Personal Outreach by a Trained Social Worker is an Effective Intervention to Reengage Patients with HIV in Care

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MUSC Authors' Affiliations

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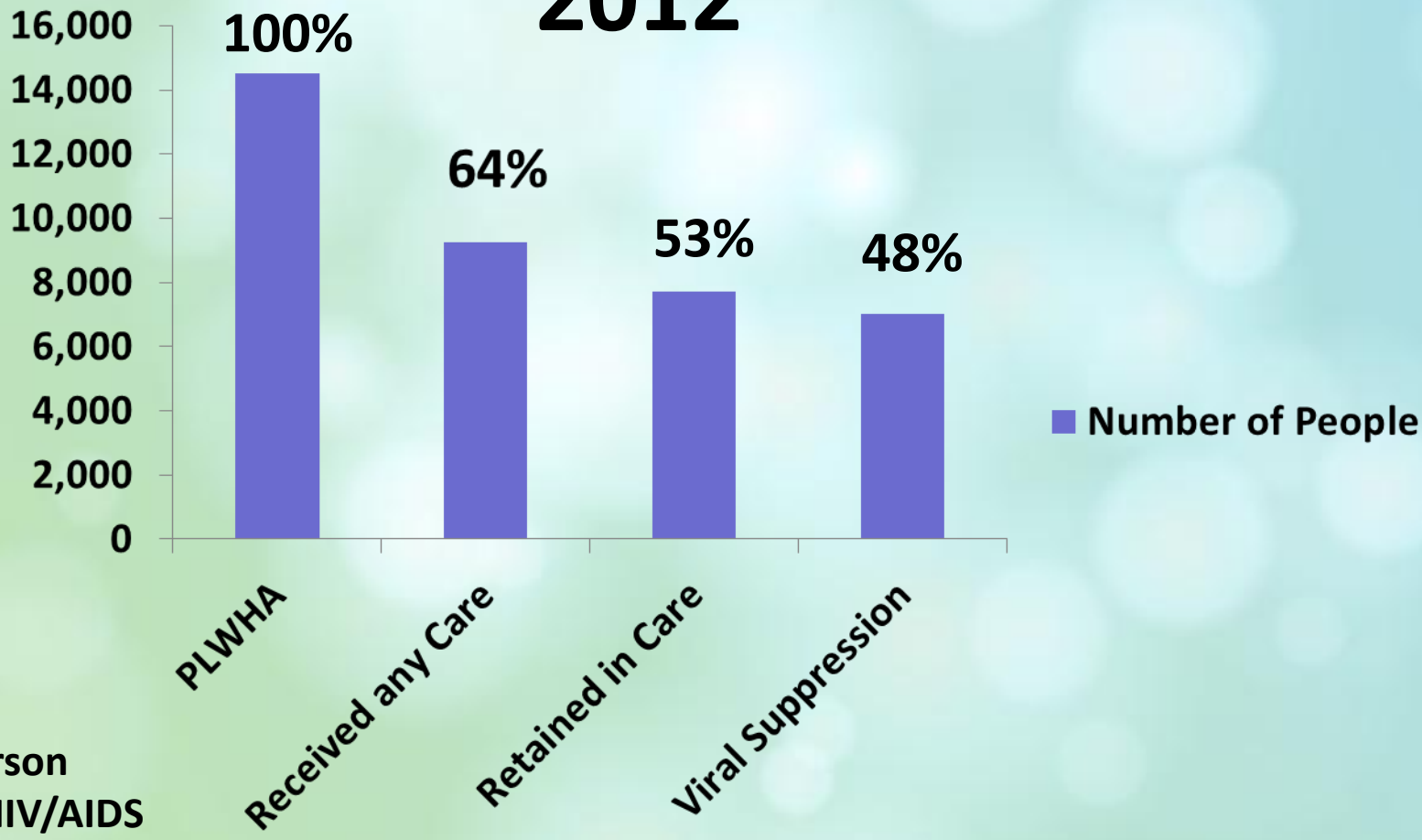
Benefits of Retention in Care

