References – Engagement and Retention in HIV Care

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Retention in care is key to effective HIV treatment, but half of PLWHA in the US are continuously engaged in care. Incarcerated individuals are an especially challenging population to retain, and empiric data specific to jail detainees is lacking. We prospectively evaluated correlates of retention in care for 867 HIV-infected jail detainees enrolled in a 10-site demonstration project. Sustained retention in care was defined as having a clinic visit during each quarter in the 6 month post-release period. The following were independently associated with retention: being male (AOR = 2.10, p ≤ 0.01), heroin use (AOR 1.49, p = 0.04), having an HIV provider (AOR 1.67, p = 0.02), and receipt of services: discharge planning (AOR 1.50, p = 0.02) and disease management session (AOR 2.25, p ≤ 0.01) during incarceration; needs assessment (AOR 1.59, p = 0.02), HIV education (AOR 2.03, p ≤ 0.01), and transportation assistance (AOR 1.54, p = 0.02) after release. Provision of education and case management services improve retention in HIV care after release from jail.

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Linkage, engagement, retention and adherence to care are necessary steps along the HIV care continuum. Progression through these steps is essential for control of the disease and interruption of transmission. Identifying and re-engaging previously diagnosed but out-of-care patients is a priority to achieve the goals of the National HIV/AIDS strategy. Participants in the EnhanceLink cohort who were previously diagnosed HIV+ (n = 1,203) were classified as not-linked to of care and non-adherent to medication prior to incarceration by self report. Results based on multivariate models indicate that recent homelessness as well as high degrees of substance abuse correlated with those classified as not-linked to care and non-adherent to medications while having insurance was associated with being linked to care and adherent to care. The majority of detainees reported being linked to care but not currently adherent to care confirming that jails are an important site for re-engaging HIV+ individuals.

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Three decades into the HIV/AIDS epidemic, HIV prevention programs have been only partially effective. New prevention tools are providing new reasons for optimism. Effective use of these new tools, including the 'test-and-treat' strategy, will require considerable effort to assure that their potential for prevention is fully realized. Challenges with the test-and-treat strategy are global ones, and include retention in care and adherence to treatment. Worldwide, those with HIV infection become less adherent to antiretroviral therapy over time. Many factors contributing to retention in care and adherence to therapy differ among countries and regions of the world. HIV-infected persons receiving treatment in sub-Saharan Africa have been reported to have higher adherence rates than those receiving treatment on the North American continent; higher health literacy and perception of treatment as a social obligation may enhance adherence to treatment and retention in care. The HIV test-and-treat strategy offers a major step forward when combined with other prevention efforts; we need to consider what additional steps are needed to deliver on the promise of prevention through treatment.

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Monitoring delayed entry to HIV medical care is needed because it signifies that opportunities to prevent HIV transmission and mitigate disease progression have been missed. A central question for population-level monitoring is whether to consider a person linked to care after receipt of one CD4 or VL test. Using HIV surveillance data, we explored two definitions for estimating the number of HIV-diagnosed persons not linked to HIV medical care. We used receipt of at least one CD4 or VL test (definition 1) and two or more CD4 or VL tests (definition 2) to define linkage to care within 12 months and within 42 months of HIV diagnosis. In five jurisdictions, persons diagnosed from 12/2006-12/2008 who had not died or moved away and who had zero, or less than two reported CD4 or VL tests by 7/31/2010 were considered not linked to care under definitions 1 and 2, respectively. Among 13,600 persons followed up for 19-42 months; 1,732 (13%) had no reported CD4 or VL tests; 2,332 persons (17%) had only one CD4 or VL test and 9,536 persons (70%) had two or more CD4 or VL tests. To summarize, after more than 19 months, 30% of persons diagnosed with HIV had less than two CD4 or VL tests; more than half of them were considered to have entered care if entering care is defined as having one CD4 or VL test. Defining linkage to care as a single CD4 or VL may overestimate entry into care, particularly for certain subgroups.

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**PROBLEM:** As of December 31, 2008, an estimated 663,084 persons were living with a diagnosis of human immunodeficiency virus (HIV) infection in the 40 U.S. states that have had confidential name-based HIV infection reporting since at least January 2006. Although HIV surveillance programs in the United States collect information about persons who have received a diagnosis of HIV infection and acquired immunodeficiency syndrome (AIDS), supplemental surveillance projects are needed to collect information about care-seeking behaviors, health-care use, and other behaviors among persons living with HIV. Data on the clinical and behavioral characteristics of persons receiving medical care for HIV infection are critical to reduce HIV-related morbidity and mortality and for program planning to allocate services and resources, guide prevention planning, assess unmet medical and ancillary service needs, and help develop intervention programs and health policies at the local, state, and national levels. **REPORTING PERIOD COVERED:** Data were collected during June 2007-September 2008 for patients who received medical care in 2007 (sampled from January 1-April 30). **DESCRIPTION OF THE SYSTEM:** The Medical Monitoring Project (MMP) is an ongoing, multisite supplemental surveillance project that assesses behaviors, clinical characteristics, and quality of care of HIV-infected persons who are receiving medical care. Participants must be aged ≥ 18 years and have received medical care at sampled facilities that provide HIV medical care within participating MMP project areas. Self-reported behavioral and selected clinical data are collected using an in-person interview. A total of 26 project areas in 19 states and Puerto Rico were funded to collect data during the 2007 MMP data collection cycle. **RESULTS:** The results from the 2007 MMP cycle indicated that among 3,643 participants, a total of 3,040 (84%) had some form of health insurance or coverage during the 12 months before the interview; of these, 45% reported having Medicaid, 37% reported having private health insurance or coverage through a health maintenance organization, and 30% reported having Medicare. A total of 3,091 (85%) of the participants were currently taking antiretroviral medications. Among 3,609 participants who reported ever having a CD4 T-lymphocyte test, 2,996 (83%) reported having three or more CD4 T-lymphocyte tests in the 12 months before the interview. Among 3,567 participants who reported ever having an HIV viral load test, 2,946 (83%) reported having three or more HIV viral load tests in the 12 months before the interview. Among 3,643 participants, 45% needed HIV case management, 33% needed mental health counseling, and 32% needed assistance finding dental services during the 12 months before the interview; 8%, 13%, and 25% of these participants who needed the services, respectively, had not received these services by the time of the interview. Noninjection drugs were used for nonmedical purposes by 1,117 (31%) participants during the 12 months before the interview, and 122 (3%) participants had used injection drugs for nonmedical purposes. Unprotected anal intercourse was reported by 527 (54%) of 970 men who reported having anal sex with a man during the 12 months before the interview. Unprotected anal or vaginal intercourse was reported by 176 (32%) of the 553 men who reported having anal or vaginal intercourse with a woman during the 12 months before the interview. Unprotected anal or vaginal intercourse was reported by 216 (42%) of the 516 women who reported having anal or vaginal intercourse with a man during the 12 months before the interview. **INTERPRETATION:** The findings in this report indicate that in 2007, most persons with HIV infection who were receiving medical care were taking antiretroviral therapy and had some form of health insurance or coverage; however, some persons were not receiving needed critical ancillary services, such as HIV case management or help finding dental services. In addition, some persons living with HIV infection engaged in behaviors, such as unprotected sex, that increase the risk for transmitting HIV to sexual partners, and some used noninjection or injection drugs for nonmedical purposes, which might decrease adherence to antiretroviral therapy and increase health-risk behaviors. **PUBLIC HEALTH ACTIONS:** MMP data can be used to monitor the national HIV/AIDS strategy goal of increasing access to care and optimizing health outcomes among persons living with HIV. Persons infected with HIV who are not receiving needed ancillary services highlight missed opportunities for access to care and other supportive services, information that can be used to advocate for additional resources. Drug use among persons with HIV infection underscores the continued need for substance abuse treatment services for this population. In addition, prevention services and programs are needed to decrease the number of HIV-infected persons engaging in unprotected sex. The data in this report can be included in local, state, and national HIV/AIDS epidemiologic profiles and shared with community stakeholders. Although data from the 2007 MMP cycle might not be representative of all persons receiving medical care for HIV infection in the United States or in the individual project areas, future MMP cycles are expected to yield weighted national estimates representing all HIV-infected persons receiving medical care in the United States.

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Of people living with HIV in the US, ~16 % or over 150,000 individuals passed through a correctional facility in 2006. Given the enormous impact of HIV within incarcerated populations, facilitating continuity of care from jails to the community is particularly important in reducing morbidity and mortality for releasees. Grantees participating in the Enhancing Linkages to HIV Primary Care in Jail Settings Initiative developed models for identifying HIV-positive detainees during incarceration and linking them to care following release. In this sample of 1,021 HIV-infected releasees, 79 % received clinical services and 74 % received additional community services within 30 days post-release. Our analysis found several significant factors associated with linkage including: receipt of HIV or medication education in jail, having a completed discharge plan at release, staff awareness of clients' release date, and stable housing on the 30th day post-release. In addition, a subset of participants who had both jail and community viral load assessments showed a statistically significant increase in suppressed viral load. EnhanceLink data suggest that jails may be effective settings to engage individuals in care.

