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

Cody J. Poerio, MPH

DREXEL UNIVERSITY
COLLEGE OF MEDICINE

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)

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

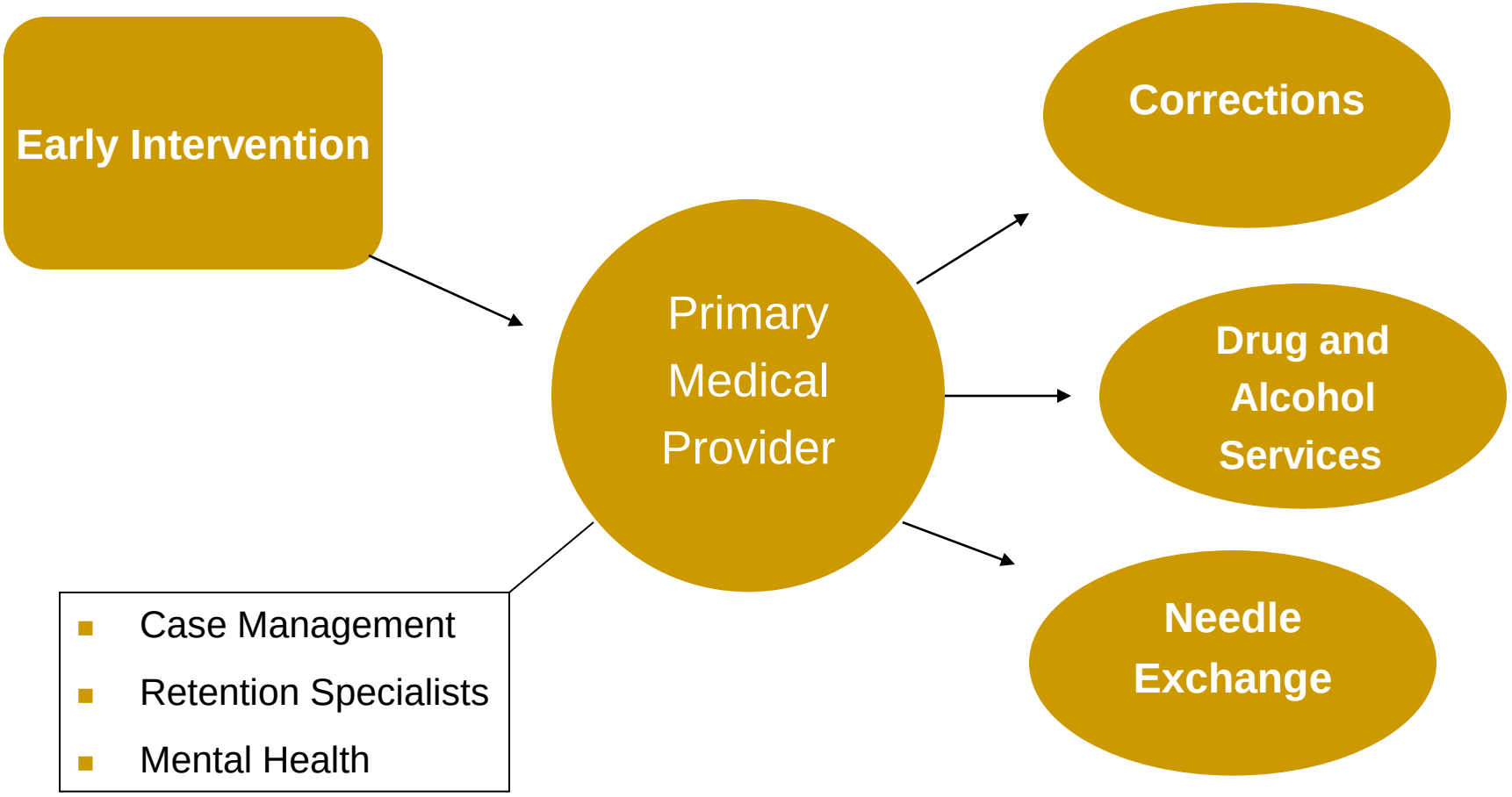
Shifting the Momentum

- 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.