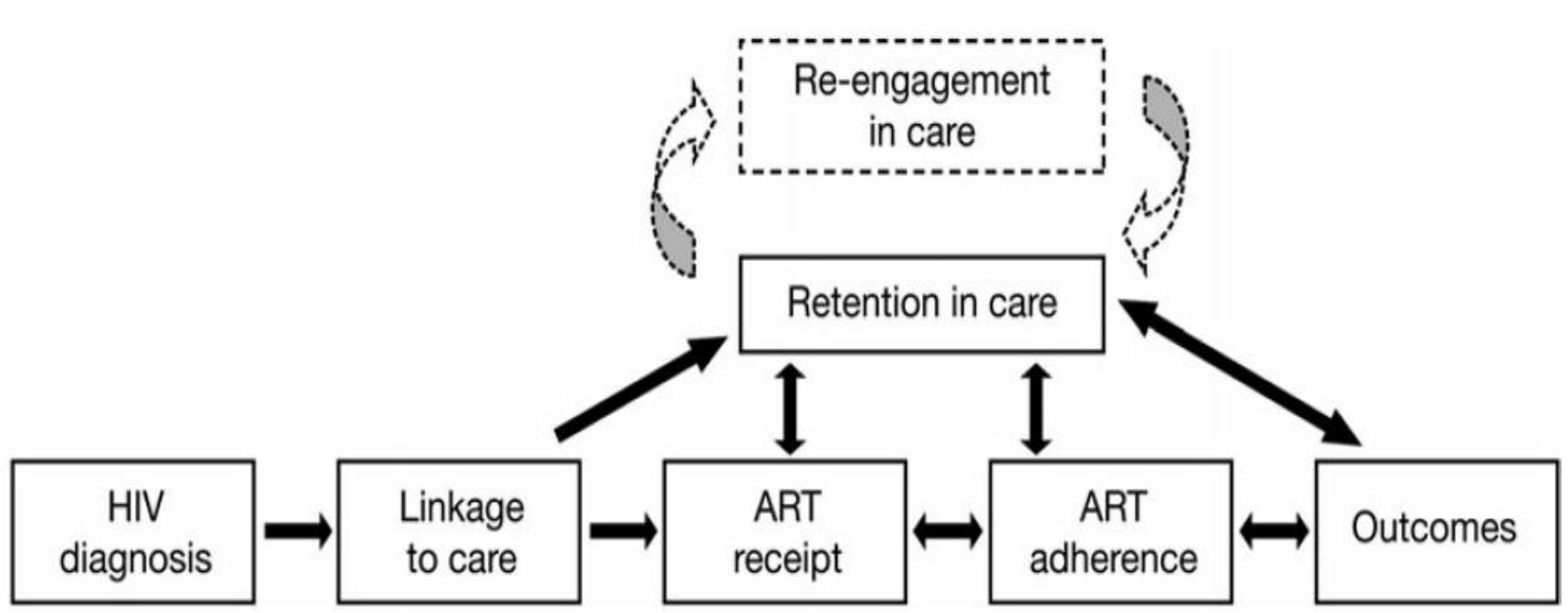
- Earlier diagnosis of HIV leads to:
  - Improved clinical outcomes
  - Decreased transmission
- Both require that the newly diagnosed patient
  - Be linked to care
  - Actively engaged in care
  - Retained in high quality care that provides ART

South Carolina Cascade of Care in 2012



PLWHA= Person living with HIV/AIDS

Edun B, et al. HIV Cascade of Care in South Carolina Comparing Urban and Rural Residents. Oral Presentation at IDSA Meeting 2014.



