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Retention in HIV Care

TA Webinar

July 19, 2012

Continuum of Engagement

Not in HIV Care ⟷ Engaged in HIV Care

Unaware of HIV infection	Aware of HIV infection (not in care)	Receiving some medical care but not HIV care	Entered HIV care but lost to follow-up	Cyclical or intermittent user of HIV care	Fully engaged in HIV care
●	●	●	●	●	↗

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Agenda

- Welcome, Overview, Participation Guidelines - 5min
- Learning Objectives - 5min
- Retention and QI - 25 mins
- Speaking from Experience / Panel Discussion, 20 mins
- Wrap-up & Evaluation - 5min

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Conversation opportunities throughout webinar

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Welcome, Participation Guidelines & Overview

- NQC Welcome
- Do not put us on hold.
- Mute your line. (press *6)
- If you'd like to make an audio comment press *6, to unmute your line. (press *6 again to remute)
- Actively participate by sharing questions and comments in the chat room

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Welcome, Participation Guidelines & Overview

- The webinar will include “pop up” questions, opportunities for you to join into discussions [both in the chat room and live on the call], and a feedback survey
- The slides and recording of this NQC TA webinar and others are available for playback and group presentations at:
  www.nationalqualitycenter.org
  NQC Activities Tab

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Learning Objectives

- Review of national retention initiatives
- Review performance measurement strategies to assess patient retention in HIV care
- Discuss high-impact tools for improving retention in HIV care at provider practices
- Discuss strategies for the effective coordination of retention activities for network lead agencies

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National Retention Initiatives

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National Retention Initiatives

in+care Campaign

- National voluntary initiative to improve retention in HIV care and re-engagement of people with HIV who have fallen out of HIV care

SPNS Linkage to Care

- 7 states funded to explore methods to improve linkage to HIV care for people newly diagnosed with HIV and re-engagement of people with HIV who have fallen out of HIV care

CDC MAI CAPUS Demonstration Project

- 18 health department grantees increase linkage to care after diagnoses are made

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Retention Initiatives and National HIV/AIDS Strategy

1. Reducing the number of people who become infected with HIV,

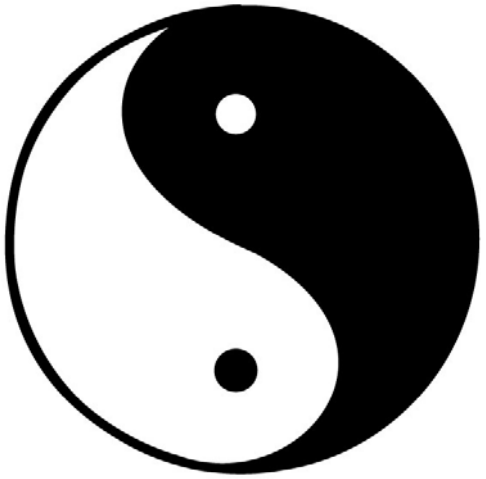
   ✓ - indirectly in all three initiatives through secondary/tertiary prevention

2. Increasing access to care and optimizing health outcomes for people living with HIV, and

   ✓ - directly through all three initiatives

3. Reducing HIV-related health disparities.

   ✓ - directly through CDC MAI CAPUS



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Pop-up Question

Which of the following retention initiatives are you involved in?

in+care Campaign

HRSA SPNS Linkage to Care

HIVQUAL-US QI Project and/or Regional Group

State or Local Initiative

I don't think we're participating in any initiatives

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Measuring Retention

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Things to Keep in Mind When Measuring Retention

Data Quality and Accessibility

1. Is data electronic or paper?
2. Does QM staff have direct access to data?
3. Completeness of demographic data in charts / EMRs
4. Completeness of clinical data in charts / EMRs
5. For regional projects, have patients been de-duplicated?

Stratification for Comparison

1. Race / Ethnicity (goal of NHAS)
2. Gender
3. Payer Source
4. Distance from Clinic

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Types of Retention Measures

Process Measures

1. Gap in Follow-up Measures
2. Visit Frequency Measures
3. Missed Visit Measures
4. New to Clinic Measures

Outcome Measures

1. Viral Load Measures

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Process Measure – Gap in Follow-up

- Low scores are good scores!
- This is similar to the HRSA HAB Measure 1
  - Utilize encounter data from your site
  - Set gap intervals for visits based on your agency policies for counting patients as lost to follow-up and as lost to care – common gap intervals for HIV appointments are (choose one):
    - 6 months
    - 9 months
    - 12 months
  - Den – visit in first interval, Num – NO visit in some subsequent intervals