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OBJECTIVE:: To compare patient retention at three stages of pre-antiretroviral (ART) care and two stages of post-ART care to identify when greatest attrition occurs. DESIGN:: An observational cohort study. METHODS:: We reviewed files of all adult, non-pregnant individuals testing HIV-positive January 1 - June 30, 2010, at a primary health clinic in Johannesburg, South Africa (N=842). We classified retention in pre-ART stage 1 (HIV diagnosis to CD4 results notification in ≤3 months), pre-ART stage 2 (initially ineligible for ART with repeat CD4 test ≤1 year of prior CD4), pre-ART stage 3 (initiating ART ≤3 months after first eligible CD4 result), as well as at 0-6 and 6-12 months post-ART. RESULTS:: Retention among all patients during pre-ART stage 1 was 69.8% (95%CI 66.7-72.9%). For patients initially ART-ineligible (n=221), 57.4% (95%CI 49.5-65.0%) returned for a repeat CD4 during pre-ART stage 2. Among those ART-eligible (n=589), 73.5% (95%CI 69.0-77.6%) were retained during pre-ART stage 3. Retention increased with time on ART, from 80.2% (95%CI 75.3-84.5%) at 6 months to 95.3% (95%CI 91.7-97.6%) between 6-12 months. Cumulative retention from diagnosis to 12 months on ART was 36.9% (95%CI 33.0-41.1%) for those ART-eligible and 43.0% (95%CI 36.4-49.8%) from diagnosis to repeat CD4 testing within one year among those ART-ineligible. CONCLUSIONS:: Patient attrition in the first year following HIV diagnosis was greatest prior to ART initiation: over 25% at each of three pre-ART stages. As countries expand HIV testing and ART programs, success will depend on linkage to care, especially prior to ART eligibility and initiation.

Conley NJ, Pavlinac PB, Guthrie BL, Mackelprang RD, Muiru AN, Choi RY, Bosire R, Gatuguta A, Farquhar C. [**Distance from home to study clinic and risk of follow-up interruption in a cohort of HIV-1-discordant couples in Nairobi, Kenya.**](http://www.ncbi.nlm.nih.gov/pubmed/22937017) PLoS One. 2012;7(8):e43138.

Longitudinal studies of HIV-1-infected individuals or those at risk of infection are subject to missed study visits that may have negative consequences on the care of participants and can jeopardize study validity due to bias and loss of statistical power. Distance between participant residence and study clinic, as well as other socioeconomic and demographic factors, may contribute to interruptions in patient follow-up. HIV-1-serodiscordant couples were enrolled between May 2007 and October 2009 and followed for two years in Nairobi, Kenya. At baseline, demographic and home location information was collected and linear distance from each participant's home to the study clinic was determined. Participants were asked to return to the study clinic for quarterly visits, with follow-up interruptions (FUI) defined as missing two consecutive visits. Cox proportional hazards regression was used to assess crude and adjusted associations between FUI and home-to-clinic distance, and other baseline characteristics. Of 469 enrolled couples, 64% had a female HIV-1-infected partner. Overall incidence of FUI was 13.4 per 100 person-years (PY), with lower incidence of FUI in HIV-1-infected (10.8 per 100 PY) versus -uninfected individuals (16.1 per 100 PY) (hazard ratio [HR] = 0.66; 95% confidence interval [CI]: 0.50, 0.88). Among HIV-1-infected participants, those living between 5 and 10 kilometers (km) from the study clinic had a two-fold increased rate of FUI compared to those living <5 km away (HR = 2.17; 95% CI: 1.09, 4.34). Other factors associated with FUI included paying higher rent (HR = 1.67; 95% CI: 1.05, 2.65), having at least primary school education (HR = 1.96; 95% CI: 1.02, 3.70), and increased HIV-1 viral load (HR = 1.23 per log(10) increase; 95% CI: 1.01, 1.51). Home-to-clinic distance, indicators of socioeconomic status, and markers of disease progression may affect compliance with study follow-up schedules. Retention strategies should focus on participants at greatest risk of FUI to ensure study validity.

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Abstract African-American and Hispanic HIV-infected youth are a high risk group for not remaining in HIV care. We examined differences in retention in care among 174 HIV-infected African-American and Hispanic youth between 13 and 23 years old who presented for HIV primary care between 1 January 2002 and 31 August 2008. Patients were included in three service eras, based on when they entered the clinic: when no youth-specific services were available (the decentralized era), after formation of a youth clinic staffed by adolescent providers and a case-manager (the centralized era), and after educational activities and support groups were added and the social services staff were trained in the use of motivational interviewing (the centralized with supportive services era). Patient and attendance data for the 12-months following entry into care were captured. Retention in HIV care was examined using two different measures: adequate visit constancy (at least three quarters with at least one visit in each quarter) and having a gap in care (two consecutive medical visits ≥180 days apart). Adequate visit constancy improved by service era from 31% in the decentralized era to 57% in the centralized era and 65% in the centralized with supportive services era (p=0.01). The percent of patients with no gap in care remained stable at about 80% in the decentralized and centralized eras, but then increased to 96% in the centralized with supportive services era (p=0.04). Results suggest that centralizing youth-specific care and expanding youth services can improve retention in HIV care. These system changes should be considered when resources allow.

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In South Africa, CD4 count results are typically available within a week of testing. However, 35%-55% of newly diagnosed HIV-positive patients do not return for their CD4 results and therefore, do not access further care. We evaluated the impact of a CD4 count result and patient written information provided immediately after diagnosis on retention in care. HIV-infected subjects were randomized to 3 arms; receipt of a CD4 result at time of HIV diagnosis, receipt of written information, and standard of care (CD4 collection after 1 week) or standard of care alone. The outcome of interest was enrollment for further care within 1 month for pre-antiretroviral therapy (ART) care or within 3 months for ART initiation. Secondary outcome was time taken from diagnosis to each stage of care pathway. Independent predictors of retention were assessed with multivariate analysis. Three hundred forty-four patients recruited, of which 64.5% were females with a median age of 30 years (interquartile range: 27-35). Subjects were similar in age, gender, CD4 count, education, and employment status. Providing CD4 results at HIV diagnosis increases the likelihood of reporting for ART initiation (risk ratio = 2.1; 95% confidence interval = 1.39 to 3.17) compared with standard of care. Written information only reduced the time to presentation for pre-ART care although increasing age was associated with retention. There was 49% attrition in the standard of care arms. Receipt of a CD4 count at the time of HIV testing increases ART initiation rates. Point-of-care diagnostics can be used to improve retention, but losses to pre-ART care remain high.

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For optimal clinical benefit, HIV-infected patients should receive periodic outpatient care indefinitely. However, initially establishing HIV care and subsequent retention in care are problematic. This study examines establishment, retention, and loss to follow-up (LTFU) in a large multi-site cohort over a 2-8 year period. Medical record data were reviewed for 22,984 adult HIV patients receiving care at 12 clinics in the HIV Research Network between 2001 and 2009. Three dichotomous outcome measures were based on each patient's history of outpatient visits. Establishment reflects whether the patient made outpatient visits for longer than 6 months after initial enrollment. The retention measure reflects whether the patient had at least 2 outpatient visits separated by 90 days in each year in care. LTFU reflects whether the patient had no outpatient visits for more than 12 months without returning. Multiple logistic regression examined demographic and clinical correlates of each outcome and the combined outcome of meeting all 3 measures. Overall, 21.7% of patients never established HIV care after an initial visit. Among established patients, 57.4% did not meet the retention criterion in all years, and 34.9% were LTFU. Only 20.4% of all patients met all 3 criteria. The odds of successfully meeting all 3 criteria were higher for women, for older patients, for Hispanics compared with whites, and for those with CD4 levels ≤50 cells per cubic millimeter. These data highlight the need to improve establishment and retention in HIV care.

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Minimizing death and ensuring high retention and good adherence remain ongoing challenges for HIV programs. We examined whether the addition of community-based accompaniment (characterized by daily home visits from a community health worker, directly observed treatment, nutritional support, transportation stipends, and other support as needed) to the Rwanda national model for antiretroviral therapy (ART) delivery would improve retention in care, viral load suppression and change in CD4 count, relative to the national model alone. We conducted a prospective observational cohort study among 610 HIV-infected adults initiating ART in one of two programs in rural Rwanda. Psychosocial and clinical characteristics were recorded at ART initiation. Death, treatment retention, and plasma viral load were assessed at one year. CD4 count was evaluated at six-month intervals. Multivariable regression models were used to adjust for baseline differences between the two populations. Eighty-five and 79 percent of participants in the community-based and clinic-based programs, respectively were retained with viral load suppression at one-year. After adjusting for CD4 count, depression, physical health quality of life, and food insecurity, community-based accompaniment was protective against death or loss-to-follow-up during the first year of ART (HR: 0.17; 95%CI: 0.09-0.35; p<.0001). In a second multivariable analysis, individuals receiving accompaniment were more likely to be retained with a suppressed viral load at one year (RR: 1.15; 95%CI: 1.03-1.27; p=0.01). These findings indicate that community-based accompaniment is effective in improving retention, when added to a clinic-based program with fewer patient support mechanisms.

