Implementing Care and Retention Measures: Don't Miss Your Shot!

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Disclosures

I have no financial relationships to disclose

Retention Initiatives and the National HIV/AIDS Strategy

National HIV / AIDS Strategy (NHAS)

- Reducing New HIV Infections
- **Increasing Access to Care and Improving Outcomes**
  - ❖ **Improving linkage into care and retention to achieve viral suppression that can reduce transmission risk**
  - ❖ **Increase a diverse workforce trained to provide specialty care**
  - ❖ **Support comprehensive, coordinated, patient-centered care**
- Reducing HIV Related Disparities and Health Inequities
- Achieve A More Coordinated National Response

Retention in HIV Medical care

Background:

Retention into medical care among people living with HIV (PLWH) is vital as this maximizes viral suppression, reduces the risk of disease progression, and viral transmission. The HIV Medicine Association guidelines endorse an emphasis be placed on retention in HIV medical care rather than just focusing on adherence to antiretroviral medications. Implementing interventions and measuring retention presents unique challenges in rural HIV clinics. We implemented three tailored interventions to determine if specific methods are associated with improved retention in HIV care.

Retention Into HIV Care

Retention in Care Measures:

1. Missed medical visits (not cancelled or rescheduled) were recorded as a count. A kept appointment was measured as a scheduled medical visit the patient attended (excluded sick visit, cm appointment).
2. Visit constancy was observed as a percentage of 6-month intervals with at least one clinic visit.

Outcome Measure:

1. Did the patient achieve Viral Load suppression at the 6 month interval visit?

Patient Care and Retention Program

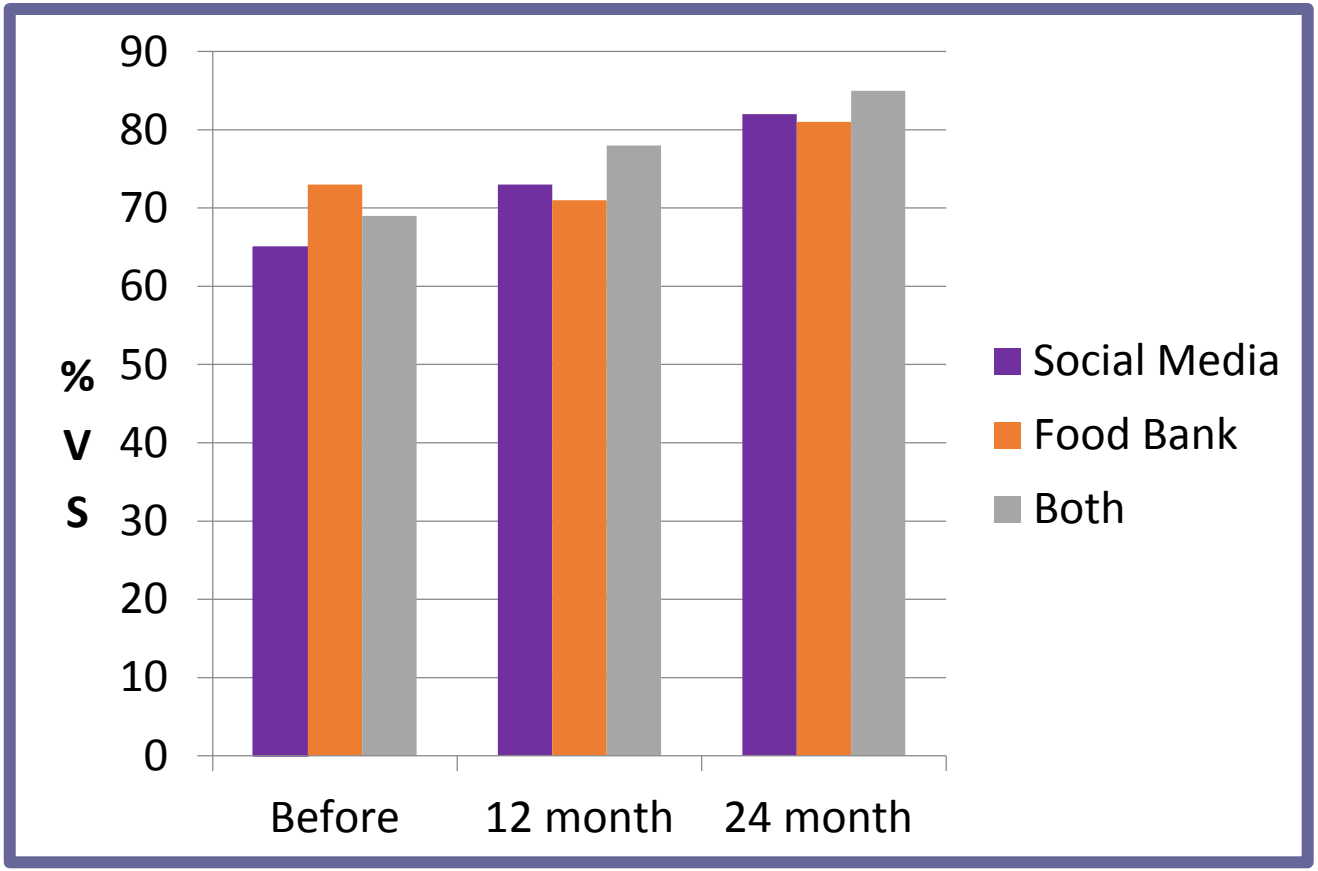
Assessment for Patient Care And Retention Program Intervention