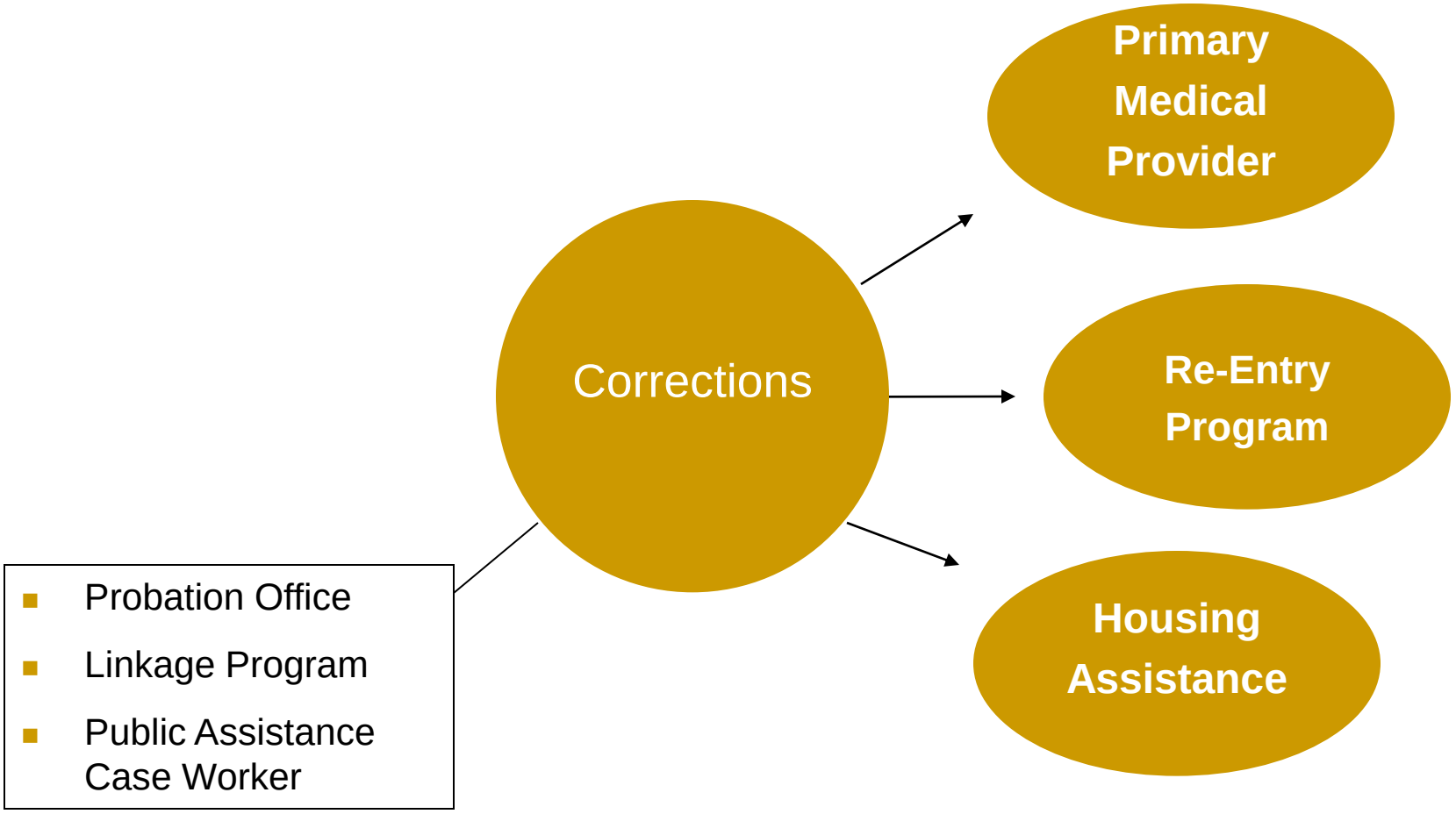
Purpose of the Community Retention Management Model

- 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.