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Retention in care for human immunodeficiency virus (HIV)-infected patients is a National HIV/AIDS Strategy priority. We hypothesized that retention could be improved with coordinated messages to encourage patients' clinic attendance. We report here the results of the first phase of the Centers for Disease Control and Prevention/Health Resources and Services Administration Retention in Care project. Six HIV-specialty clinics participated in a cross-sectionally sampled pretest-posttest evaluation of brochures, posters, and messages that conveyed the importance of regular clinic attendance. 10 018 patients in 2008-2009 (preintervention period) and 11 039 patients in 2009-2010 (intervention period) were followed up for clinic attendance. Outcome variables were the percentage of patients who kept 2 consecutive primary care visits and the mean proportion of all primary care visits kept. Stratification variables were: new, reengaging, and active patients, HIV RNA viral load, CD4 cell count, age, sex, race or ethnicity, risk group, number of scheduled visits, and clinic site. Data were analyzed by multivariable log-binomial and linear models using generalized estimation equation methods. Clinic attendance for primary care was significantly higher in the intervention versus preintervention year. Overall relative improvement was 7.0% for keeping 2 consecutive visits and 3.0% for the mean proportion of all visits kept (P < .0001). Larger relative improvement for both outcomes was observed for new or reengaging patients, young patients and patients with elevated viral loads. Improved attendance among the new or reengaging patients was consistent across the 6 clinics, and less consistent across clinics for active patients. Targeted messages on staying in care, which were delivered at minimal effort and cost, improved clinic attendance, especially for new or reengaging patients, young patients, and those with elevated viral loads.

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Disparities in access to and retention of regular HIV medical treatment persist among African Americans living with HIV. Many scholars believe that the mistrust of health care held by many African Americans stems from a legacy of abuse, from medical experimentation on slaves to the unethical practices with patients in the Tuskegee Syphilis study. We performed a systematic appraisal of the literature, using several key terms, in order to understand how attitudes about HIV-related health care influence African Americans' engagement in care. We examined peer-reviewed studies published during the period January 2001 through May 2012. An initial search generated 326 studies. Sixteen descriptive studies met our inclusion criteria. Experiences of racism, conspiracy beliefs and the quality of provider relationships appeared to impact engagement. Providers should openly investigate personal beliefs that adversely affect their treatment decisions, listen to patient narratives, and share treatment decisions in order to create a transparent environment.

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HIV-positive children in low-income settings face many challenges to adherence to antiretroviral treatment (ART) and have increased mortality on treatment compared to children in developed countries. Adult ART programmes have demonstrated benefit from community support to improve treatment outcomes; however, there are no empirical data on the effectiveness of this intervention in children. This study compared clinical, virological and immunological outcomes between children who received and who did not receive community-based adherence support from patient advocates (PAs) in four South African provinces. A multicentre cohort study of ART-naïve children was conducted at 47 public ART facilities. Outcome measures were mortality, patient retention, virological suppression and CD4 percentage changes on ART. PAs are lay community health workers who provide adherence and psychosocial support for children's caregivers, and they undertake home visits to ascertain household challenges potentially impacting on adherence in the child. Corrected mortality estimates were calculated, correcting for deaths amongst those lost to follow-up (LTFU) using probability-weighted Kaplan-Meier and Cox functions. Three thousand five hundred and sixty three children were included with a median baseline age of 6.3 years and a median baseline CD4 cell percentage of 12.0%. PA-supported children numbered 323 (9.1%). Baseline clinical status variables were equivalent between the two groups. Amongst children LTFU, 38.7% were known to have died. Patient retention after 3 years of ART was 91.5% (95% CI: 86.8% to 94.7%) vs. 85.6% (95% CI: 83.3% to 87.6%) amongst children with and without PAs, respectively (p = 0.027). Amongst children aged below 2 years at baseline, retention after 3 years was 92.2% (95% CI: 76.7% to 97.6%) vs. 74.2% (95% CI: 65.4% to 81.0%) in children with and without PAs, respectively (p = 0.053). Corrected mortality after 3 years of ART was 3.7% (95% CI: 1.9% to 7.4%) vs. 8.0% (95% CI: 6.5% to 9.8%) amongst children with and without PAs, respectively (p = 0.060). In multivariable analyses, children with PAs had reduced probabilities of both attrition and mortality, adjusted hazard ratio (AHR) 0.57 (95% CI: 0.35 to 0.94) and 0.39 (95% CI: 0.15 to 1.04), respectively. Community-based adherence support is an effective way to improve patient retention amongst children on ART. Expanded implementation of this intervention should be considered in order to reach ART programmatic goals in low-income settings as more children access treatment.

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Retaining HIV-diagnosed persons in care is a national priority, but little is known on what intervention strategies are most effective for promoting retention in care. We conducted a systematic search and qualitatively reviewed 13 published studies and three recent conference presentations to identify evidence-informed retention strategies. We extracted information on study design, methods, and intervention characteristics. Strengths-based case management that encourages clients to recognize and use their own internal abilities to access resources and solve problems offered strong evidence for retention in care. Other evidence-informed strategies included peer navigation, reducing structural- and system-level barriers, including peers as part of a health care team, displaying posters and brochures in waiting rooms, having medical providers present brief messages to patients, and having clinics stay in closer contact with patients across time. Opportunities for additional intervention strategies include using community-based organizations as a setting for engaging HIV-infected persons about the importance of regular care and involving patients' significant others in retention in care interventions.

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The types of pharmacist-provided medication therapy management (MTM) services provided to patients with human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) and the effects of MTM on medication adherence and patient outcomes have only recently begun to be studied. Although available studies suggest that patients receiving MTM services have better antiretroviral therapy (ART) adherence and outcomes, only 1 study has examined a large group of patients with HIV/AIDS, and none has examined adherence or outcomes for more than 1 year. A pilot program conducted by the California Department of Health Care Services (DHCS) and Medi-Cal (California's Medicaid program) provided an opportunity to examine ART adherence and outcomes in a large patient population receiving MTM services in community pharmacies over 3 years. To examine an HIV/AIDS pharmacy MTM compensation pilot program over a 3-year period (2005- 2007) in a sample of Medi-Cal beneficiaries by describing the associations between use of pilot pharmacies and (a) adherence to ART regimens; (b) medication utilization, including number and type of ART medication regimens and use of contraindicated ART regimens; (c) occurrence of opportunistic infections; and (d) all-cause pharmacy and medical costs. This was a cohort study examining Medi-Cal pharmacy and medical claims data (2005-2007) for patients with HIV/AIDS who were served by pilot pharmacies versus other (nonpilot) pharmacies. The study groups, pilot and nonpilot pharmacy patients with HIV/AIDS, consisted of Medi-Cal beneficiaries aged 18 years or older as of January 1, 2005, who were continuously enrolled from January 1, 2004, through December 31, 2007, and who received both a diagnosis of HIV/AIDS and at least 1 ART pharmacy claim during both the index period (2004) and the study period (January 1, 2005, through December 31, 2007). Pilot pharmacy patients were identified as having filled 50% or more of their ART prescriptions each year at 1 of the 10 pilot pharmacies. Patients for whom comprehensive medication data were not available, including those enrolled in managed care plans and/or Medicare, were excluded. Adherence was defined as a medication possession ratio (MPR) of 80%-120% and excess medication fills as MPR greater than 120%. Logistic regression was used to investigate the factors associated with adherence. Comparisons were made between groups using bivariate statistics (Pearson chi-square for categorical variables and t-tests for continuous variables). For comparisons of costs, generalized linear models were used including predictor variables for age, gender, and race/ethnicity. RESEARCH RESULTS: The study sample consisted of 2,234 patients meeting the study inclusion criteria. The proportion of study patients receiving the majority of their prescription medications (ART plus non-ART) at pilot pharmacies was 19.7% in 2005 and increased to 27.6% in 2006 and 28.1% in 2007. The demographic profile of pilot pharmacy patients was similar to that of patients receiving medications at nonpilot pharmacies, except that pilot pharmacies had a higher proportion of Latino patients (e.g., 19.7% vs. 14.9% in 2007, respectively, P = 0.006). A greater percentage of pilot than nonpilot pharmacy patients were adherent to their ART medication regimens (e.g., 2007: 69.4% vs. 47.3%, respectively, P < 0.001). After controlling for age, gender, and ethnicity/race in logistic regression analysis, use of a pilot pharmacy (odds ratio [OR] = 2.74, 95% CI = 2.44-3.10) was the most important factor associated with likelihood of adherence. Each year, pilot pharmacy patients were more likely than nonpilot pharmacy patients to remain on a single type of ART regimen (e.g., 2007: 71.7% vs. 49.1%, respectively, P < 0.001) and less likely to have excess fills (e.g., 2007: 12.9% vs. 35.5%, respectively, P < 0.001) and to use contraindicated regimens (e.g., 2007: 8.9% vs. 12.2%, respectively, P = 0.027). The percentages of patients experiencing opportunistic infections were similar between groups each year, approximately 35% (P = 0.809-0.945). In the generalized linear model analyses, the between-group differences in predicted mean (standard error [SE]) total health care costs per patient were not significantly different in any year (e.g., 2007: $38,983 [$1,023] vs. $38,856 [$633], respectively, P = 0.915). In each year, predicted non- ART medication costs were approximately 30%-40% greater in the pilot pharmacy than nonpilot pharmacy group (e.g., 2007: $10,815 [$538] vs. $8,190 [$252], respectively, P < 0.001); however, predicted expenditures for inpatient services were significantly lower (e.g., 2007: $3,083 [$293] vs. $5,186 [$300], respectively, P < 0.001). Payment from the DHCS Medi-Cal program for MTM services was approximately $1,000 per pilot pharmacy patient per year. Over a 3-year period, patients at pilot pharmacies consistently had higher medication adherence rates, were more likely to remain on a single type of ART regimen throughout the year, had fewer excess fills, and used fewer contraindicated regimens than nonpilot pharmacy patients. There were no significant differences in mean total cost per patient per group, and the additional MTM services payment added less than 3% to the total cost.

