Analyzing Barriers to Participating in Healthcare by Individuals who are Non-Adherent to Treatment

Background

According to the Centers for Disease Control and Prevention (CDC), Hawaii ranks 35th among the United States for rate of diagnosis of HIV infection, as of 2017. With recent technological advances, antiretroviral therapy can be used to suppress the HIV infection to the point where transmission does not occur. Researchers have emphasized retention in HIV care remains critical to the health of the individual as well as the community; factors that impact healthcare engagement need to be identified and addressed to permit the re-engagement of HIV-diagnosed individuals who have fallen out of treatment. A large gap persists in research, revolving around interventions for re-engaging non-adherent patients back into care. Maintaining consistent preventive medicine measures will allow those with HIV to live with an undetectable viral load.

Objectives

1. Determine the barriers to engaging in healthcare services faced by people living with HIV but have fallen out of care in Hawaii.
2. Propose possible solutions to the specific healthcare barriers and prevent future lapse in care, considering the target population.

Methodology

1. Working in conjunction with the University of Hawaii at Manoa
2. Clinical recruitment of 20 patients from Clint Spencer Clinic on Oahu
3. Direct one-on-one interviews using standardized questionnaire
4. Data Analysis
   i. Review of health-related questions and self-reported barriers from interview
   ii. Identification of possible solutions

Results

Clinical staff at the Clint Spencer Clinic in Honolulu identified and recruited 20 non-adherent HIV-positive patients for this study, with age ranging from 25 - 70 (M=46). A majority (55%) of the participants identified ethnically as Hawaiian. Monthly income reported a range of $435-$3300 (M=$985.30) with assistance from SSI, Food Stamps, and little levels of employment. The lower income area of Oahu is the West side of the island; most of the participants in the study reported to live on the West side.

The CDC utilizes a state-based Behavioral Risk Factor Surveillance System (BRFSS) for health data collection of the general population of the United States. BRFSS seeks to identify health-related risks for US residents. Utilizing the standardized set of questions from BRFSS, comparison of the data collected from the HIV study can be compared to that of the general US population.

<table>
<thead>
<tr>
<th>Table 1: Health-Related Quality of Life Indicators – Mean Scores</th>
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<tr>
<td>HIV Participants</td>
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<td>hp N= 20</td>
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<td>Would you say that in general your health is:</td>
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<td>In the past 30 days, how many days was your physical health NOT good?</td>
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<tr>
<td>In the past 30 days, how many days was your mental health NOT good?</td>
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<td>In the past 30 days, how many days did you feel SAD, BLUE, or DEPRESSED?</td>
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<td>In the past 30 days, how many days havepeculiarly high responses</td>
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| Many of the patients in the study reported fair or poor general health (52%); this report is considerably higher compared to that of the general adult population (14%; 2016 BRFSS). Research participants reported, on average, over 14 days of poor physical (55%) and mental (68%) mental health in the past month. Yet again, the results of poor physical and mental health days remain higher than that of the national average (8%). The results from the BRFSS, regarding the HIV patients, repeatedly report higher averages for poor health days than that of the general US adult population.

The standardized questionnaire contained a treatment self-efficacy portion; patients were asked about their confidence in ability to adhere to HIV treatment on a scale from 0 (“Cannot do at all”) to 10 (“Completely certain can do”). The patients expressed a high ability, a mean of 8.5, to maintain treatment on a regular basis, even with interferences in daily routine. Later during the interview, the patients self-reported barriers to obtaining healthcare through open ended questions; factors described were previously stated as not an issue for adherence.

Barriers to healthcare were recorded with considerations about transportation to the clinic, keeping appointments, medication consumption, lack of treatment, and other general concerns of the patients.

Each patient reported multiple types of barriers to compliance of HIV treatments. Most self-identified barriers did not consider the actual health of the patient, but other exogenous factors.

Conclusions

The standardized question set from the BRFSS allowed for collection and analysis of healthcare barriers in Hawaii for the HIV-positive population of the study. Recent findings suggest both physical and mental aspects prevent the steady connection with the health care system. The highest physical barrier to obtaining adequate treatments was concluded to be the lack of reliable transportation to the health clinics in Honolulu, HI. Mental barriers can be seen through the overwhelmingly high responses for low quality of life reported through the CDC Healthy Days survey. Interventions should revolve around mental and physical health of this afflicted population; re-engaging these individuals starts by improving their overall health stability.

Proposed Solutions

Hypotheses of possible solutions to re-engaging those HIV-positive patients who have fallen out of care can be concluded based on the evaluation of the most prominent barriers to healthcare engagement, combined with prior knowledge of services on Oahu. My suggested solutions are:

- Additional HIV clinics located in larger cities on the West side of the island
- Waianae, Kapolei, and Waipahu areas
- Additional Hawaii Health and Harm Reduction Centers
  - Case management services
  - Medical transportation services
  - Mental health services
- Rail system from the West side to Honolulu

References
