
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

Male	Female	Transgender
63%	36%	1%

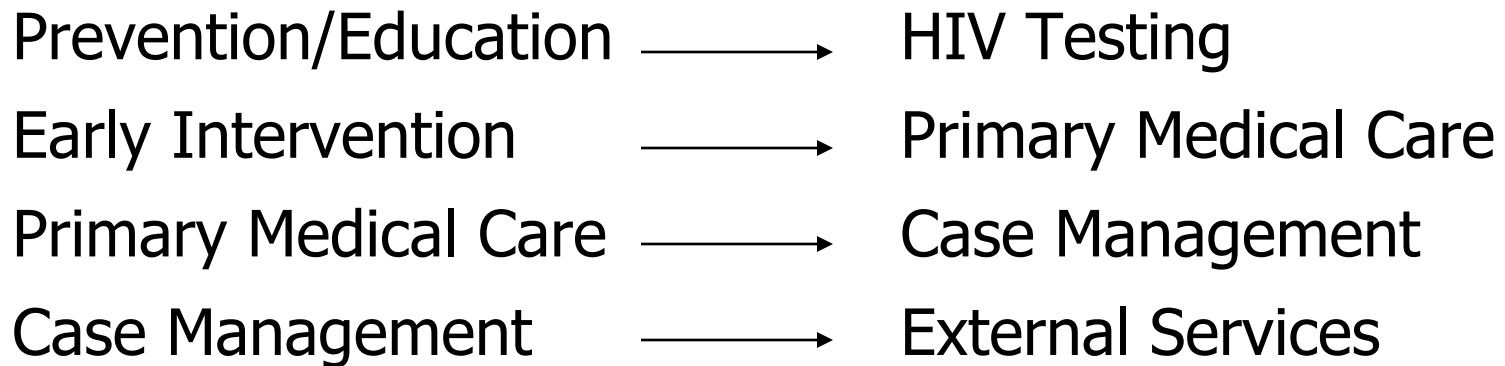
- Racial Group

African American	Caucasian	Hispanic	Other
72%	14%	13%	1%

- 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)



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.