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Poor engagement in HIV care has been associated with delayed access to antiretroviral treatment and increased HIV transmission. Using viral load (VL) results from HIV laboratory surveillance data to conduct longitudinal and cross-sectional analyses, we examined linkage to care, retention in care, and their associated factors in 37,325 persons living with HIV (PLWH) in Los Angeles County (LAC). Linkage to care was considered timely if a VL test result was present ≤3 months of diagnosis. Successful retention in care was defined as having two or more VL test results ≥90 days apart during 2009. Of 6841 persons newly diagnosed with HIV in 2007-2009, 67% were linked to care within 3 months of diagnosis. Factors associated with delayed linkage to care included being African American, Latino, and Asian/Pacific Islander (adjusted hazard ratio [AHR]=0.81; 95% CI=0.75-0.87, AHR=0.83; 95% CI=0.77-0.89, AHR=0.82; 95% CI=0.71-0.94, respectively). Of the 37,325 PLWH, 52% were retained in care during 2009. Factors associated with lack of retention in care included injection drug use (adjusted prevalence ratio [APR]=0.88; 95% CI=0.84-0.93), incarceration at diagnosis (APR=0.56; 95% CI=0.51-0.61), being diagnosed in pre-highly active antiretroviral therapy (HAART) era (APR=0.94; 95% CI=0.92-0.96) or at a public facility (APR=0.97; 95% CI=0.95-1.00), age <45 years (APR=0.87; 95% CI=0.86-0.89), and having concurrent HIV/AIDS diagnoses (APR=0.94; 95% CI=0.92-0.96). This study demonstrates the value of using VL surveillance data to monitor engagement in care among PLWH, and its potential to improve linkage and retention efforts where disparities in care are observed.

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Timely linkage to appropriate care after human immunodeficiency virus (HIV) diagnosis is critical to optimizing patient outcomes. Medicaid is the largest source of health care coverage for patients with HIV in the United States, yet no studies of linkage to appropriate HIV care have focused solely on the Medicaid population. This is a retrospective study using Medicaid claims data from 15 states. Study sample comprised patients aged 18 to 64 years with 1 or more HIV tests between January 1, 2003, to May 1, 2010, followed or accompanied by HIV diagnosis. The "Test Index" corresponded to the HIV test that was temporally proximate to first HIV diagnosis. Study end point was linkage to appropriate HIV care, defined as receipt of CD4 and viral load tests as per US treatment guidelines. Time-to-event analyses characterized patterns and correlates of linkage to appropriate care. This study included 6684 patients, with a mean age of 35 years, 70% female, and 47% black race. Overall, 21.0% of patients linked to appropriate care within 1 year of the Test Index and 26.4% within 5 years. Compared with whites, blacks had a significantly shorter time to linkage to HIV appropriate care (hazard ratio, 2.034; P < 0.001). These findings in Medicaid patients newly diagnosed with HIV contrast with prior research show disparities in access to HIV care favoring whites. Overall, the proportion of patients who linked to appropriate HIV care was very low given the availability of effective treatment, suggesting a need for more effective interventions promoting timely linkage to appropriate care after diagnosis.

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African Americans are disproportionately affected by acquired immunodeficiency syndrome (AIDS). New treatments that slow the progression of human immunodeficiency virus (HIV) infection offer hope for individuals living with HIV/AIDS, but lack of access to care and poor treatment adherence remain significant obstacles to HIV treatment. This study investigated the association between education literacy to HIV treatment adherence and barriers to care among African Americans living with HIV/AIDS. A community-recruited sample of 85 African-American men and 53 women receiving HIV treatment completed measures of health literacy, health status, treatment adherence, emotional well-being, and barriers to care. Nearly one-third (29%) of the participants had < 12 years of education or were functionally illiterate, and those with low-education literacy were less likely to be adherent to HIV medications within the previous two days. Lower-education literacy also was related to reasons for missing medications and barriers to accessing medical care. Individuals of law-education literacy also were more emotionally distressed, lacked social support, and were less optimistic than those with higher education. These results indicate that education and health literacy are important factors in HIV-treatment adherence and access to medical care. Interventions are needed for improving treatment adherence among law-income minorities, and such interventions will need tailoring for individuals with limited reading ability.

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Reflecting trends in health care delivery, pharmacy practice has shifted from a drug-specific to a patient-centered model of care, aimed at improving the quality of patient care and reducing health care costs. In this article, we outline a theoretical model of patient-centered pharmacy services (PCPS), based on in-depth, qualitative interviews with a purposive sample of 28 pharmacists providing care to HIV-infected patients in specialty, semispecialty, and nonspecialty pharmacy settings. Data analysis was an interactive process informed by pharmacists' interviews and a review of the general literature on patient centered care, including Medication Therapy Management (MTM) services. Our main finding was that the current models of pharmacy services, including MTM, do not capture the range of pharmacy services in excess of mandated drug dispensing services. In this article, we propose a theoretical PCPS model that reflects the actual services pharmacists provide. The model includes five elements: (1) addressing patients as whole, contextualized persons; (2) customizing interventions to unique patient circumstances; (3) empowering patients to take responsibility for their own health care; (4) collaborating with clinical and nonclinical providers to address patient needs; and (5) developing sustained relationships with patients. The overarching goal of PCPS is to empower patients' to take responsibility for their own health care and self-manage their HIV-infection. Our findings provide the foundation for future studies regarding how widespread these practices are in diverse community settings, the validity of the proposed PCPS model, the potential for standardizing pharmacist practices, and the feasibility of a PCPS framework to reimburse pharmacists services.

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We reviewed recent literature on the cascade of HIV care from HIV testing to suppression of viral load, which has emerged as a critical focus as HIV treatment programs have scaled up. In low- and middle-income countries, HIV testing and diagnosis of people living with HIV (PLHIV), although rapidly expanding, are generally relatively low. Linkage and retention in care are global challenges, with substantial attrition between diagnosis, laboratory or clinical staging, and antiretroviral therapy (ART) initiation, and additional substantial attrition on ART due to loss to follow-up and death. ART coverage is rapidly expanding but is still relatively low, especially when considered as a percentage of all PLHIV. Adherence is also suboptimal and virological suppression is incomplete. Taken together, the attrition at each step of the cascade of care results in overall low levels of viral load suppression in the total population of PLHIV. More robust monitoring from the facility to global levels and implementation of established and emerging interventions are needed at each step of the cascade to enhance HIV diagnosis, linkage to and retention in care, ART use, and adherence, and ultimately reduce viral load, improve clinical outcomes, and reduce HIV transmission.

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Strict adherence to HIV medications is critical to ensure long-term disease control, and adherence interventions that are possible in a clinic setting with limited resources are needed. This randomized controlled pilot study tested an adherence intervention guided by the Information-Motivation-Behavioral Skills (IMB) model. The intervention included HIV education, a peer video, motivational interviewing, and attention to behavioral skills including communication with providers and adherence-enhancing devices. Dependent variables included 3-4 week adherence recall, medication refill rate, changes in IMB subscale scores, appointment attendance, and HIV-associated laboratory findings. Seventy-three individuals starting or restarting antiretroviral therapy were enrolled and 56 were randomized. Improvements were seen in most outcomes, with small to moderate effect sizes, but the study was not powered to show statistical significance. Threats to power included a 51% attrition rate, resulting mostly from loss to clinical care or prolonged gaps in care. A telephone-based intervention to improve HIV medication adherence shows promise. Further study is needed with greater attention to retention in care.

