New Ways to Think About Retention in Care

Participant Notes, Oct. 17 & 31, 2014

At greatest risk for not being retained

Research tells us that individuals infected with HIV and not engaged in care tend to be…

- People of color
- Experiencing homelessness
- Dual diagnosed (mental illness)
- Diagnosed with higher CD4 counts
- In poverty
- Substance users
- Younger

Why are they not in care?

The social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness.

- economics
- social policies
- politics

Why does it matter if they are not in care?

- It is critical for individuals living with HIV, who are linked to care, to maintain optimal retention as this maximizes viral suppression, reduces the risk of AIDS progression, and reduces the risk of HIV transmission.
- Failure to initiate timely HIV care after diagnosis is common. Longer delays in linkage with medical care are associated with greater likelihood of progression to AIDS by CD4cell criteria.
- Poor engagement in care is associated with poor health outcomes, including increased mortality.

What can we do? *"Risk Reduction Indicator Tool"*

☑ **Identify the Treatment Team's primary goals**

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.

What can we do? *"Risk Reduction Indicator Tool"*

☑ **Identify the clinic procedures, programs, or protocols**

Identify the clinic structure, provider approaches, and auxiliary services that would be most appropriate to implement with this patient – and those that might become potential barriers to patient retention.

What can we do? *"Risk Reduction Indicator Tool"*

☑ **Identify individual factors need to be assessed**

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 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).

What can we do? *"Risk Reduction Indicator Tool"*

☑ **Identify priority steps**

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… because you can't possibly do it all at once!

Measuring Retention

- ***Missed Visits*** - Number of missed visits
- ***Visit Constancy*** - Proportion of time periods (e.g. 3 months) with at least 1 completed visit
- ***Gaps in Care*** - Length of time between visits (e.g. between 4 and 12 months)
- ***Appointment Adherence*** - Number of completed visits over scheduled visits
- ***HRSA performance measure*** - at least 1 medical visit in each 6 month period over 24 months separated by 60 days or more

Advantages & Disadvantages to each Measure

- Ease of use
- Experience or comfort with approach
- How much time or effort to follow up on no-shows
- Scheduling practices
- Administrative needs vs. programmatic needs

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