Retention Readiness Indicator Tool

Why Retention Matters

The Retention Readiness Indicator Tool (RRIT) uses the latest research on why the most vulnerable populations fall out of care, and is intended to support HIV treatment teams in assessing their ability to screen for and counter these factors. By identifying the treatment team's goals for a patient and assessing both individual and structural barriers to care, RRIT provides the opportunity for evidence-based decisions with patients.

Practical Retention Strategies

The 4 components of the RRIT can be used independently or comprehensively, depending on the needs of your patients and your resources and infrastructure. The tool can be used as a framework for case conferencing, as a checklist for clinicians at screening or intake, as a treatment planning worksheet, or infused into quality assurance protocols.

Measure Retention Efforts

HIV treatment and care providers are working to implement high-impact prevention to better serve the 80% of HIV infected individuals who are not fully engaged in care. The RRIT identifies opportunities to evaluate the process measures that have been shown to lead to increased retention in care.

For More Support Contact us:

CIS-CBA developed a series of webinars and tip sheets highlighting the 4 RRIT parts. You may access all webinar recordings and other helpful resources at:

www.etr.org/cis/

When you use the RRIT in part or in whole, we would love to hear from you. We can offer FREE capacity building support or help you develop an evaluation plan for capturing and analyzing your efforts!

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Retention Readiness Indicator Tool

Date: _____ Treatment Team: _____

Patient Name: _____ Retention Risk Score: _____

Instructions:

This Retention Readiness Indicator can be used by the HIV Treatment Team member for each new patient during or after the first visit to determine the patient's risk of falling out of care as well as the critical elements that may affect that patient's ability to remain in care. The tool can help identify in-depth assessments that should be completed, strategies that the HIV Treatment Team may incorporate to support adherence to appointments, medication, and auxiliary services.

- **Step 1:** Identify the Treatment Team's primary goals for this patient. These goals may depend on life circumstance, disease stage, experience in treatment, and ART use.
- **Step 2:** Identify the clinic procedures, programs, or protocols that would be most appropriate to implement with this patient – and those that might become potential barriers to patient retention.
- **Step 3:** Review your treatment plan and determine which individual factors need to be assessed more fully and addressed in the patient's treatment plan. Determine if these issues are already assessed in existing intake forms or treatment questionnaires/documents administered by various providers working with the patient or if a full assessment should be conducted (e.g. a CES-D Scale, CAGE tool, or environmental assessment).
- **Step 4:** Based on your assessment of the patient's risk of falling out of care, identify priority steps to take with the patient to increase retention.

I. Identify clinician's current goals for patient

"…poor engagement in care is associated with poor health outcomes, including increased mortality."[1]

Desired outcomes	Top Priority	Medium Priority	Low Priority
Establish connection to HIV clinic			
Increase HIV care specific appointment adherence			
Increase secondary/co-occurring condition/treatment appointment adherence			
Consent to and initiate ART			
Maintain/increase ART adherence			
Reduce transmission risk acts			
CD_4 reconstitution			
Viral load suppression			
Opportunistic infections management			
Other: (please describe)			

[1] Gardner, EM, McLees, MP, Steiner, JF, Del Rio, C, Burman, WJ. The Spectrum of Engagement in HIV Care and its Relevance to Test and Treat Strategies for Prevention of HIV Infection. Clinical Infection Disease 2011; 52(6): 793-800

II. Determine the strategies relevant for patient to engage and remain in care

"Participants who reported receiving any program service and feeling respected at their site of HIV care were significantly less likely to miss a visit."[2]

Components	Need to Try	Using Now	Not Applicable
Clinic Structures			
Promote cultural competency framework			
Utilize appointment setting system			
Staff diversity mirrors patient diversity			
Access to medical interpreters			
Appointment reminders / contact between visits			
Obtain regular updates to patient contact information			
Provide convenient appointment times			
Initiate contact during time from initial call to first appointment			
Measure and track patient retention rates			
Provider Approaches			
Involve multidisciplinary team			
Utilize C-V-P Engagement Approach			
Utilize cross cultural communication strategies			
Identify individual health belief model of illness			
Identify potential medical cross-cultural differences			
Provide follow-up written materials			
Have non-physician staff follow-up to answer questions			
Identify emotional barriers to care			
Identify circumstantial/contextual barriers care			
Auxiliary Services			
Case management			
Peer navigators			
Outreach			
Linkage to support services			
Support groups			
Peer educators			
Community viral load tracking			
HIV treatment options information			
Patient's Retention Risk Score			

[2] Christopoulos, KA, Das, M, Colfax, GN. Linkage and Retention in HIV Care among Men Who Have Sex with Men in the United States. Clinical Infection Disease 2011; 52(S2): S214-S222

III. Culturally Competent Treatment Planning - Identify issues relevant to the patient retention

"A successful connection to the HIV clinic must occur before patients can be retained in care over time. Patients may demonstrate cyclical pattern of being in and out of care."[3]

Components	Need to Address	Currently Addressed	Not an Issue	Comments
Personal/Cultural				
Social support system				
Coping/self-efficacy skills				
Emotional barriers to treatment				
Misconceptions about HIV and/or treatment				
Lack of trust in health care system				
Lack of trust in medical providers				
Acceptance of HIV diagnosis				
Perception of HIV+ stigma				
Experiences with HIV+ stigma				
Perception of HIV risk				
Perception of sexism				
Perception of racism				
Perception of homophobia				
Language barriers				
Trauma history				
Domestic abuse history				
Incarceration history				
Immigration/migration status				
Financial				
Employment status				
Insurance status				
Transportation				
Child care				
Housing situation				
Medical				
Self-perceived health status				
Symptoms				
Viral load				
Disease stage				
ART				
Multiple providers/clinics				
Co-existing conditions				
Mental health				
Substance use				
Other STD				
Other chronic disease:				
Other prescriptions:				
Patient Retention Risk Score				

[3] ibid

VI. Identify priority steps to take with patient

"The quality of the patient-provider relationship may be one of the most important predictors of adherence, particularly among minority patients and women with HIV."[4]

1.