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Abstract Adherence to antiretroviral medication for the treatment of HIV is a significant predictor of virologic suppression and is associated with dramatic reductions in mortality and morbidity and other improved clinical outcomes for pediatric patient populations. Effective strategies for addressing adherence problems in youth infected with HIV are needed and require significant attention to the complex interplay of multiple, interacting causal risk factors that lead to poor self-care. Within the context of a pilot randomized trial, we evaluated the feasibility and initial efficacy of a multisystemic therapy (MST) intervention adapted to address HIV medication adherence problems against a usual care condition that was bolstered with a single session of motivational interviewing (MI). For 34 participating youth, health outcomes (viral load [VL] and CD4 count) were obtained from approximately 10 months pre-baseline through approximately 6 months post-baseline and self-reported medication adherence outcomes were obtained quarterly from baseline through 9 months post-baseline. Using mixed-effects regression models we examined within- and between-groups differences in the slopes of these outcomes. Feasibility was supported, with a 77% recruitment rate and near-maximal treatment and research retention and completion rates. Initial efficacy also was supported, with the MST condition but not the MI condition demonstrating statistically and clinically significant VL reductions following the start of treatment. There was also some support for improved CD4 count and self-reported medication adherence for the MST but not the MI condition. MST was successfully adapted to improve the health outcomes of youth poorly adherent to antiretroviral medications. Replication trials and studies designed to identify the mechanisms of action are important next steps.

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The purpose of this study was to evaluate HIV-related outcomes associated with use of a novel public health information exchange that was designed to identify out of care HIV-infected individuals seen within a large, integrated delivery network (IDN). A novel, secure, bidirectional health care delivery-public health information exchange, the Louisiana Public Health Information Exchange (LaPHIE) was developed between a multi-geographical IDN and the Louisiana public health authority in response to the high proportion of out of care HIV-infected persons. The system provides real-time provider alerts when any HIV-infected person who has not had CD4 or HIV viral load (VL) monitoring in >1 year receives non-HIV care within the IDN, allowing immediate linkage to HIV specialty care. Persons identified over the first 30 months of the system's implementation were characterized using a case-cohort approach to compare out-of-care individuals with randomly sampled, time-matched in-care controls. Between 2/1/09 and 7/31/11, 549 alerts identified 419 unduplicated HIV-infected individuals without a CD4 count or VL in >1 year. Patients were identified at 60 clinics and alerts shown to 223 clinicians in 7 participating facilities. A quarter (24%) of those identified had not had a CD4 count or VL conducted since their initial diagnosis. Of the remaining 76% who had been in care previously, over half (55%) had been out of care for ≥18 months, with a median time of 19.4 months [IQR 15.0-32.5] since their previous visit. Following LaPHIE identification, 42% had CD4 counts<200 cells/mm(3) and 62% had VL>10,000 RNA copies/mL. Of the 344 patients with at least 6 months of follow up, 85% had at least one CD4 and/or VL test after being identified. The results of this study demonstrate that an information exchange can effectively facilitate engagement, re-engagement, and retention of out-of care HIV-infected persons in HIV specialty care. Within two years, we were able to observe significant improvements in HIV-related utilization and disease progression indices. Future programs should consider adopting this innovative strategy to improve HIV care at both the individual and population levels.

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Many adults in the USA enter primary care late in the course of HIV infection, countering the clinical benefits of timely HIV services and missing opportunities for risk reduction. Our objective was to determine if perceived social support was associated with delay entering care after an HIV diagnosis. Two hundred and sixteen patients receiving primary care at a large, university-based HIV outpatient clinic in North Carolina were included in the study. Dimensions of functional social support (emotional/informational, tangible, affectionate, and positive social interaction) were quantified with a modified Medical Outcomes Study Social Support Scale and included in proportional hazards models to determine their effect on delays seeking care. The median delay between diagnosis and entry to primary care was 5.9 months. Levels of social support were high but only positive social interaction was moderately associated with delayed presentation in adjusted models. The effect of low perceived positive social interaction on the time to initiation of primary care differed by history of alcoholism (no history of alcoholism, hazard ratio (HR): 1.43, 95% confidence interval (CI): 0.88, 2.34; history of alcoholism, HR: 0.71, 95% CI: 0.40, 1.28). Ensuring timely access to HIV care remains a challenge in the southeastern USA. Affectionate, tangible, and emotional/informational social support were not associated with the time from diagnosis to care. The presence of positive social interaction may be an important factor influencing care-seeking behavior after diagnosis.

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Persons with unrecognized HIV infection forgo timely clinical intervention and may unknowingly transmit HIV to partners. However, in the USA, unrecognized infection and late diagnosis are common. To understand barriers and facilitators to HIV testing and care, we conducted a qualitative study of 24 HIV infected persons attending a Southeastern HIV clinic who presented with clinically advanced illness. The primary barrier to HIV testing prior to diagnosis was perception of risk; consequently, most participants were diagnosed after the onset of clinical symptoms. While most patients were anxious to initiate care rapidly after diagnosis, some felt frustrated by the passive process of connecting to specialty care. The first visit with an HIV care provider was identified as critical in the coping process for many patients. Implications for the implementation of Centers for Disease Control and Prevention HIV routine screening guidelines are discussed.

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Background: Prompt entry into care and retention in care are critical for improving outcomes among HIV-infected individuals. This study identified factors associated with HIV-infected adolescents who delayed entry into HIV care (DEC) after diagnosis of HIV or who fail to remain in care afterward (FRC). Methods: We reviewed clinical, demographic, and social data from the records of 202 HIV-positive adolescents (13-21 years old) infected via high-risk behaviors. Strength of association between clinical and social factors and DEC or FRC were estimated with log-linear regression models. Results: DEC occurred in 38% (76/202) of adolescents. Factors independently associated with DEC were unstable residence (RR 1.5; CI: 1.0-2.1) and, compared with less education, college attendance (RR 2.1; CI: 1.5-3.2). FRC occurred in 29% (52/177) of adolescents established in care. Compared with college attendees, high school students (RR: 4.5; CI: 1.2-17.3) and those who dropped out of high school (RR: 4.0; CI: 1.1-15) were more likely to FRC. Compared with adolescents with private insurance, adolescents without insurance (despite access to free care) were more likely to FRC (RR: 2.8; CI: 1.1-6.9). Controlling for sex, adolescents with children were more likely to FRC (RR: 1.8; CI: 1.0-3.1). Conclusions: Interventions to avoid DEC that target HIV-infected adolescents with unstable residences or those diagnosed while attending college are warranted. Among patients engaged in care, those with only high school education or without insurance-which may be markers for socioeconomic status-need additional attention to keep them in care.

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Engagement in HIV care is increasingly recognized as a crucial step in maximizing individual patient outcomes. The recently updated HIV Medicine Association primary HIV care guidelines include a new recommendation highlighting the importance of extending adherence beyond antiretroviral medications to include adherence to clinical care. Beyond individual health, emphasis on a "test and treat" approach to HIV prevention highlights the public health importance of engagement in clinical care as an essential intermediary between the putative benefits of universal HIV testing ("test") followed by ubiquitous antiretroviral treatment ("treat"). One challenge to administrators, researchers and clinicians who want to systematically evaluate HIV clinical engagement is deciding on how to measure retention in care. Measuring retention is complex as this process includes multiple clinic visits (repeated measures) occurring longitudinally over time. This article provides a synthesis of five commonly used measures of retention in HIV care, highlighting their methodological and conceptual strengths and limitations, and suggesting situations where certain measures may be preferred over others. The five measures are missed visits, appointment adherence, visit constancy, gaps in care, and the Human Resources and Services Administration HIV/AIDS Bureau (HRSA HAB) performance measure for retention in HIV care. As has been noted for antiretroviral medication adherence, there is no gold standard to measure retention in care, and consideration of the advantages and limitations of each measure, particularly in the context of the desired application, should guide selection of a retention measure.

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BACKGROUND:: Measuring retention in HIV primary care is complex as care includes multiple visits scheduled at varying intervals over time. We evaluated six commonly used retention measures in predicting viral load (VL) suppression and the correlation among measures. METHODS:: Clinic-wide patient-level data from six academic HIV clinics were used for 12-months preceding implementation of the CDC/HRSA Retention in Care intervention. Six retention measures were calculated for each patient based upon scheduled primary HIV provider visits: count and dichotomous missed visits, visit adherence, 6-month gap, 4-month visit constancy, and the HRSA HAB retention measure. Spearman correlation coefficients and separate unadjusted logistic regression models compared retention measures to one another and with 12-month VL suppression, respectively. The discriminatory capacity of each measure was assessed with the c-statistic. RESULTS:: Among 10,053 patients, 8,235 (82%) had 12-month VL measures, with 6,304 (77%) achieving suppression (VL<400 c/mL). All six retention measures were significantly associated (P<0.0001) with VL suppression (OR;95%CI, c-statistic): missed visit count (0.73;0.71-0.75,0.67), missed visit dichotomous (3.2;2.8-3.6,0.62), visit adherence (3.9;3.5-4.3,0.69), gap (3.0;2.6-3.3,0.61), visit constancy (2.8;2.5-3.0,0.63), HRSA HAB (3.8;3.3-4.4,0.59). Measures incorporating "no show" visits were highly correlated (Spearman coefficient=0.83-0.85), as were measures based solely upon kept visits (Spearman coefficient=0.72-0.77). Correlation coefficients were lower across these two groups of measures (Range=0.16-0.57). CONCLUSIONS:: Six retention measures displayed a wide range of correlation with one another, yet each measure had significant association and modest discrimination for VL suppression. These data suggest there is no clear gold standard, and that selection of a retention measure may be tailored to context.

