

# Overcoming barriers to rapid ART in real-world community health center and public hospital settings

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## 1 Background

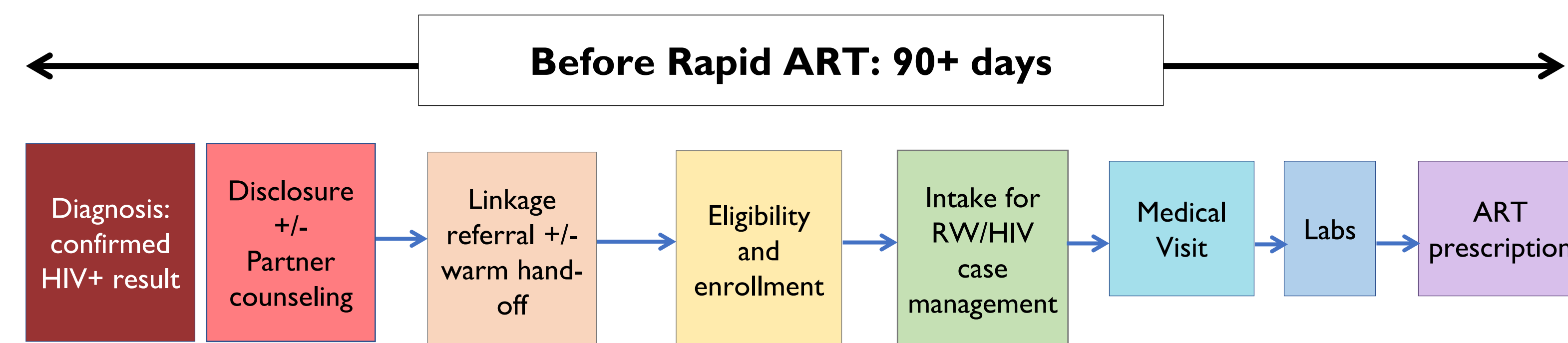
Timely access to HIV antiretroviral therapy (ART) remains a challenge worldwide, with 74% people living with HIV (PLWH) who are newly diagnosed linked to care within 30 days in the US, and globally 53% PLWH achieving viral load suppression.

In 2019 HIV care teams from four community health centers and the county public hospital serving low-income populations in the HIV ACCESS network of Alameda County, California, USA implemented standardized metrics and collected data on barriers to rapid ART as a quality improvement project.

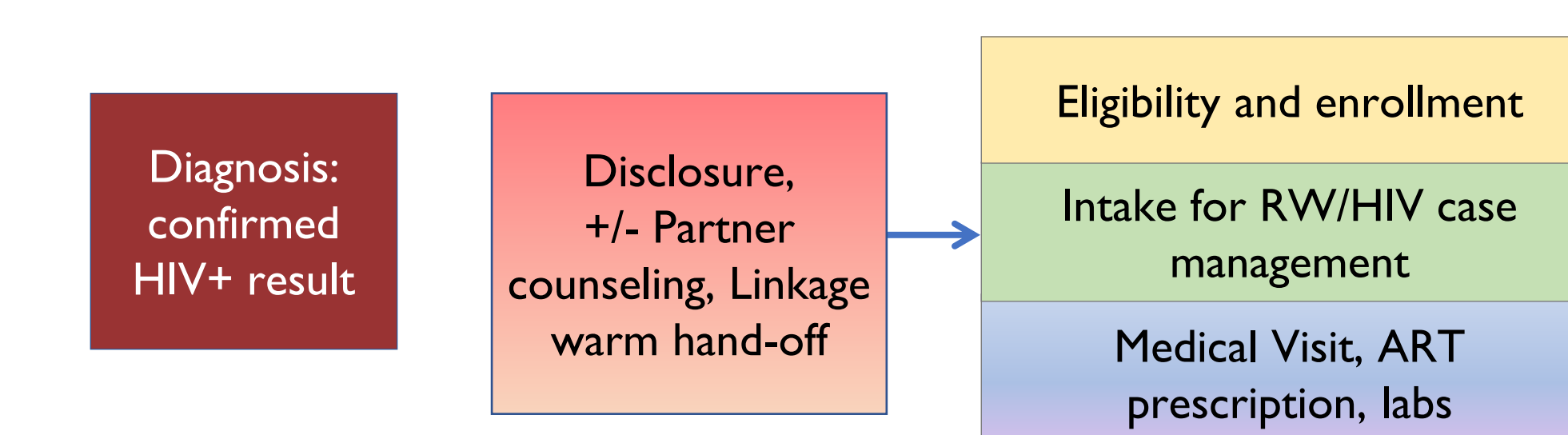
During the COVID-19 pandemic, it has become even more important that PLWH can access ART in rapid, streamlined ways that reduce the need for multiple in-person visits and potential exposures.

