

The HIV Care Continuum in Atlanta: A Medical Student's Unique Perspective

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As a member of the newest generation of physicians in training, I was born after the panicked days in the early 1980s when a new disease was killing young men in Los Angeles and New York.¹ By the time I was born, more than 20 million people worldwide had already contracted the virus now known as human immunodeficiency virus (HIV). HIV has since evolved from a death sentence into a manageable chronic condition which, when treated, has little effect on lifespan.² Despite this biomedical success, we face an implementation gap between our current knowledge and effective care delivery, especially among vulnerable populations. This gap is created by upstream social determinants and structural barriers to care, extending far beyond the clinician's exam room.

In recognition of the importance of the entire process of care, the United States National HIV/AIDS Strategy (NHAS) prioritizes the Care Continuum Initiative.³ Testing, linkage to care, retention, and chronic disease management all require community engagement. Yet traditional medical education provides few opportunities to interact with patients outside of the formal healthcare system. Therefore, as a second-year medical student I created a multidisciplinary elective in order to experience each step of the HIV care continuum in Atlanta, Georgia.

The goals of the elective were threefold: 1. Experience the care continuum from the perspective of an Atlantan newly diagnosed with

HIV; 2. Understand the social and economic factors that perpetuate the HIV epidemic in Atlanta; and 3. Propose novel solutions to improving the care continuum.

These goals were achieved by engaging in the healthcare system at various points along the care continuum, beginning with testing and linkage. An estimated 19 percent of Georgians living with HIV are unaware of their status and while an opt-out HIV testing program at Grady Memorial Hospital (GMH) has increased the number of HIV screenings and disclosures made, a positive test is only the beginning of the journey to viral suppression.⁴ In the GMH emergency department (ED), social workers (SWs) are responsible for counseling and informing patients of a new diagnosis then linking them to care. Early one morning, the SWs were busy tracking down two patients who tested positive the night before but were discharged prior to business hours. In that moment, as calls to the patients rang unanswered, viral suppression still felt like a world away, reaffirming the barriers to linkage reported domestically and abroad: homelessness, substance use, stigma, denial, misinformation, and limited access to transportation.^{5,6}

After diagnosis and disclosure, the ED social worker provides linkage services to area clinics, principally the Grady Infectious Disease Program (IDP). IDP is a large, Ryan White-funded HIV/AIDS Program serving more than 5,800 underin-

ured and economically disenfranchised patients. I walked through the enrollment process with new patients and quickly learned that physically transitioning from testing site to the HIV clinic does not equate to receiving HIV care. Enrollment involves hours of intake assessments, financial counseling meetings, HIV education classes, and an initial nursing assessment before a provider visit is scheduled. As a medical student, I would traditionally only see the patient after he/she has successfully navigated this process. Now, I have a greater appreciation of the time and effort required to enroll in care. This better equips me to advocate on my patients' behalf, identify barriers, and work toward personalized solutions.

While I was born after the early days of the epidemic, the experience rounding with the inpatient HIV service at GMH is reminiscent of wards in the 1980s, busy with opportunistic infections and AIDS-related malignancies that now represent a failure of the care continuum rather than the end result of untreatable disease.⁷ Ironically, my preclinical education and boards review had prepared me only for this part of the experience. Rather than discussing primary or secondary prevention, medical students become experts at reciting the imaging features that differentiate cerebral toxoplasmosis from primary CNS lymphoma. That knowledge, though useful, does little to help my patients remain engaged in outpatient care or adherent to chronic

continued on page 2

PERSPECTIVE

continued from page 1

medications when biopsychosocial and structural barriers abound.

Through National Institutes of Drug Abuse funding, small-scale community outreach teams work to reengage poorly retained patients. Here, I stepped into the patients' environment, a rare experience for a physician in training. This proved more emotional than anticipated as a few miles from work and school, the stark reality of poverty, addiction, and sex work make consistent access to the formal healthcare system next to impossible. Overcoming such challenging social situations will require more patient-centered approaches, moving care delivery closer to the community, decreasing stigma, and better integrating HIV care and substance use services. This experience also helped me understand why long term retention in care after successful linkage to care remains challenging. At IDP, only 49 percent of patients are retained continuously over 36 months.⁸ Now, when a patient apologizes for missing his last appointment, I nod in understanding, not because this is what we are taught to do, but because I more fully appreciate the barriers he has faced to even reach this point.

While the focus of domestic HIV research is increasingly transitioning to managing long-term complications of infection and treatment, there is a clear need to improve the delivery of the tools we currently possess. My experience with the HIV care continuum in Atlanta points to barriers to care more commonly associated with Khayelitsha, South Africa, than San Francisco, California. Working in Khayelitsha and Gugulethu townships, it became clear that groups facing grinding poverty have difficulty making long-term commitments to traditional treatment, challenges that are not limited to developing countries.⁹ Our current healthcare system is designed for those delivering care rather than those receiving it. We

are in need of differentiated models of care and implementation science to develop innovative solutions for delivering patient-centered care to our most vulnerable patients. In Gugulethu, this meant creating adherence clubs where clinic meetings are moved into the community and tasks are shifted from physicians to nurses and finally to community health workers.¹⁰ Models like this can be adapted for use in the United States, continuing the tradition of reverse innovation. Fundamental change in our care delivery systems will require new funding models with support for roles outside the traditional provider visit. Improving the care continuum and halting the epidemic in more vulnerable populations may depend on it.

In summary, this experience reinforced the idea that we must advocate for models of compassionate care that fit our patient's lives, yet creating effective models requires a realistic understanding of our patients' lives. If we remain focused only on the clinical presentation and do not see patients as existing at the crossroads of social, political and economic barriers to health, we will fail to deliver better health outcomes. As I enter the clinical years of medical school, I will be better prepared to understand and connect with my patients, provide compassionate care aimed at their most pressing problems, medical or otherwise, and advocate on their behalf both inside and outside of clinic walls. While this experience has highlighted both the gaps in medical education and the HIV care continuum, it has also provided a framework for a way forward.

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