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Patient adherence (the degree to which patients follow their therapeutic regimen as prescribed within a set period of time) and persistence (the time to treatment discontinuation, with a permissible gap) with drug therapy are essential components of HIV/AIDS treatment. Select community pharmacies offer specialized services for HIV/AIDS patients to help combat some of the barriers to adherence and persistence. We assessed adherence and persistence with antiretroviral therapy (ART) for patients using HIV-specialized pharmacies in nine cities from seven states compared to traditional community pharmacy users over a 1-year period. Data were limited to one pharmacy chain. Propensity scoring was used to obtain 1:1 matches for "Specialized" and "Traditional" pharmacy users based on age, gender, number of prescription-inferred chronic conditions (obtained by mapping a patient's prescriptions to the Medi-Span Drug Indications Database), and presence of prescription anxiety and/or depression medication, resulting in 7064 patients in each group. Proportion of days covered (PDC) was used to measure adherence. Specialized pharmacy users had a significantly greater mean (74.1% versus 69.2%, p<0.0001) and median (90.3% versus 86.3%, p<0.0001) PDC. A greater percentage of patients in the Specialized group were able to obtain a PDC of 95% or better (39.3% versus 35.5%). Patients in the Specialized group were significantly more persistent (p=0.0117). Community pharmacies specialized in HIV services may be effective avenues for helping patients achieve greater adherence and persistence with ART. Given the value of specialized community pharmacies, payers should consider implementing policies to encourage the use of such pharmacies for filling ART.

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The impact of severe mental illness (SMI) on retention in HIV care remains uncertain. We aimed to measure the association between SMI at antiretroviral therapy (ART) initiation and subsequent retention in care in HIV-infected Ugandan adults. We conducted cohort study of 773 patients who initiated ART between January 2005 and July 2009 at the Butabika HIV clinic in Kampala, Uganda. SMI was defined as any clinically diagnosed organic brain syndrome, affective disorder or psychotic disorder. We used Kaplan-Meier and Cox proportional hazards analysis to evaluate the association between SMI and retention in care. The prevalence of SMI at ART initiation was 23%. Patients with SMI at baseline were similar to those without SMI in terms of age (median [IQR]: 35 [28-40] vs. 35 [30-40], P = 0.03), sex (36% vs. 35% female, P = 0.86) and baseline CD4+ T-cell count (112 [54-175] vs. 120 [48-187] cells/mm3, P = 0.86). At 12 months after ART initiation, Kaplan-Meier estimates of continuous retention in care were 65% (95% confidence interval, CI: 31-39%) among patients without SMI, vs. 47% (95% CI: 39-55%) among those with SMI (P < 0.001). All-cause mortality in the two groups was similar: 1.2% vs. 2.0% (P > 0.05). In multivariable analysis, the only baseline variable independently associated with breakage of continuous care was SMI (HR = 1.58, 95% CI: 1.06─2.33). Severe mental illness at ART initiation is associated with worse retention in HIV care in this urban Ugandan referral hospital. As ART is scaled up across sub-Saharan Africa, greater attention must be paid to the burden of mental illness and its impact on retention in care.

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We present the development and validation of a theory-derived scale measuring patients' behavioral intention to adhere to HIV care. Adherence to HIV care includes attendance at appointments and adherence to highly active antiretroviral therapy (HAART) regimens. These two components have been independently associated with long-term HIV outcomes. Items were chosen to reflect behavioral intention as defined by the Health Action Process Approach to health-seeking behavior. Items reflecting self-reported HIV knowledge were also included after expert panel review. The study took place from October 2009 to April 2010 at two HIV clinics in Houston, Texas. Participants were 287 adults with HIV/AIDS (10.1% female, mean age 50.8); 56.5% were African-American and 17% were Hispanic. Of the total, 87.1% were on HAART at enrollment. Factor analysis of survey items resulted in the retention of two domains, knowledge and intention, based on scree plot analysis of eigenvalues. Questions with factor loadings >0.4 were retained, yielding 4 knowledge questions and 10 intention questions. The survey had good internal consistency for knowledge (Cronbach's α=0.83) and for intention (Cronbach's α=0.81). In multivariate analysis, intention was associated with HIV viral suppression, defined as HIV-1 viral load <400 RNA copies/mL, (odds ratio [OR]=1.75, 95% .confidence interval [CI]=1.00-3.07). Knowledge was also associated with HIV suppression (OR=1.55, 95%, CI=1.09-2.12). The resulting study describes the development and preliminary validation of an HIV treatment-seeking intention measure. Additional studies are needed to validate this instrument in other populations.

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OBJECTIVE:: We report rates and risk factors for attrition in the first cohort of patients followed through all stages from HIV testing to ART initiation. DESIGN:: Cohort study of all patients diagnosed with HIV between January and June, 2009. METHODS:: We calculated the proportion of patients who completed CD4 cell counts and initiated ART or remained in pre-ART care during two years of follow-up, and assessed predictors of attrition. RESULTS:: Of 1,427 patients newly diagnosed with HIV, 680 (48%) either initiated ART or were retained in pre-ART care for the subsequent two years.One thousand eighty-three patients (76%) received a CD4 cell count and 973 (90%) returned for result; 297 (31%) had CD4 cell count <200 cells/µl and of these, 256 (86%) initiated ART.Among 429 patients with CD4 >350 cells/µl, 215 (50%) started ART or were retained in pre-ART care.Active TB was associated with lower odds of attrition prior to CD4 cell count (OR: 0.08; 95% CI: 0.03-0.25) but also higher odds of attrition prior to ART initiation (OR: 2.46; 95% CI: 1.29-4.71). Lower annual income (≤$US125) was associated with higher odds of attrition prior to CD4 cell count (OR 1.65; 95% CI: 1.25-2.19), and prior to ART initiation among those with CD4 cell count >350 cells/µl (OR: 1.74; 95% CI: 1.20-2.52).After tracking patients through a national database, the retention rate increased to only 57%. CONCLUSION:: Fewer than half of patients newly diagnosed with HIV initiate ART or remain in pre-ART care for two years in a clinic providing comprehensive services.Additional efforts to improve retention in pre-ART are critically needed.

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Approximately 17% of individuals living with HIV/AIDS pass through the correctional system each year. Jails provide a unique opportunity to diagnose and treat HIV infection among high-risk, transient populations with limited access to medical services. In 2007, the US Health Resources and Services Administration funded a multi-site demonstration project entitled Enhancing Linkages to HIV Primary Care in Jail Settings that aims to improve diagnosis and treatment services for HIV-positive jail detainees and link them to community-based medical care and social services upon release. We performed an evaluation of the Rhode Island demonstration site entitled Community Partnerships and Supportive Services for HIV-Infected People Leaving Jail (COMPASS). Through in-depth qualitative interviews among 20 HIV-positive COMPASS participants in Rhode Island, we assessed how COMPASS impacted access to health care and social services utilization. Most individuals were receiving HIV treatment and care services upon enrollment, but COMPASS enhanced linkage to medical care and follow-up visits for HIV and other co-morbidities for most participants. Several participants were successfully linked to new medical services as a result of COMPASS, including one individual newly diagnosed with HIV and another who had been living with HIV for many years and was able to commence highly active antiretroviral therapy (HAART). While many individuals reported that COMPASS support prevented substance abuse relapse, ongoing substance abuse nevertheless remained a challenge for several participants. Most participants enrolled in one or more new social services as a result of COMPASS, including Medicaid, Supplemental Security Income, food assistance, and housing programs. The primary unmet needs of COMPASS participants were access to mental health services and stable housing. Intensive case management of HIV-positive jail detainees enhances access to medical and social support services and helps prevent relapse to substance abuse. Expanding intensive case management programs, public housing, and mental health services for recently released HIV-positive detainees should be public health priorities.

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BACKGROUND:: Retention in care is key to improving HIV outcomes. Our goal was to describe "churn" in patterns of entry, exit, and retention in HIV care in the US and Canada. METHODS:: Adults contributing ≥1 CD4 count or HIV-1 RNA (HIV-lab) from 2000-2008 in North American Cohort Collaboration on Research and Design (NA-ACCORD) clinical cohorts were included. Incomplete retention was defined as lack of 2 HIV-labs (≥90 days apart) within 12 months, summarized by calendar year. We used beta-binomial regression models to estimate adjusted odds ratios (OR) and 95% confidence intervals (CI) of factors associated with incomplete retention. RESULTS:: Among 61,438 participants, 15,360 (25%) with incomplete retention significantly differed in univariate analyses (p<0.001) from 46,078 (75%) consistently retained by age, race/ethnicity, HIV risk, CD4, ART use, and country of care (US vs. Canada). From 2000-2004, females (OR=0.82, CI:0.70-0.95), older individuals (OR=0.78, CI:0.74-0.83 per 10 years), and ART users (OR= 0.61, CI:0.54-0.68 vs all others) were less likely to have incomplete retention, while black individuals (OR=1.31, CI:1.16-1.49, vs. white), those with injection drug use (IDU) HIV risk (OR=1.68, CI:1.49-1.89, vs. non-IDU) and those in care longer (OR=1.09, CI:1.07-1.11 per year) were more likely to have incomplete retention. Results from 2005-2008 were similar. DISCUSSION:: From 2000 to 2008, 75% of the NA-ACCORD population was consistently retained in care with 25% experiencing some change in status, or churn. In addition to the programmatic and policy implications, our findings identify patient groups who may benefit from focused retention efforts.

