How to Measure Engagement in Care

• Know well what works for linkage to care, much less so for retention and re-engagement
• Variety of approaches and metrics being used depending on availability of data
  – Clinic data
  – Surveillance data
  – MMP
  – HRSA CDC definition
• Importance of regularity measurement
Why do people fall out of care?

• Linkage is well defined but initial engagement period is crucial
• Need to understand why fall out of care in first place
• Limited data on reasons why people are not engaged
• Is it patient-physician relationship or competing priorities?
• What do patients perceive as being “engaged”
What do we know about engagement?

• When diagnosed in non-traditional places such as ED, need to be oriented to what primary care means
• Patients often fall out of care b/c of front office staff so perhaps we need to meet people where their needs are
• Providers do not set patient expectations or provide assistance regarding navigation
• Need to be proactive regarding patient appointments and follow up after missed visits (Gardner et al)
• Importance of messaging regarding staying in care
  – Provider training and making sure clinical staff are all on same page (CID)
• Increasing engagement in care could in the short term impact the proportion who are virally suppressed but in the longer term....
How is engagement being addressed?

- Patient centered approach...such as peer-navigation program (Chicago)
- Have different strategies for certain populations for re-engagement, use community peer models (NYC, CEG)
- Philly has looked at LTC and then not retained population and have not found anything systematically
- LaPhie System in Louisiana
- Brown/RI is giving providers a form to complete for out of care patients to submit to the hlth dept. (Brown/RI DOH)
- CAPUS funding and CFAR engaged research
What are opportunities for Re-engagement?

• During hospitalization
• While incarcerated
• Work with DOH to determine if OOJ, dead, in care elsewhere esp since labor intensive process
• When known positives are retesting
• Point of crisis may facilitate re-engagement-access to case mgmnt, housing
Where can we focus our efforts?

• Returning phone calls
• Front office staff
• Wrap around services
• Changes in Medicaid can be a positive or a negative opportunity
  – may facilitate engagement but if patient can’t navigate systems.....
How can we prioritize who we focus our engagement efforts on?

– RI- phylogenetic testing for acute clusters for recent transmission clusters (for linkage to care)
– Prioritize those w high VL (>50-100K, low CD4 counts, young MSM and other high incidence groups (DC, Philly, Chicago, Cleveland)
– If ever been seen in hosp system-newly diagnosed and never engaged in care and also focus on those out of care longer (Cleveland)
Future Scientific Directions