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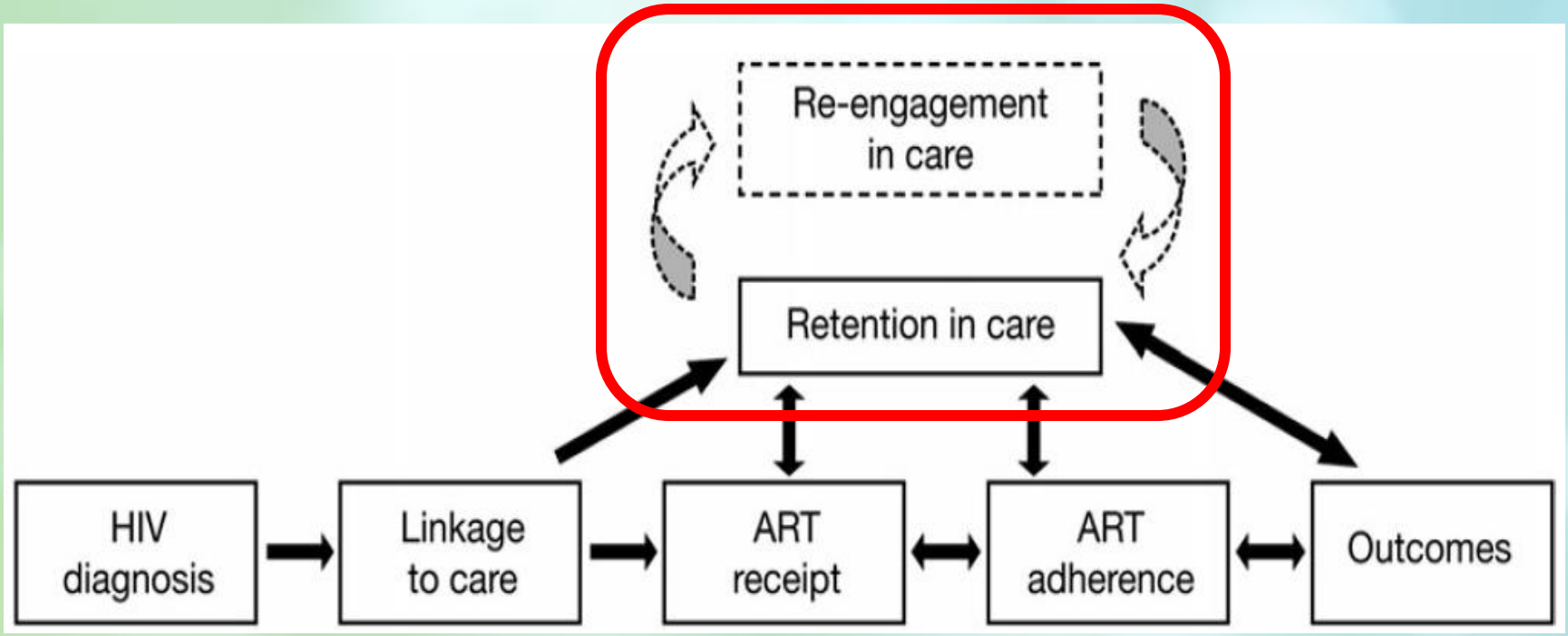

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Community-Based Outreach Pilot Program

- Creation of a new part-time position
  - Funding via Ryan White Part D grant
- Credentials
  - Masters in Clinical Counseling
  - Certified as a Licensed Professional Counselor
  - Certified Addictions Counselor
- Goals
  - Identify and re-engage patients who are poorly retained in care

Community-Based Outreach Pilot Program

- Identified patients not retained in care
  - Attended clinic within the recent 5 years
  - Did not meet HRSA definition of “Retained in Care” in 2014
    - 2 visits to an HIV provider in 1 year, at least 90 days apart
- Determined need for re-engagement in care
  - Consulted EMR, obituaries, or personal communication
  - Categorized as deceased, incarcerated, moved/transferred care, or need of re-engagement
- Protection of patient privacy
  - Outreach with generic voice message or letter

Phone Call Intervention

- Once identified, call placed to phone number(s) in EMR
- Intervention based on patient response
  - If answered, coordinator actively worked to re-engage the patient in care
  - If unable to reach patient, if possible, left generic message for patient to call back