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Access to antiretroviral therapy (ART) has rapidly expanded; as of the end of 2010, an estimated 6.6 million people are receiving ART in low-income and middle-income countries. Few reports have focused on the experiences of rural health centers or the use of community health workers. We report clinical and programatic outcomes at 24 months for a cohort of patients enrolled in a community-based ART program in southeastern Rwanda under collaboration between Partners In Health and the Rwandan Ministry of Health. A retrospective medical record review was performed for a cohort of 1041 HIV+ adult patients initiating community-based ART between June 1, 2005, and April 30, 2006. Key programatic elements included free ART with direct observation by community health worker, tuberculosis screening and treatment, nutritional support, a transportation allowance, and social support. Among 1041 patients who initiated community-based ART, 961 (92.3%) were retained in care, 52 (5%) died and 28 (2.7%) were lost to follow-up. Median CD4 T-cell count increase was 336 cells per microliter [interquartile range: (IQR): 212-493] from median 190 cells per microliter (IQR: 116-270) at initiation. A program of intensive community-based treatment support for ART in rural Rwanda had excellent outcomes in 24-month retention in care. Having committed to improving access to HIV treatment in sub-Saharan Africa, the international community, including country HIV programs, should set high programmatic outcome benchmarks.

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Despite extensive prevention efforts, an estimated 21% of individuals with HIV/AIDS in the United States are unaware of their status, placing them at greater risk for spreading the virus to others. HIV treatment as prevention (TasP) is rapidly becoming an important public health strategy to reduce HIV transmission at the population level. Data for this study were collected on a sample of 11,397 HIV-positive individuals in the Ryan White system, a publicly funded system of care for HIV-positive individuals in Los Angeles County who are uninsured, in 2009 to examine two components of TasP: baseline rates and factors associated with antiretroviral therapy (ART) use and viral load (VL) suppression in a publicly funded system of care. ART coverage among our sample was 90%. In multivariate analyses, those with a higher odds of having unsuppressed VL included: females compared to males (adjusted odds ratio [AOR]=1.25; 95% confidence interval [CI]=1.06, 1.47); African Americans compared to whites (AOR=1.42; 95% CI=1.24, 1.62); men who have sex with men compared to heterosexuals (AOR=1.15; 95% CI=1.00, 1.32); recent substance abusers compared to nonsubstance abusers (AOR=1.35; 95% CI=1.17, 1.55); those recently incarcerated or ever incarcerated compared to those never incarcerated (AOR=1.37; 95% CI=1.15, 1.63; and AOR=1.28; 95% CI=1.09, 1.50); and those retained in care compared to those not retained in care (AOR=1.98; 95% CI=1.76, 2.22). Understanding the key sociodemographic, geographic and behavioral factors associated with ART use as well as HIV VL suppression will be useful for informing the development and deployment of targeted programming and policies that may further enhance the implementation of the TasP approach in communities across the United States.

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The purpose of this article is to describe how comprehensive HIV care is delivered within Ryan White Program (RWP)-funded clinics and to characterize proposed health information exchange (HIE) interventions, which employ technology to exchange information among providers, designed to improve the quality and coordination of clinical and support services. We use HIV patient care quality and coordination indicators from electronic data systems to describe care delivery in six RWP demonstration sites and describe HIE interventions designed to enhance that care. Among patients currently in care, 91% were retained in care in the previous six months (range across sites: 63-99%), 79% were appropriately prescribed antiretroviral therapy (54-91%) and 52% had achieved undetectable HIV viral load (16-85%). To facilitate coordination of care across clinical and support services, sites designed HIE interventions to access a variety of data systems (e.g. surveillance, electronic health records, laboratory and billing) and focused on improving linkage and retention, quality and efficiency of care and increased access to patient information. Care quality in RWP settings can be improved with HIE tools facilitating linkage, retention and coordination of care. When fully leveraged, HIE interventions have the potential to improve coordination of care and thereby enhance patient health outcomes.

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Here, we describe our patient-centered medical home (PCMH) quality improvement retention project conducted by a Health Resources and Services Administration (HRSA) Ryan White-funded Primary Care HIV clinic. The single urban academic clinic serving 2,776 active HIV positive patients identified 25.8% (716/2,776) patients who had not been retained in care within the prior six months during two separate six-month interval analyses. Multiple modalities including a retention specialist, a secure clinic phone message line, algorithms, flyers, brochures, database, and staff education were built to facilitate re-engagement. The project located 87.7% (628/716) patients who had not been retained. The retention specialist was directly responsible for the return of 16.2% (116/716) patients. Results from the project demonstrated that a formalized approach is a necessary component to effective retention efforts. We believe that this work will provide a strategic framework for the development of randomized control trials to formally evaluate an HIV retention intervention.

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The current study provides a qualitative test of a recently proposed application of an Information, Motivation, Behavioral Skills (IMB) model of health behavior situated to the social-environmental, structural, cognitive-affective, and behavioral demands of retention in HIV care. Mixed-methods qualitative analysis was used to identify the content and context of critical theory-based determinants of retention in HIV care, and to evaluate the relative fit of the model to the qualitative data collected via in-depth semi-structured interviews with a sample of inner-city patients accessing traditional and nontraditional HIV care services in the Bronx, NY. The sample reflected a diverse marginalized patient population who commonly experienced comorbid chronic conditions (e.g., psychiatric disorders, substance abuse disorders, diabetes, hepatitis C). Through deductive content coding, situated IMB model-based content was identified in all but 7.1% of statements discussing facilitators or barriers to retention in HIV care. Inductive emergent theme identification yielded a number of important themes influencing retention in HIV care (e.g., acceptance of diagnosis, stigma, HIV cognitive/physical impairments, and global constructs of self-care). Multiple elements of these themes strongly aligned with the model's IMB constructs. The convergence of the results from both sets of analysis demonstrate that participants' experiences map well onto the content and structure of the situated IMB model, providing a systematic classification of important theoretical and contextual determinants of retention in care. Future intervention efforts to enhance retention in HIV care should address these multiple determinants (i.e., information, motivation, behavioral skills) of self-directed retention in HIV care.

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Over 9 million persons in the United States (US) are admitted each year to jails. HIV prevalence among detainees is higher than the general population, which creates a public health need for linking HIV-infected detainees to services during jail and after release. The EnhanceLink initiative was funded as demonstration projects in 10 communities at 20 separate jails across the US. Grantees implemented and evaluated innovative models of HIV testing in jails and linkage of HIV-infected individuals to community services post release. In this paper, we describe services delivered with the EnhanceLink initiative. During 877,119 admission events, 210,267 inmates agreed to HIV testing and 822 new diagnoses of HIV were made. The majority of persons served with transitional services were previously diagnosed before the current incarceration. Cumulatively, 9,837 HIV+ persons were offered linkage and transitional services and 8,056 (82 %) accepted the offer. EnhanceLink demonstrated the feasibility of HIV testing in jail settings and provision of linkage services to enhance continuity of HIV care post-release.

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Black individuals represent 13 % of the US population but 46 % of HIV positive persons and 40 % of incarcerated persons. The national EnhanceLink project evaluated characteristics of HIV-positive jail entrants at ten sites and explored associations between race and HIV disease state. Between 1/2008 and 10/2011, 1,270 study participants provided demographic and clinical data. Adjusted odds ratios (aORs) were calculated for advanced HIV disease (CD4 < 200 cells/mm(3)) and uncontrolled viremia (viral load > 400 copies/ml) for Black (n = 807) versus non-Black (n = 426) participants. Sixty-five percent of HIV-positive jail participants self-identified as Black. Among all participants, fewer than half had a high school diploma or GED, the median number of lifetime arrests was 15, and major mental illness and substance abuse were common. Black participants were more likely to be older than non-Black participants, and less likely to have health insurance (70 vs 83 %) or an HIV provider (73 vs 81 %) in the prior 30 days. Among all male study participants (n = 870), 20 % self-identified as homosexual or bisexual. Black male participants were more likely to be homosexual or bisexual (22 vs 16 %) and less likely to have a history of injection drug use (20 vs 50 %) than non-Black male participants. Advanced HIV disease was associated with self-identification as Black (aOR = 1.84, 95 % CI 1.16-2.93) and time since HIV diagnosis of more than two years (aOR = 3.55, 95 % CI 1.52-8.31); advanced disease was inversely associated with age of less than 38 years (aOR = 0.41, 95 % CI 0.24-0.70). Uncontrolled viremia was inversely associated with use of antiretroviral therapy (ART) in the prior 7 days (aOR = 0.25, 95 % CI 0.15-0.43) and insurance coverage in the prior 30 days (aOR = 0.46, 95 % CI 0.26-0.81). Conclusions: The racial disparities of HIV and incarceration among Black individuals in the US are underscored by the finding that 65 % of HIV-positive jail participants self-identified as Black in this ten-site study. Our study also found that 22 % of Black male participants self-identified as men who have sex with men (MSM). We believe these findings support jails as strategic venues to reach heterosexual, bisexual, and homosexual HIV-positive Black men who may have been overlooked in the community. Among HIV-positive jail entrants, Black individuals had more advanced HIV disease. Self-identification as Black was associated with a lower likelihood of having health insurance or an HIV provider prior to incarceration. HIV care and linkage interventions are needed within jails to better treat HIV and to address these racial disparities.