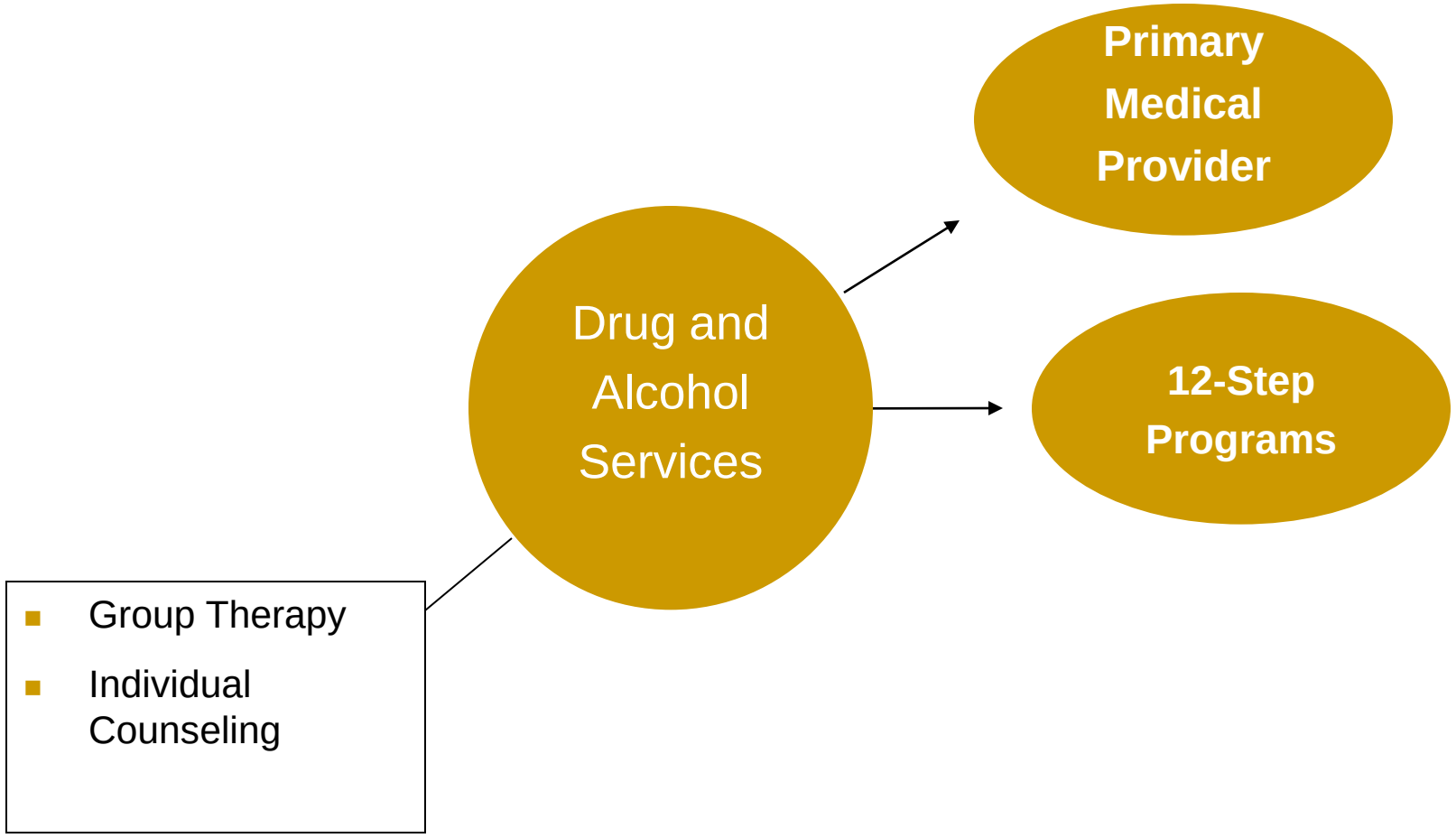
Community Retention Management Model Linkage Diagram