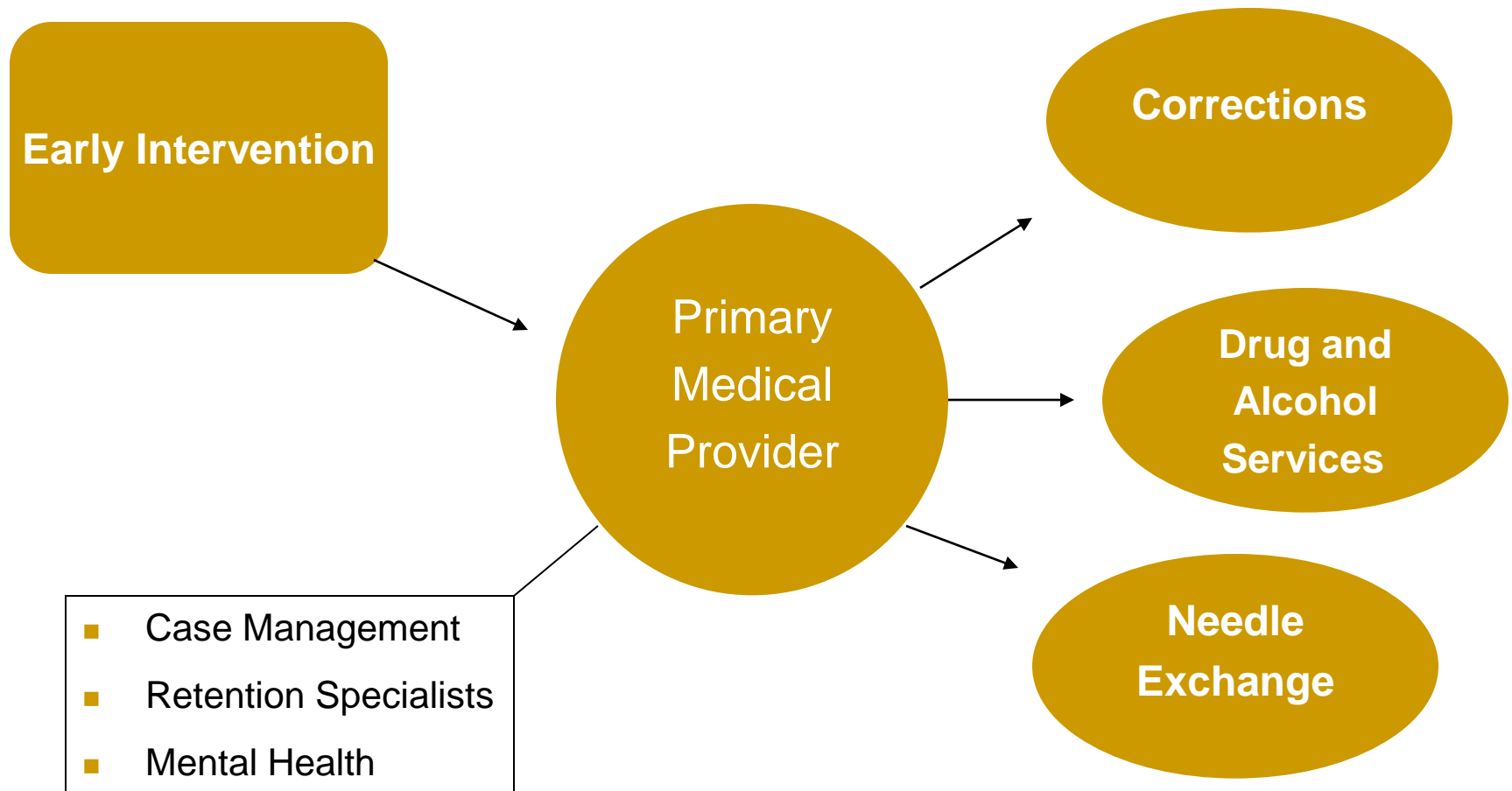


Purpose of the Community Retention Management Model

- 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.