## 2 Description

Rapid, same-day access to ART was initially implemented at the four community health centers in 2017. Early inconsistencies in how rapid ART was defined and how data was collected led to network-wide collaborative protocols, a shared definition, and a shared data collection spreadsheet in 2018. These tools were implemented at the community health centers and the public hospital in 2019. The data was collected and analyzed for quarterly network-wide quality improvement reports.



← After Rapid ART: ≤6 days →



**HIV ACCESS Rapid ART = ↑ ART the same day as intake (ideally same day as disclosure)**



## 3 Lessons learned

The HIV ACCESS network defined rapid ART as ART prescribed within 1 day of the first in-person visit with the HIV team. From October 2018 through September 2019, 86% PLWH (56 of 65) who were newly diagnosed and referred to the HIV ACCESS teams received rapid ART.

Of the 9 PLWH who did not receive rapid ART, 4 (44%) were due to provider availability delay, 3 (33%) were due to difficulty contacting the client at the public hospital, and 2 (22%) were due to a provider determination that neurological evaluation was needed before starting ART. There were no cases in which the client declined rapid ART.

The majority of barriers to rapid ART in this setting were due to provider-related delays. Support and uptake of rapid ART was strong among non-provider staff and PLWH.

## 4 Conclusions & next steps

These findings highlight the need to improve provider availability for rapid ART, including telehealth systems, and invest in provider education, reliable client contacts, staff retention and task-shifting. The next steps are to ensure rapid ART coverage during times HIV providers are not in clinic, support staff retention, implement sustained telehealth protocols for rapid ART (“Tele-Rapid” protocols), document multiple ways to contact clients, task-shift to nurse-led rapid ART visits, and train non-HIV provider staff on the provision of streamlined, people-centered linkages and rapid ART.