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Process Measure – Visit Frequency

- The inverse of Gaps in Care
- Also known as Persistence and Visit Intervals
  - Utilize encounter data from your site
  - Set frequency intervals for visits based on your agency policies for counting patients as lost to follow-up and as lost to care – common frequency intervals for HIV appointments are (choose one):
    - 6 months
    - 9 months
    - 12 months
  - Ideally, establish measurement periods greater than 12 months
  - Den – visit in first interval, Num –visit in each subsequent interval

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Process Measure – Missed Visits

- Patient-Level Measures
  - Utilize encounter data from your site
  - What percentage of patients have missed more than 3 visits within 1 year
- Clinic-Level Measures
  - Utilize encounter data from your site
  - What percentage of appointments were not kept over the course of 1 year

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Process Measure – New To Clinic

- Frequency of patient visits over the first year
  - Utilize encounter data from your site
  - Set 3 or 4 month visit intervals for assessment (base this on your agency practices)
  - Den – visit in first interval, Num – visit in subsequent intervals
- Number of patient visits completed
  - Utilize encounter data from your site
  - Has the patient completed 4 or 5 visits within 1 year of initiating care (base this on your agency practices)

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Outcome Measure – Viral Loads

- Viral Suppression Measures (regardless of ART)
  - Utilize last known viral load value for active patients at your agency
  - Cut-offs for suppressed viral loads are usually 10 times the minimum detectable viral load to allow for viral blips

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Pop-up Question

Which of the following types of retention measures have you implemented at your agency?

Gap in Follow-up Measures

Visit Frequency Measures

Missed Visit Measures

New to Clinic Measures

Viral Load Measures

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Tools to Improve Retention – Provider Level

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Types of Tools

Communication Strategies

1. Communication with patients
2. Communication with other providers

Operational Strategies

1. Process Diagram Initiation / Revision
2. Use retention / adherence / outreach specialists and/or patient navigators
3. Data Quality Improvement / Enhancement

Visit www.incarecampaign.org RESOURCES for examples

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Communication Strategies – w/Patients

- Reminder calls for appointments. Follow-up calls for missed appointments
- Text messaging reminders
- Use of patient portals (PHR) within EMRs
- Use of Facebook and other social media
- Motivational Interviewing
- Health literacy education
- CAB workgroup focused on retention

Visit www.incarecampaign.org RESOURCES for examples

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Communication Strategies – w/Other Providers

- Create opportunities for staff of various agencies/office to interact
- Interdisciplinary teams that operate across agencies
- Include private practice offices in communications
- Actively participate in available communities of learning
- Co-locate services from different agencies
- Allow for longer transitions (especially pediatric to adult)
- Institute joint-CABs and other joint programs
- Case Conferencing and Panel Lists

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Operational Strategies – Process Diagrams

- New patient enrollment and follow-up
- Patient appointment reminders and follow-up on missed visits
- Patient re-consent and eligibility redetermination
- Prioritizing patients for navigation services
- Prioritizing patients for home visit services
- Patient transition / case closure processes
- Communication strategy with lead agencies and other provider agencies
- Viral Load Suppression

Visit www.incarecampaign.org RESOURCES for examples

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Operational Strategies – Staff/Volunteer/Intern Roles

- Greeters in clinic lobby
- Do everything possible to decrease on-hold times for calls
- Ensure timely responses to email questions/requests
- Patient Navigation / Peer Navigation
- Patient Educators / Peer Educators

Visit www.incarecampaign.org RESOURCES for examples

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Operational Strategies – Data Quality Improvement

- Ensure data system has structured ways to capture patient status
- Advocate for timely access to your data (large systems)
- Review Pharmacy Access data when available
- Review Medicaid Access data when available
- Review Prison/Incarceration data when available
- Review Death, Marriage, Cancer and other registries
- Include a data quality component to peer review processes
- Administrative supervision includes data quality component

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Tools to Improve Retention – Regional Level

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Types of Tools

Peer Navigaton / Care Coordination Strategies

Data Management Strategies

Community of Learning Strategies

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Peer Navigation / Care Coordination Strategies

- Require interdisciplinary teams contractually
- Require interdisciplinary teams through standards of care
- Provide funding opportunities for patient navigation and care coordination services
- Link with community college Community Health Worker training programs

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Data Management Systems

- Recapture Blitz!
- Training providers on patient panel list making and managing their patient populations as part of a team of agencies
- Unmet need research to find patients who are out of care
- Work with lab companies on eHARS data quality

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Community of Learning Strategies

