Remember to offer pneumococcal and flu vaccinations.)

5. Don't forget other blood borne viruses

Screen your population for blood borne viruses, offering simultaneously a test for HIV, Hepatitis B Surface antibody and Hepatitis C serologies. This is particularly indicated for all new patient registrations and NHS checks.

6. Code patients' notes who decline an HIV test

Almost no one will opt out. Often the ones who do are those who perceive themselves most at risk. Please code "HIV test declined" and, if unable to discuss then, make a note to do so at next opportunity.

7. Strengthen collaboration with secondary care HIV clinics and community organisations

This contributes to offering cohesive care and support for our patients living with HIV. Good communication will also facilitate detection and reconnection of patients lost to follow-up.

8. Help patients living with HIV to disclose their status

Research shows that around 8% of patients living with HIV have not disclosed their condition to their GPs due to fear of stigma. By offering an HIV test routinely, and talking about and treating it as any other chronic condition, you will be contributing to reducing stigma.

Special thank you to

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One Health Lewisham

Lewisham Primary care colleagues

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