High Risk	Moderate Risk	Low Risk
No reliable Transportation	**Inconsistent Transportation**	KARTS for transportation
Unstable Housing / Homeless	Recent change in housing	Has Stable Housing
Invalid Contact Information	Change in contact information	Social Media / valid contact
Food Insecurity / Resources	**Decrease in food stamps**	Adequate food / Nutrition
History of poor adherence to medication / medical visits	**Lack of family support system**	Family aware of status
Mental Health / current substance abuse (opioids)	History of treatment for mental health / substance abuse	No substance abuse issues
Missed at least 2 consecutive visits. “Frequent Fliers”	Frequent Flier	No missed visits in previous 12 months
Missed 1 medical visit in 6 mos. Without reason (Stigma, fear, denial)	**Rescheduled at least 1 medical visit in 6 months without identified barrier**	Rescheduled at least 1 medical visit in 12 months without identified barrier
Increased VL or no longer virally suppressed	Virally suppressed but admits stigma, fear, accepting dx.	Virally Suppressed

High Risk Patient Care And Retention Program Demographics 2013-2015

	Total	High Risk		Before PCARP	Viral Suppression	
	N (%)	*12 mos*	*24 mos*	***Viral Suppression***	*12 mos*	*24 mos*
Total	282	145 (51%)	160 (57%)	69%	104 (81%)	126 (79%)
Age: mean yrs	38	48	47			
Female (Trans)	107(38%)	64 (48%)	71 (43%)		38 (59%)	55 (77%)
Male	**175 (62%)**	**81 (63%)**	**89 (56%)**		**63 (78%)**	**71 (80%)**
MSM	88 (50%)	36 (44%)	46 (52%)		29 (81%)	38 (83%)
Race						
Non-white	243 (86%)	114 (89%)	143 (89%)		91 (86%)	110 (85%)
White	39(14%)	14 (11%)	17 (11%)		13 (93%)	16 (94%)
Social Media		51 (37%)	57 (36%)	65%	37 (73%)	46 (82%)
Fb/Text /Glide						
Voxer/Appt. App						
Food Bank		94 (65%)	103 (64%)	73%	67 (71%)	84 (81%)
SM/F		73 (50%)	80 (50%)		57 (78%)	68 (85%)

Patient Care And Retention Program Results 2013-2015
Outcome Measure



Patient Care And Retention Program and Adherence to Medical Visits
2013-2015

PCARP	Appointments Total	kept	Missed	No Show Rate
Social Media				
• 12 mos	142	119	23	16%
• 24 mos	161	133	28	17%
Food Bank				
• 12 mos	261	226	35	13%
• 24 mos	289	256	33	11%
PCARP TOTAL				
• 12 mos	403	345	58	14%
• 24 mos	450	389	61	13%

Patient Care And Retention Program: Don't Miss Your Shot! Conclusion

- Identifying which patients are at highest risk for not being retained is important to target intervention efforts to those groups.
- Invalid contact information, food insecurity, lack of nutritional resources and not being virally suppressed are strong predictors of retention.
- Other important factors more specific to rural communities are inconsistent transportation and lack of a family based support network.
- Characteristics associated with retention will necessarily vary between urban and rural clinics. Rurality of HIV in the deep south becomes important when prioritizing interventions for improvement.
- We highlight the importance and positive impact of supportive service programs on patient retention, including case management, transportation, use of social media, food and nutrition.

Wait….What?

- We need to fundamentally rethink the way health care services are delivered especially in under resourced rural communities.
- We need to redefine what a “visit” means. Virtual visits, social media contact, communication with case management, etc.
  - Stigma
  - Co-pay
  - Fear
- We need to make better use of technology available to us to improve clinical outcomes. Better outcomes with less dollars is the expectation.

PCARP Team

Lester, Harmon, DNP - Provider

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