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Modest or even occasional nonadherence to combined antiretroviral therapy (cART) can result in adverse clinical outcomes. African Americans demonstrate lower rates of adherence than Caucasians or Latinos. Identifying factors that influence medication adherence among African Americans is a critical step toward reducing HIV/AIDS disease progression and mortality. In a sample of 181 African American (n=144) and Caucasian (n=37) HIV-positive drug-using individuals [age (M=42.31; SD=6.6) education (M=13.41; SD=2.1)], we examined the influence of baseline drug use, literacy, neurocognition, depression, treatment-specific social support, and patient satisfaction with health care provider on medication adherence averaged over the course of 6 months (study dates 2002-2006). Our findings suggest differential baseline predictors of medication adherence for African Americans and Caucasians, such that patient satisfaction with provider was the strongest predictor of follow-up medication adherence for African Americans whereas for Caucasians depressive symptoms and treatment-specific social support were predictive of medication adherence (after controlling for duration of drug use).

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Despite the availability and proven efficacy of medical treatment, many individuals living with HIV in the United States today are not engaged in regular HIV medical care or receiving antiretroviral medications. This journal supplement highlights results of a national 5-year multisite Outreach Initiative, funded by the Health Resources and Services Administration (HRSA) in 2001 to "engage people in HIV care, turn sporadic users of care into regular users, and promote retention in care." The introductory paper for the supplement provides background information on the characteristics of individuals who are not engaged in regular HIV care, the barriers they face, intervention options, and the public policy implications of this issue. Interventions to engage and retain underserved populations living with HIV in medical care are essential to ensure access to medical care and to reduce disparities in health outcomes.

[Tripathi A](http://www.ncbi.nlm.nih.gov/pubmed?term=Tripathi%20A%5BAuthor%5D&cauthor=true&cauthor_uid=22022847), [Gardner LI](http://www.ncbi.nlm.nih.gov/pubmed?term=Gardner%20LI%5BAuthor%5D&cauthor=true&cauthor_uid=22022847), [Ogbuanu I](http://www.ncbi.nlm.nih.gov/pubmed?term=Ogbuanu%20I%5BAuthor%5D&cauthor=true&cauthor_uid=22022847), [Youmans E](http://www.ncbi.nlm.nih.gov/pubmed?term=Youmans%20E%5BAuthor%5D&cauthor=true&cauthor_uid=22022847), [Stephens T](http://www.ncbi.nlm.nih.gov/pubmed?term=Stephens%20T%5BAuthor%5D&cauthor=true&cauthor_uid=22022847), [Gibson JJ](http://www.ncbi.nlm.nih.gov/pubmed?term=Gibson%20JJ%5BAuthor%5D&cauthor=true&cauthor_uid=22022847), [Duffus WA](http://www.ncbi.nlm.nih.gov/pubmed?term=Duffus%20WA%5BAuthor%5D&cauthor=true&cauthor_uid=22022847). **Predictors of time to enter medical care after a new HIV diagnosis: a statewide population-based study.** [AIDS Care.](http://www.ncbi.nlm.nih.gov/pubmed/22022847) 2011 Nov;23(11):1366-73.

Public health benefits of expanded HIV screening will be adequately realized only if an early diagnosis is followed by prompt linkage to care. We characterized rates and factors associated with failure to enter into medical care within three months of HIV diagnosis and assessed the predictors of time to enter care over a follow-up period of up to 60 months. The study cohort included 3697 South Carolina (SC) residents' ≥13 years who were newly HIV-diagnosed in 2004-2008. Date of first laboratory report of CD4(+) T-cell count or viral load (VL) test after 30 days of confirmatory HIV diagnosis was used to define time to linkage to care. Results showed that of the total 3697 persons, 1768 (48%) entered care within three months, 1115 (30%) in four-12 months after diagnosis, and 814 (22%) failed to initiate care within 12 months of HIV diagnosis. At the end of study follow-up period of up to 60 months from the date of HIV diagnosis, 472/3697 (13%) individuals remained out of care. Multivariable Cox proportional hazards analysis showed that compared with hospitals, time to enter care was shorter in those diagnosed at state mental health/correctional facilities (adjusted hazards ratio [aHR] 1.16; 95% confidence interval [CI] 1.02-1.34) and longer in those diagnosed at county health departments (aHR 0.87; 95% CI 0.80-0.96) and at "Other/unknown" facilities (aHR 0.79; 95% CI 0.70-0.89). Time to entry into care was longer for men (aHR 0.82; 95% CI 0.75-0.89) compared with women, blacks (aHR 0.91; 95% CI 0.83-0.98) compared with whites, and males who have sex with males (MSM) (aHR 0.89; 95% CI 0.80-0.98) compared with heterosexual exposure. Delayed entry into HIV care remains a challenge in controlling HIV transmission in SC. Better integration of testing and care facilities could improve the proportion of newly HIV-diagnosed persons who enter care in a timely manner.

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Following HIV diagnosis, linkage to outpatient treatment, antiretroviral initiation, and longitudinal retention in care represent the foundation for successful treatment. While prior studies have evaluated these processes in isolation, a systematic evaluation of successive steps in the same cohort of patients has not yet been performed. To ensure optimal long-term outcomes, a better understanding of the interplay of these processes is needed. Therefore, a retrospective cohort study of patients initiating outpatient care at the University of Alabama at Birmingham 1917 HIV=AIDS Clinic between January 2000 and December 2005 was undertaken. Multivariable models determined factors associated with: late diagnosis=linkage to care (initial CD4 < 350 cells=mm3), timely antiretroviral initiation, and retention across the first two years of care. Delayed linkage was observed in two-thirds of the overall sample (n = 567) and was associated with older age (odds ratio [OR] = 1.31 per 10 years; 95%confidence interval [CI] = 1.06-1.62) and African American race (OR = 2.45; 95% CI = 1.60-3.74). Attending all clinic visits (hazard ratio [HR] = 6.45; 95% CI = 4.47-9.31) and lower initial CD4 counts led to earlier antiretroviral initiation. Worse retention in the first 2 years was associated with younger age (OR = 0.68 per 10 years;95% CI = 0.56-0.83), higher baseline CD4 count, and substance abuse (OR = 1.78; 95% CI = 1.16-2.73). Interventions to improve timely HIV diagnosis and linkage to care should focus on older patients and African Americans while efforts to improve retention should address younger patients, those with higher baseline CD4 counts, and substance abuse. Missed clinic visits represent an important obstacle to the timely initiation of antiretroviral therapy. These data inform development of interventions to improve linkage and retention in HIV care, an emerging area of growing importance.

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People who are incarcerated have a disproportionately high risk of HIV infection. They also tend to have risk factors associated with underutilization of antiretroviral therapy (ART) such as substance abuse, mental illness, and poor access to care. In this review, we describe how incarceration is a marker of vulnerability for suboptimal HIV care, and also how criminal justice settings may be leveraged as a platform for promoting testing, linkage, and retention in HIV care for a high-risk, marginalized population. In both prisons and jails, routine, opt-out HIV testing strategies are more appropriate for screening correctional populations than traditional, risk-based strategies. Rapid HIV testing is feasible and acceptable in busy, urban jail settings. Although ART is successfully administered in many prison settings, release to the community is strongly associated with inconsistent access to medications and other structural factors leading to loss of viral suppression. Collaborations among HIV clinicians, criminal justice personnel, and public health practitioners represent an important strategy for turning the tide on the HIV epidemic. Success will depend upon scaled-up efforts to seek individuals with undiagnosed infection and bring those who are out-of-care into long-term treatment.

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The US National HIV/AIDS Strategy identifies retention in care as an important quality performance measure. There is no gold standard to measure retention in care. This study is the first to compare different measures of retention, using a large geographically diverse sample. A prospective cohort of 17,425 HIV-infected adults enrolled in care at 12 US HIV clinics between 2001 and 2008. We compared three measures of retention for each patient: proportion of time not spent in a gap of more than 6 months between successive outpatient visits; proportion of 91-day quarters in which at least one visit occurred; proportion of years in which two or more visits separated by at least 90 days occurred. Associations among measures and effects of sociodemographic and clinical characteristics were examined. The three measures of retention were moderately to strongly correlated. Averaging across patients, 71% of time in care was not spent in a gap more than 6 months; 73% of all quarters had at least one visit; and 75% of all years had at least two visits separated by at least 90 days. For all measures, retention was significantly higher for women, whites, older individuals, men who had sex with men (MSM)-related HIV transmission, and initial CD4 cell counts 50 cell/μl or less. This is one of the first studies to provide a national estimate of retention in HIV care in the US, which ranged from 71 to 75% using any of the accepted retention measures. Future studies should assess how well different measures predict clinical outcomes and establish acceptable target levels for retention.