"Kept in the Loop": How Care Coordination Within the HIV Care Team Addresses Patient Wellness Priorities in the Context of Social Determinants of Health

Kole, L., Uradu, T., Obeng-Sefah, P., Harrell, K., Burwell, N., Rivera Vazquez, O., Momplaisir, F., Nkwihoreze, H., Kearney, M., Obans, M., & Johnson, G.

Perelman School of Medicine, University of Pennsylvania

Background: People living with HIV (PLWH) face social and structural barriers that can complicate care during and after hospitalization. This Penn CFAR/SPIDR Scholars project explored opportunities to improve discharge care coordination on the Penn ID primary service, strengthen care transitions, and improve outcomes for PLWH.

Methods: During a 4-week summer institute focused on ethical, professional, and multi-modal research methods, 6 CFAR/SPIDR scholars were trained (week one) on rapid ethnographic methods, systemic social observation, and qualitative analysis. Weeks 2 to 4 consisted of three rotations where the scholars conducted interviews with patients, members of the clinical team in one hospital and two HIV clinics, systemic observation, and surveys. A modified grounded theory approach was used to generate the codebook and the thematic analysis for the interviews. The findings from the field note observations were integrated with the qualitative data analysis, using a convergent mixed-method approach.

Results: A total of 37 interviews (patients n=18, physicians n=9, social workers n=3, case managers n=3, care navigators n=2, nurse manager n=1, and program manager n=1) and 24 field note observations were generated. The hospital discharge was described as a vulnerable period for poor health outcomes. Patients wanted to be seen holistically and did not want the clinical team to reduce them to their presenting problem. There was consensus across all participants that effective care delivery occurred when in-patient and out-patient multidisciplinary connection occurred. Barriers to effective communication included team members not always being on the same page about updated care plans and the clinical and social work team rounding separately. Patients appreciated being “kept in the loop” and being provided frequent, brief updates about their condition and discharge planning. Maximizing resources (People, Communication Tools, Systems & Space) and providing frequent and accurate updates to patients emerged as potential strategies.

Conclusions: Addressing communication barriers and strengthening interdisciplinary coordination may improve the delivery of patient-centered care. Leveraging existing team strengths provides an opportunity to better integrate medical and social support for PLWH.