Linkage Diagram
Community Partner Perspective



Linkage Diagram
Community Partner Perspective



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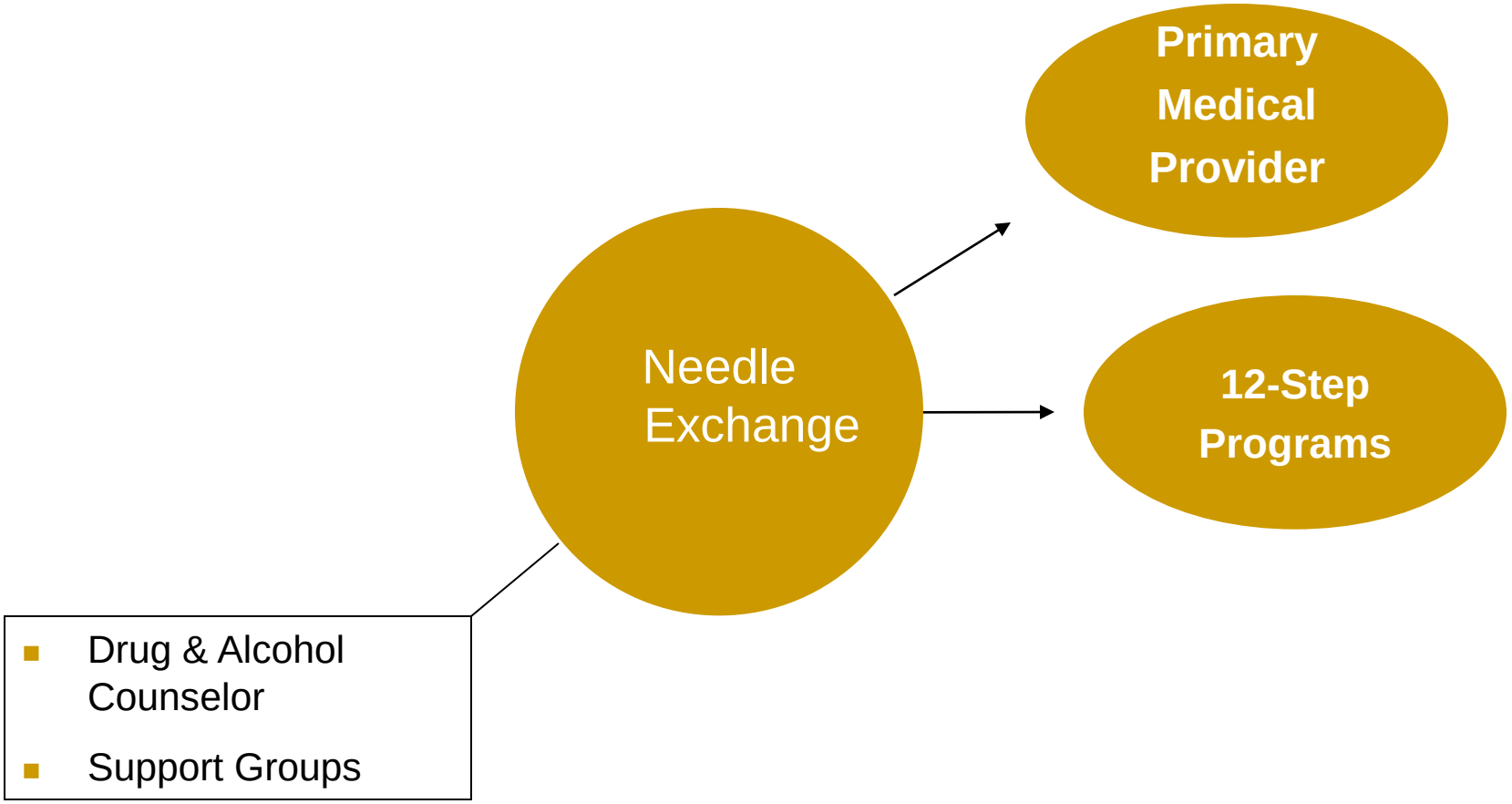

What Makes it Work

- 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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- ARS Questions