- Actively participate in existing community of learning opportunities
- Create additional communities of learning where indicated (special focuses on certain providers and sub-populations as needed)
- Invite all the stakeholders to communities of learning
- Contractually require grantees/sub-grantees to participate in communities of learning
- Compel grantees/sub-grantees to participate in communities of learning through standards of care

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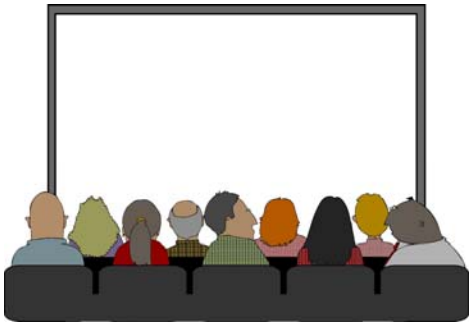
Speaking from Experience: Improving Retention at our Agencies



What have we learned from our experiences about improving retention at our agencies?

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Speaking from Experience: Improving Retention at Our Agencies

What measures do you use to assess retention in HIV care and why? What makes you feel these measures are better than other possible measures?

Let us know your experiences in the chat room!

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Speaking from Experience: Improving Retention at Our Agencies

What improvement strategies have you implemented based on your agency performance on these measures?

Let us know your experiences in the chat room!

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Speaking from Experience: Improving Retention at Our Agencies

How do you share performance and improvement strategy implementation results with your colleagues and your patients?

Let us know your experiences in the chat room!

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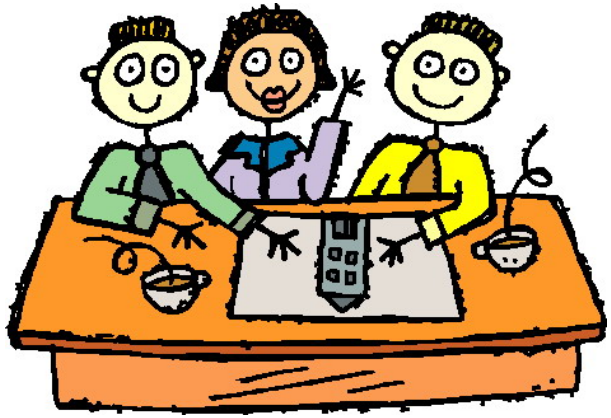
Speaking from Experience: Improving Retention at Our Agencies

Do you ever work collaboratively with other provider agencies in your area on issues related to retention in HIV care?



Let us know your experiences in the chat room!

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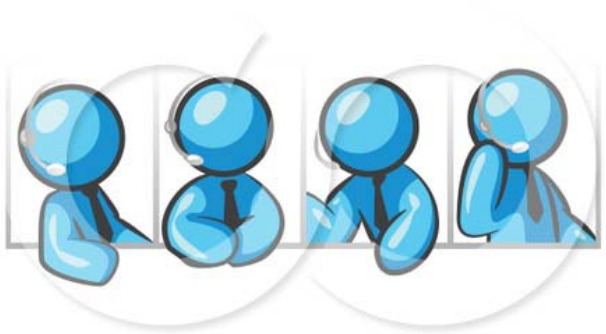
Speaking from Experience: Improving Retention at Our Agencies

What is the single most important lesson learned in measuring retention in HIV care and implementing improvement strategies?



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Let us know your experiences in the chat room!

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Speaking from Experience: Improving Retention at Our Agencies

Why do you focus on retention in HIV care with so many other competing priorities?

Let us know your experiences in the chat room!

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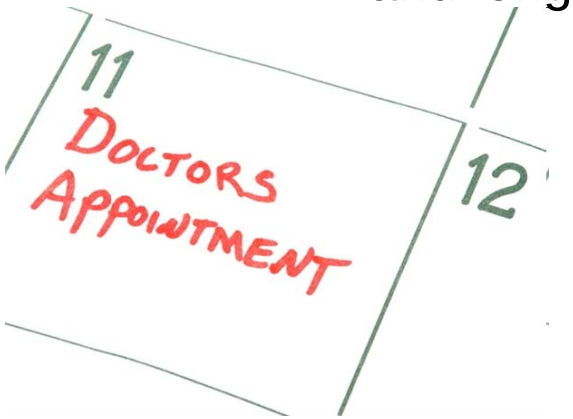
Conclusion

- Retention in HIV care is a national priority
- There are many ways to measure performance for patient retention in HIV care
- There is a growing library of resources available for provider practices and network lead agencies to utilize in planning short-term retention QI strategies and long-term QI projects



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Webinar Evaluation

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