2.

3.

Scoring the Tool

1. Score Part 2: Determine the strategies relevant for patient to engage and remain in care
    a. For each component, score as 0-2 based on response (see below)

Need to Try	Using Now	Not Applicable
2	1	0

    b. Sum each of the 3 columns and divide the total of the 3 columns by 26
    c. The higher the score, the greater the risk of falling out of care
    d. Priority steps should include strategies from multiple components of structural factors

2. Score Part 3: Culturally Competent Treatment Planning - Identify issues relevant to the patient retention
    a. For each component, score as 0-2 based on response (see below)

Need to Address	Currently Addressed	Not an Issue
2	1	0

    b. Sum each of the 3 columns and divide the total of the 3 columns by 34
    c. The higher the score, the greater the risk of falling out of care
    d. Priority steps should include strategies from the factors the personal and cultural factors in addition to addressing the medical and co-existing conditions

3. Review the goals and priority steps with the patient to identify key approaches to increase retention

[4] Stone, VE. Optimizing the Care of Minority Patients with HIV/AIDS. Clinical Infection Disease 2004; 38: 400-4

Sample Items for Process Measurement of Patient Retention in HIV Care and Treatment

Patient Satisfaction Survey Sample Items

Do you feel the front desk staff treats you respectfully?	All of the time ☐	Most of the time ☐	Some of the time ☐	Not at all ☐
Did you get a reminder for your appointment?	Yes, phone message ☐	Yes, text message ☐	Yes, email message ☐	No ☐
At the clinic which person do you feel you could call or talk to if you had a question after your visit?	Social worker ☐	Nursing staff ☐	Medical provider ☐	Pharmacist ☐
	Clinic coordinator ☐	I didn't know I could talk to anyone ☐	Someone else _____ ☐	No one ☐
How confident do you feel about the steps you are to follow after your visit?	Very confident ☐	Kind of confident ☐	Somewhat confident ☐	Not at all confident ☐

Referral Log Sample Items

How was referral given to patient?	Did the patient follow-up?
☐ Contact information provided ☐ Appointment Made ☐ Transportation provided ☐ Accompanied patient ☐ Other: _____	☐ Yes ☐ No (reason : _____) ☐ Unsure
Additional follow-up needed?	
☐ Yes (list or check box) ☐ No	

Chart Review Sample Items

Was updated contact information requested at visit?	Is preferred reminder method noted?
☐ Yes ☐ No	☐ No ☐ Yes
Is medical interpreter needed?	Was medical interpreter provided?
☐ Yes ☐ No	☐ No ☐ Yes

Process Evaluation

Process evaluation helps document the interventions, programs, and strategies that are implemented. This measures the means to the end. Efforts to increase retention can be evaluated by adding questions or items to existing tools or by creating new tools to track or measure what happens along the way. Here are common approaches that can be used:

- Survey (clients, providers, staff, family, referral networks)
- Logs (of referrals, assessments, appointments, calls completed by staff)
- Interview (clients, providers, staff, family, referral networks)
- Focus Group (clients, providers, staff, family, referral networks)
- Observation (of session, of behavior of staff or patient, of waiting room environment)
- Document Review (case notes, meeting minutes, assessment results, referral paperwork)
- Case studies (success stories, barriers to retention)
- Photo voice (individual experiences of clients, providers, families)

Tips for Outcome Measurement of Patient Retention in HIV Care and Treatment

How Will You Use the Data

- Administrative decisions (e.g. setting benchmarks, scheduling and staffing)
- Treatment decisions (e.g. visit frequency, type of appointment, sub-specialties)
- Program decisions (e.g. new strategies, interventions, or approaches)
- Reporting (e.g. federal funders, executive director, board of directors)

Who Will Collect and Analyze the Data

- Automated system
- Support staff
- Information Technology staff
- Clinicians
- Quality Assurance Manager

Factors that May Affect Measurement

- Auto-scheduling system
- Lost to follow-up procedures
- Treatment team approach
- Disease stage
- ART use

Ask yourself…

- Do we need detailed information or can we meet our needs with a crude measure?
- Do we need to use a measure that is easy to calculate across all patients or do we need to look at treatment needs of individual clients?
- Do we implement a commonly used adherence model or is a specific HIV care measure more appropriate?

5 Methodologies to Measure

There is no gold standard of measuring client retention in care. Studies have shown that the different methods are comparable[1]. Therefore, you should select a method that best meets the specific needs and resources of your organization.

- **Missed Visits**
  - Counts the number of missed visits
  - Can be reported as a count or as a Yes/No
- **Visit Adherence**
  - Proportion of completed visits over scheduled visits
- **Gaps In Care**
  - Assesses time interval between visits
  - Appropriate time interval set for each patient
- **Visit Constancy**
  - Proportion of time interval with at least 1 visit
  - Appropriate interval set for each patient
- **HRSA Measure**
  - Counts at least 1 medical visits every 6 months over 24 months, at least 60 days apart
  - Required by some funders

[1]Mugavero, M.J, Davila, J.A.,Nevin, C.R., Giordano, T.P. (2010) . "From Access to Engagement: Measuring Retention in Outpatient HIV Clinical Care."AIDS PATIENT CARE and STDs Volume 24, Number 10, 2010