A Population Health Based Strategy for Achieving 90% Retention in Care

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INTRODUCTION

- In a general sense, retention in care is defined as a patient's regular engagement with medical care at a health care facility after initial entry into the system.[1] Retention in care has been linked to improved clinical outcomes in people with HIV.[2]
- The CDC estimated in 2016 that 57.6% of HIV patients were retained in care. Very little change from a low in 2011 of 53.6% was reported over 5 years of surveillance data. [2] The National HIV/AIDS Strategy 2020 has set a goal of 90% retention in care. [3]
- Various sources have outlined strategies to address this gap.[4] Several services that may bolster retention in care are consistent with population health princples.[5]
- In January 2018, we undertook to apply a population health-based, patient-centered approach to improve our center's retention in care measure to try to meet the 2020 Goal of 90%.

ABOUT MIAMI BEACH COMMUNITY HEALTH CENTER

- Miami Beach Community Health Center is a Federally Qualified Community Health Center located in South Florida.
- We have served our community for over 40 years and have participated in the Ryan White Program for since 1990.
- Over 52,000 patients of all ages accessed our services in 2019, 1200 of which were People Living with HIV.
- Over 90% of our patients fall under 200% of the Federal Poverty Line. 87% identify as part of a racial or ethnic minority, 77% of which are Latinx. 56% state that they are best served in a language other than English.
- We have 6 full time Ryan White Certified Primary Care Provider and 4 In Training. We employ 11 Ryan White Case Managers and 3 Peer Educators. Through our specialty network, we are the largest Ryan White provider in Miami-Dade County.

METHODS AND ACTIVITES

- We followed the criteria outlined in the "HIV Medical Visit Frequency (NQF 2079)" to define "Retention in Care". That is, we measured the "percentage of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits." [5]
- The project launched in January 2018 and is ongoing.
- We developed and maintained a registry corresponding to those patients "with a diagnosis of HIV with at least one medical visit in the first 6-months of the 24-month measurement period." [5]
- Each patient was assigned to one of 6 Chronic Disease Navigators who were responsible for making sure patients were scheduled to see their assigned HIV medical provider, facilitated their attendance at appointments (e.g. arranged transportation, meet the patients at the front door, expedited check in with front desk staff, etc) and followed up with the patient after the visit.
- A multidisciplinary task force was formed consisting of the navigators, Ryan White case managers, department heads, clinical leadership, nursing and quality management personnel. This task force met weekly to bimonthly to set goals, review progress and develop strategies to overcome challenges.

RESULTS

2016-2017

	Jan–Jun 2016	Jul–Dec 2016	Jan–Jun 2017	Jul–Dec 2017
# Patients	956	831	745	693
% Retained	100.00%	86.92%	77.93%	72.49%
% Attrition	0.00%	13.08% (2)	9.00%	5.44%

2017–2018

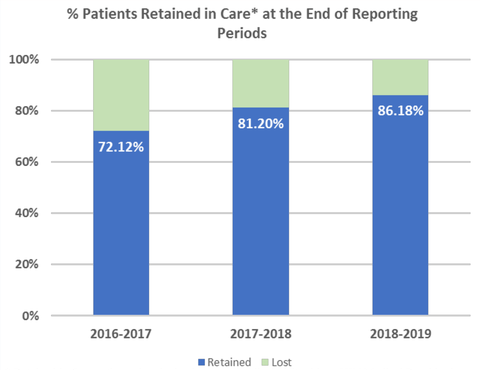
	Jan–Jun 2017	Jul–Dec 2017	Jan–Jun 2018	Jul–Dec 2018
# Patients	803	691	668	652
% Retained	100.00%	86.05%	83.19%	81.20%
% Attrition	0.00%	13.95% (3)	2.86% (1)	1.99%

2018–2019

	Jan–Jun 2018	Jul–Dec 2018	Jan–Jun 2019	Jul–Dec 2019
# Patients	832	789	750	717
% Retained	100.00%	94.83%	90.14%	86.18%
% Attrition	0.00%	5.17%	4.69%	3.97%

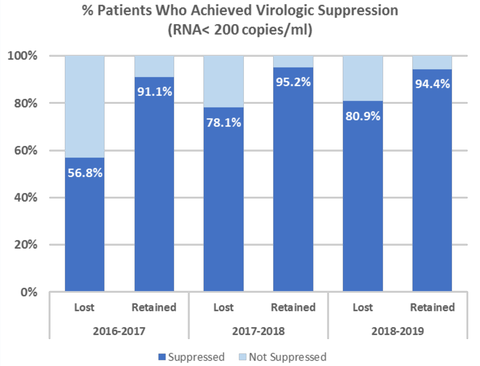
- We saw an immediate and marked decrease in attrition (% of patients lost to care) in the first measurement period (January to June 2018) after onset of the project. (1)
- In the second year of the project, the overall attrition rates were higher; however, the typically very high initial attrition (13.08% in 2016-2017 (2) and 13.95% in 2018-2019 (3)) was reduced by over 70% to 5.17%.
- We were able to maintain lower attrition rates in the first full 24-month reporting period of the project (2018-2019) which yielded an 18.89% relative improvement compared to the last reporting period before the project (2016-2017)

RESULTS



* Retained in Care = the patient had at least one medical visit with an HIV Medical Provider in each of four 6-month measurement periods during a 24- month reporting period.

- In the first year of this project, we were able to markedly improve our percentage of patients retained in care by 9%. We continued to see improvements in the second year, but more modestly with an 5% increase in percentage of patients retained in care.
- Virologic suppression seemed to have a modest improvement among those retained in care at the end of the first year of the project (2018). There was no improvement in virologic suppression seen after the second (2019).



CHALLENGES

- Patient perceptions – many of our patients were accustomed to dealing with only their medical provider and the medical assistants when scheduling and keeping appointments. Introduction of a multidisciplinary care team approach proved to be a steep learning curve.
- Provider inertia – some medical providers and their teams resisted what they felt was interference in the workflows they were used to.
- Social determinants of health – working around patient's work schedules, transportation, dealing with clinic wait times, etc. were identified as barriers retaining patients in care.

CONCLUSIONS

Craw et al. outline five components for optimizing retention in care: appointment reminders, follow up on missed appointments, patient navigation, reinforcement of follow up visits and monitoring of retention in care in all HIV patients.[7] At our Community Health Center, it seems that these population health principles can successfully be applied to the care of People Living with HIV to yield measurable improvements in retention in care. We have some ground to cover before we will meet the goal set by the National HIV/AIDS Strategy Statement of 90% by 2020. This project is ongoing, and other approaches such as incorporation of telemedicine, improved outreach, patient education programs and incentives need to be investigated and tested.

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