The Engagement & Retention in Medical Care of HIV-Positive Clients

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Learning Objective

- Utilize the Community Retention Management Model (CRMM) for building community collaborations in order to improve the retention of HIV-positive patients by your practice.

Disclosure: I do not intend to discuss any non-FDA-approved or investigational uses of any products/devices in this presentation.
The Partnership Comprehensive Care Practice

- The Partnership Comprehensive Care Practice (Partnership) is the HIV clinical program of the Division of Infectious Diseases and HIV Medicine at Drexel University College of Medicine.

- The Partnership’s mission is to enhance the quality of life for persons with HIV/AIDS by providing comprehensive, integrated HIV care to all individuals regardless of their ability to pay.

- The Partnership is the largest comprehensive adult HIV primary care practice in the region, serving more than 1,700 patients in 2009.
Partnership Patient Population (2009 Program Data Report)

- **Gender**
  
<table>
<thead>
<tr>
<th>Gender</th>
<th>Male</th>
<th>Female</th>
<th>Transgender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>63%</td>
<td></td>
<td>1%</td>
</tr>
<tr>
<td>Female</td>
<td>36%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transgender</td>
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</table>

- **Racial Group**
  
<table>
<thead>
<tr>
<th>Racial Group</th>
<th>African American</th>
<th>Caucasian</th>
<th>Hispanic</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>72%</td>
<td>14%</td>
<td>13%</td>
<td>1%</td>
</tr>
<tr>
<td>Caucasian</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Hispanic</td>
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<tr>
<td>Other</td>
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- 82% reported household income to be below the Federal poverty level
Research supports the use of community partnership/community collaboration throughout efforts of patient linkage to HIV medical care and ancillary services. (Cheever, L.W 2007; Tobias, C. 2007)

Prevention/Education → HIV Testing
Early Intervention → Primary Medical Care
Primary Medical Care → Case Management
Case Management → External Services
Shifting the Momentum

- The Community Retention Management Model explores the use of community partnerships to reinforce the fluidity of patient retention (or) connectedness to primary HIV medical care.

- As providers, our focus has been primarily on bringing patients from early intervention services into medical care. CRMM increases the likeliness of retention by connecting patients to community services and consistently re-connecting back to primary medical care.
Purpose of the Community Retention Management Model

- To decrease mortality rates of HIV-positive individuals who have a history of having never been in medical care and those who are inconsistently compliant to medical care.

- To increase the avenues in which a person can enter/re-enter into primary HIV medical care.

- To provide consistent messages throughout both internal and external resources regarding the importance of medical compliance.

- To minimize the number of patients who remain not connected to primary HIV medical care.
Community Retention Management Model Linkage Diagram

- Early Intervention
- Primary Medical Provider
  - Case Management
  - Retention Specialists
  - Mental Health
- Corrections
- Drug and Alcohol Services
- Needle Exchange
Linkage Diagram
Community Partner Perspective

- Probation Office
- Linkage Program
- Public Assistance Case Worker

Primary Medical Provider
Re-Entry Program
Housing Assistance
Linkage Diagram
Community Partner Perspective

Drug and Alcohol Services

- Group Therapy
- Individual Counseling

Primary Medical Provider

12-Step Programs
Linkage Diagram
Community Partner Perspective

- Drug & Alcohol Counselor
- Support Groups
What Makes it Work

- Strong collegial relationships
- Active engagement of outreach personnel
- Stakeholders who exhibit a demonstrated commitment to the model
- Signed service agreements outlining communication expectations
## Partnership 2009 Patient Retention

<table>
<thead>
<tr>
<th>Year</th>
<th>2009</th>
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<tbody>
<tr>
<td>Established New Patients</td>
<td>255</td>
</tr>
<tr>
<td>Retention</td>
<td>208</td>
</tr>
<tr>
<td>Retention Rate</td>
<td>82%</td>
</tr>
<tr>
<td>Incarcerated</td>
<td>11</td>
</tr>
<tr>
<td>In-PT D&amp;A</td>
<td>5</td>
</tr>
<tr>
<td>Returned After last date of service</td>
<td>9</td>
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</table>

- Retention rates are based on the calendar year from January 2009 through December 31, 2009.

- Retention was reliant on the patients arrival for at least two medical visits within a 12 month span.

- One in the first half of the year, the second in the following six months.

* Patient returned to medical care following the last day of the calendar year.

Numbers do not reflect mortality rates for 2009.
How Does the Patient Benefit?

- Decreased mortality (Mugavero, 2009)
- Creates a support system of a provider network
- Better adherence to HAART (Ulett, 2009)
- Fewer ER visits and Hospitalization
- Reduction of AIDS progression
- Increased secondary health prevention
- Increases consistency of care for individual patients
- Decreases the likelihood of discontinued care
- Increases patient accountability
- Reduced spending of overall health care costs
How Do other Community Service Providers Benefit?

- Allows for external referral sources to provide a reliable, comprehensive, and accessible medical care office to HIV positive clients.
- Better compliance to medical care can build higher self-efficacy. In turn, there may be less need for engagement in ongoing social services.
- Increased compliance to social service requirements.
References

- Tobias, C. (Ed.) Making the Connection: The Importance of Engagement and Retention in HIV Medical Care. *AIDS Patient Care and STDs.* 2007; 21 (Suppl 1.): S1-S93.
ARS Questions