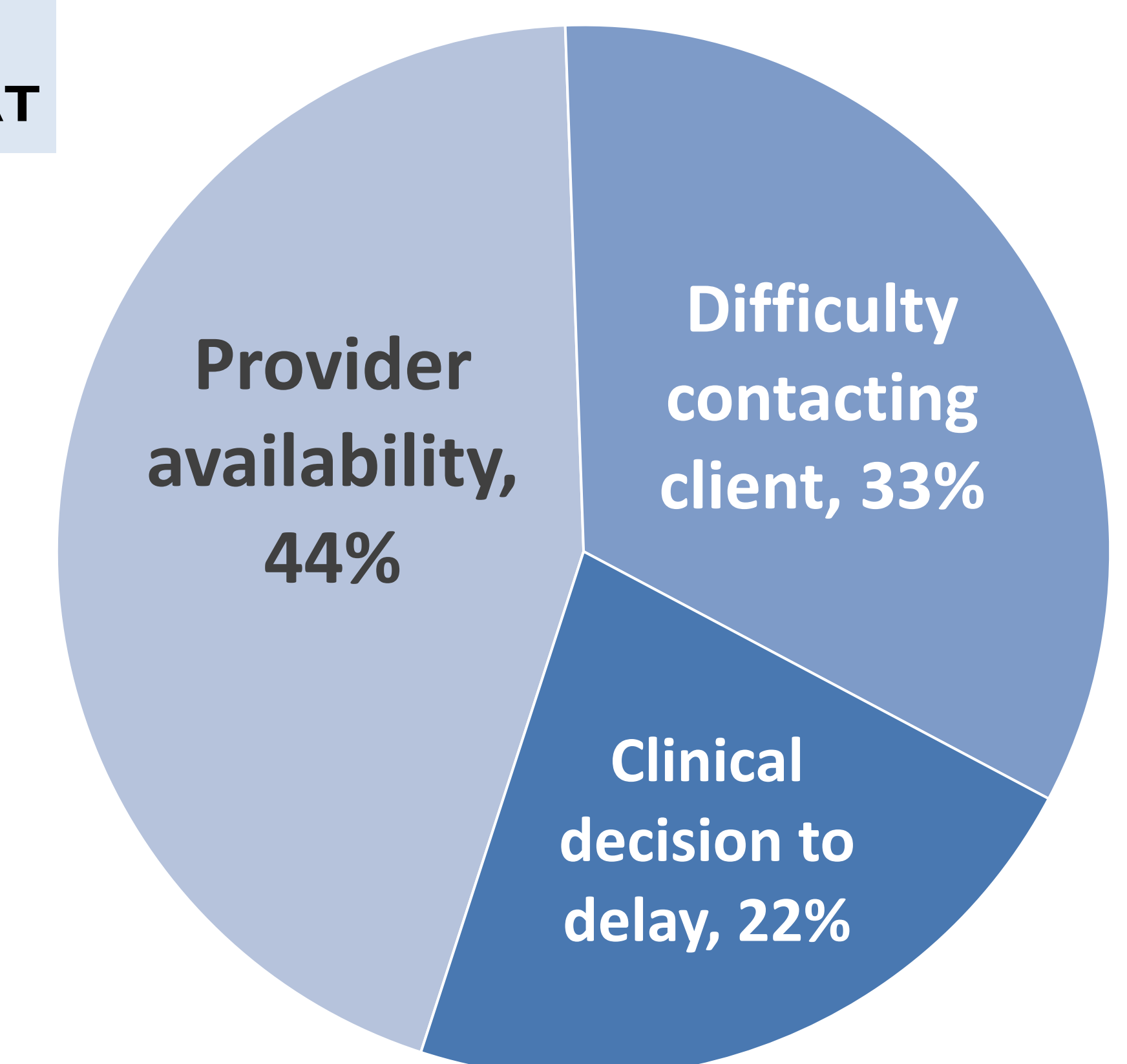
## Rapid ART tools implemented

- 1 Warm hand-off linkage protocol
  - 2 Rapid ART protocol and one-page handout
  - 3 Shared definitions/metrics (see Rapid ART protocol)
  - 4 Linkage & Rapid ART tracking sheet
- (Click on text to download; updates posted here.)

## Outcomes

**86%**  
newly diagnosed  
PLWH received  
same-day rapid ART

### Barriers identified:

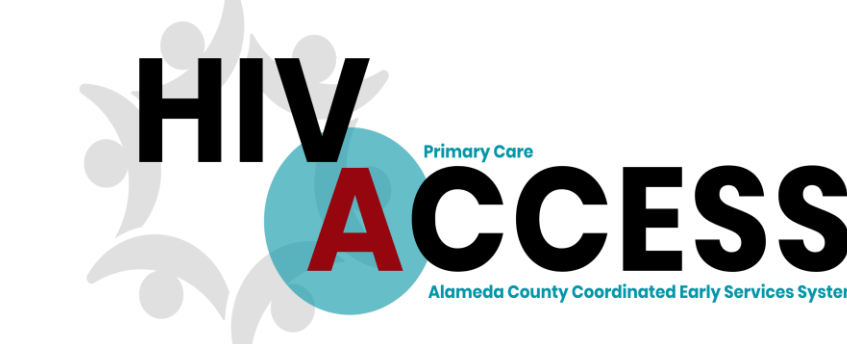


## Summary of next steps

- 1 Schedule rapid ART coverage when there's no clinic
- 2 Support staff retention
- 3 Implement Tele-Rapid protocols
- 4 Document multiple ways to contact clients
- 5 Task-shift to nurse-led rapid ART visits
- 6 Train non-HIV providers & staff on rapid ART



## HIV ACCESS network



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