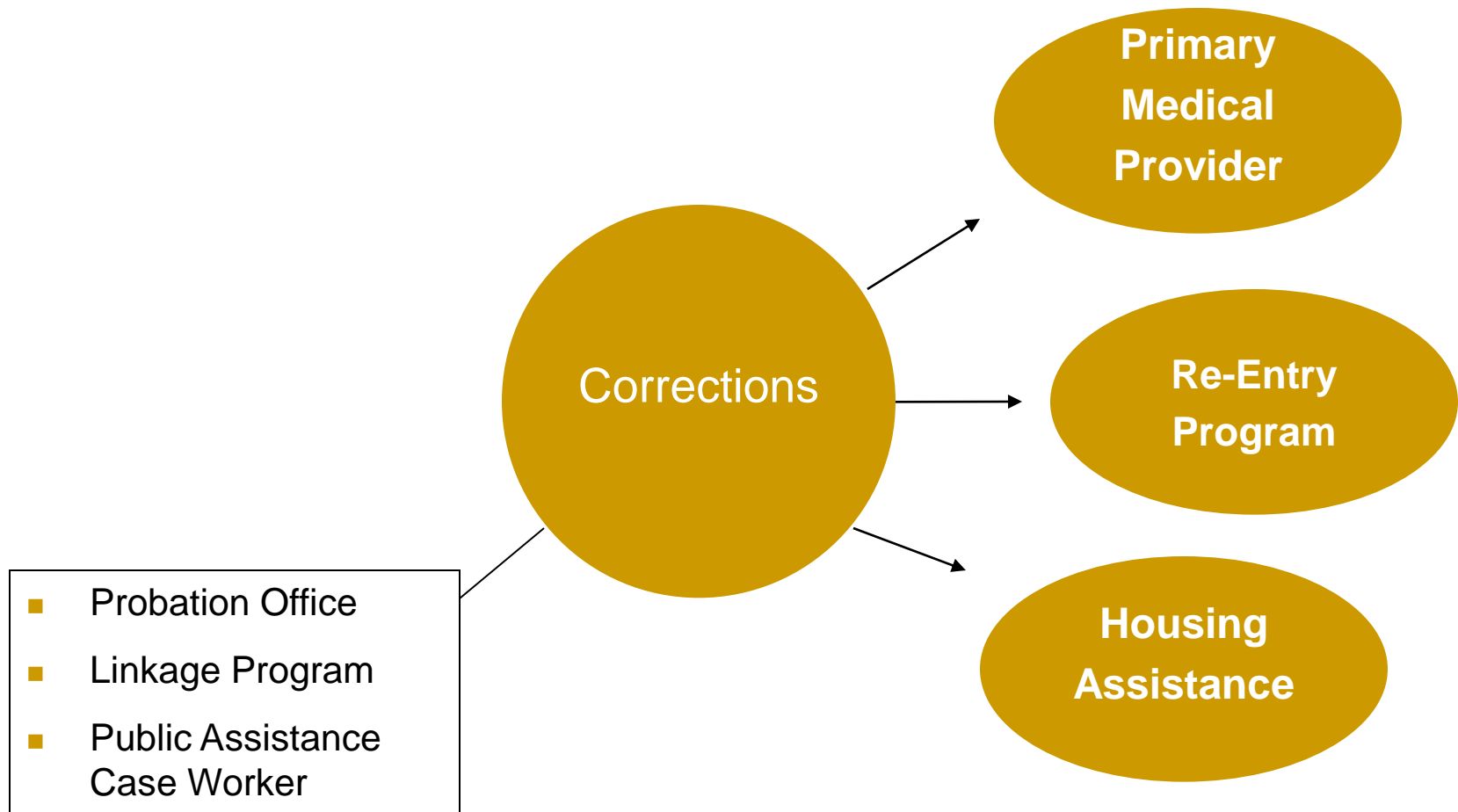


Community Retention Management Model Linkage Diagram



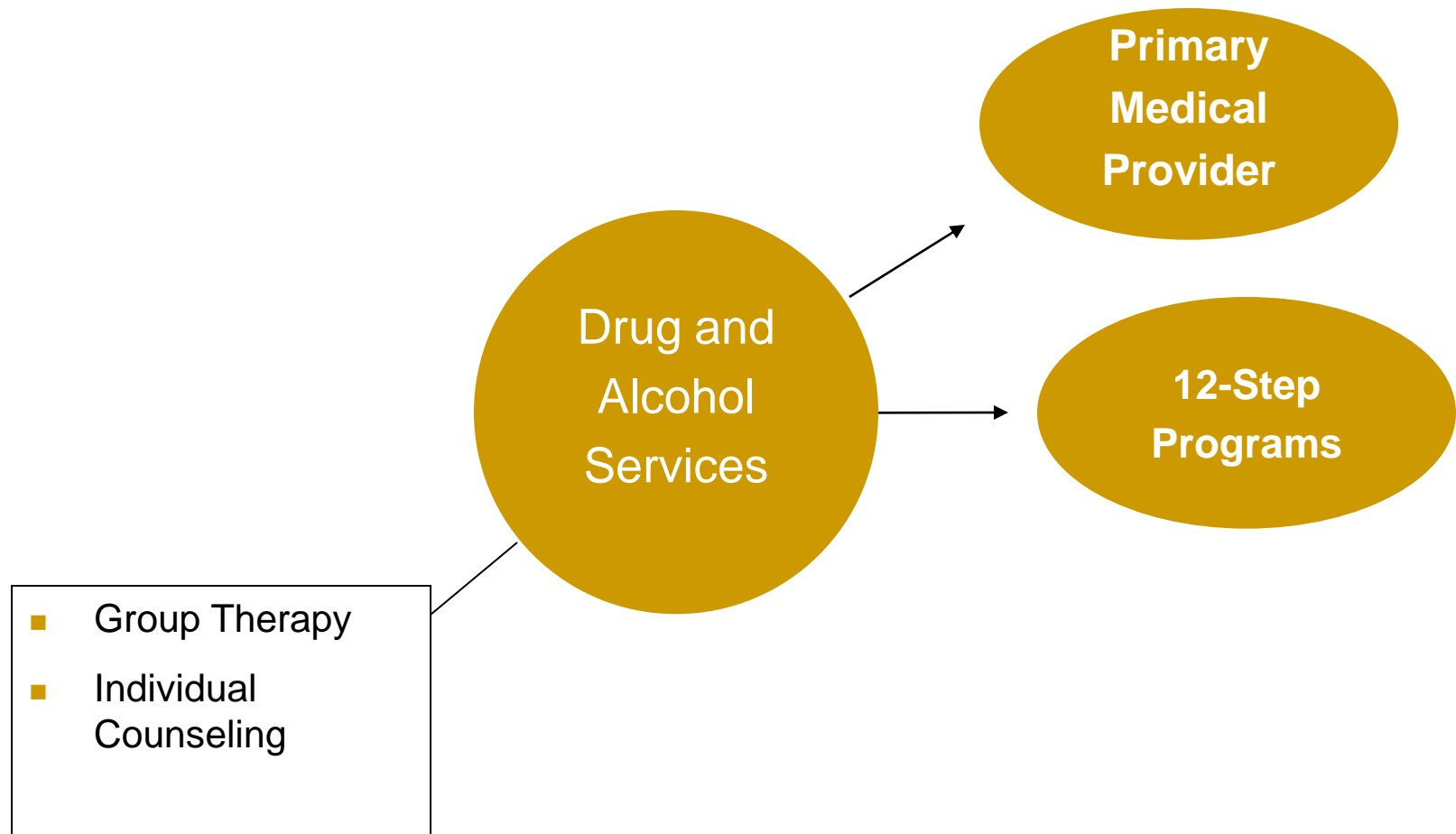
Linkage Diagram

Community Partner Perspective



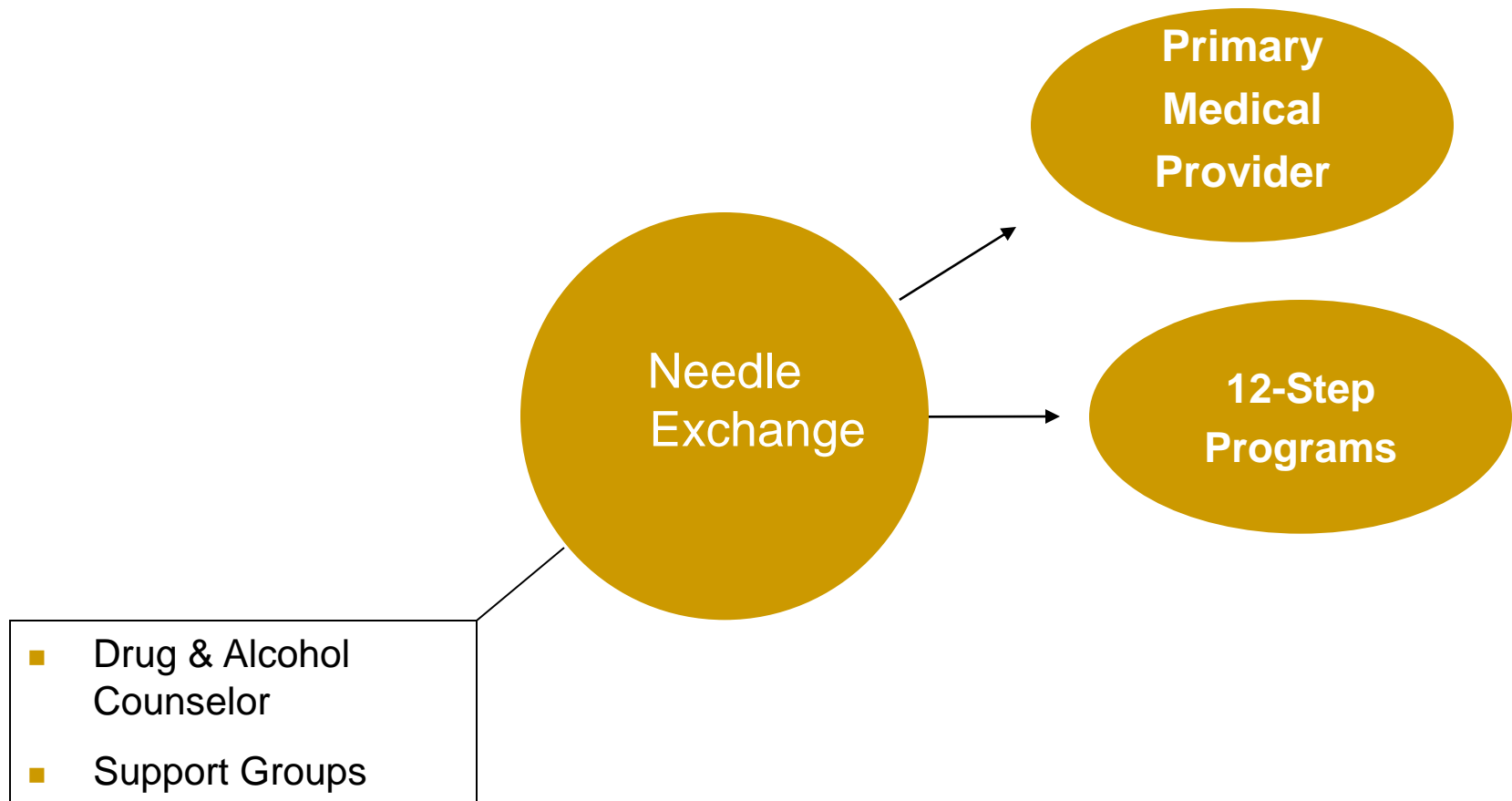
Linkage Diagram

Community Partner Perspective



Linkage Diagram

Community Partner Perspective



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

Year	2009
Established New Patients	255
Retention	208
Retention Rate	82%
Incarcerated	11
In-PT D&A	5
Returned After last date of service	9

- 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

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- 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