Letter Intervention

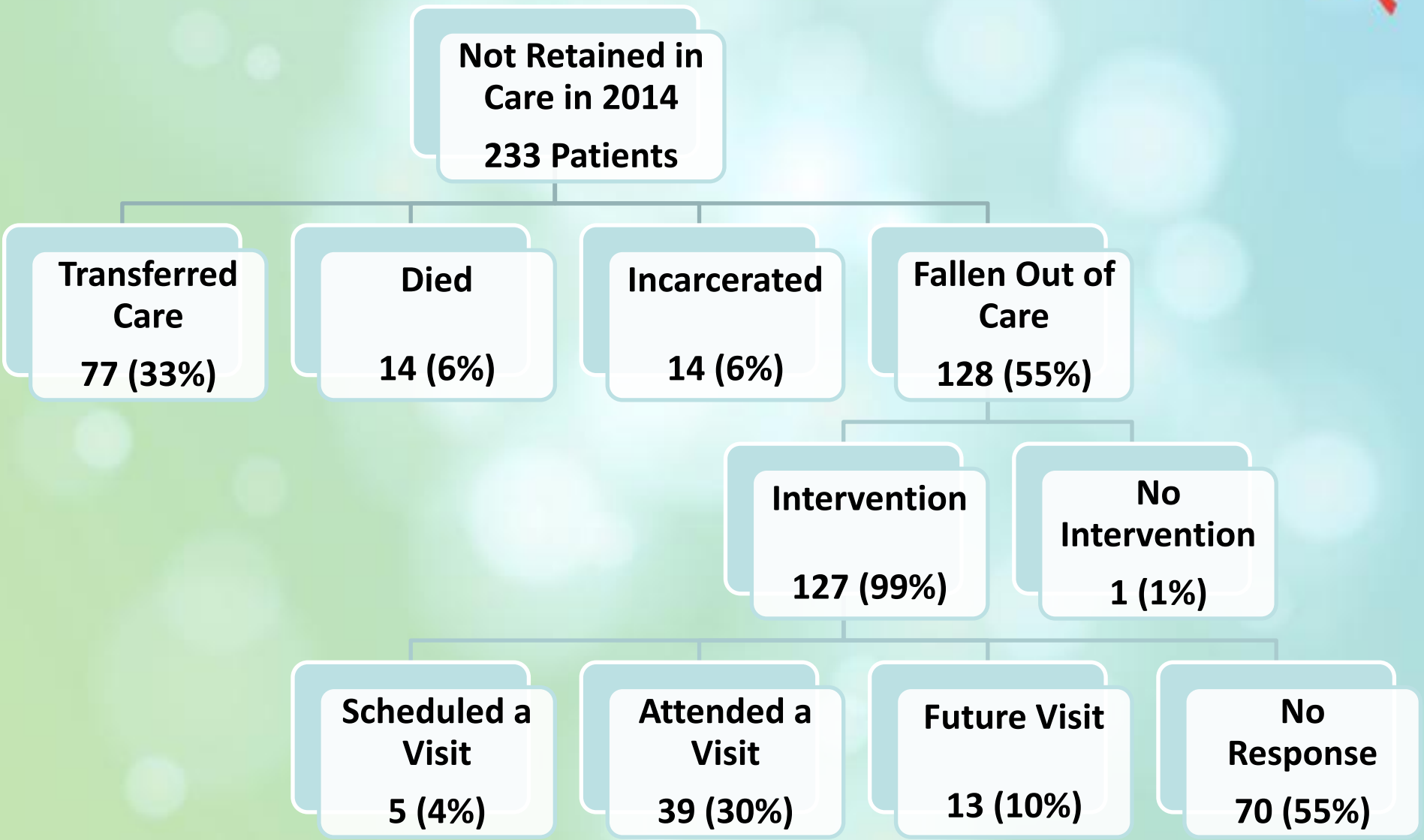
- If unable to reach patient via phone call:
  - Letter written and mailed to patient at address noted in the EMR
  - Letter offered assistance with re-engagement
  - Included contact information for the coordinator

Home Visit Intervention

- If patient did not respond to letter, or if letter was returned:
  - Home visit considered if time available
- Response to visit:
  - If patient was home, attempted reengagement
  - If someone other than patient was home, left card
  - If no one was available, left card in sealed envelope with note to “Please call when possible”
- If time available, repeat visits in following week(s) at different times

Response Definitions

- Study response categories
  - Scheduled visit (“No-show”)
  - Attended visit
  - Future visit
- All other patients considered “no response”
- Data collection initiated October 1, 2014
  - If no previous visit, automatically met study definition
- Collection completed April 30, 2015
  - Allowed time for response to an intervention


Not Retained in Care in 2014
233 Patients
Transferred Care
77 (33%)
Died
14 (6%)
Incarcerated
14 (6%)
Fallen Out of Care
128 (55%)
Intervention
127 (99%)
No Intervention
1 (1%)
Scheduled a Visit
5 (4%)
Attended a Visit
39 (30%)
Future Visit
13 (10%)
No Response
70 (55%)

Demographics

	Fallen Out of Care (n=128)
Age (years)	42
Male	92 (72%)
African-American	101 (79%)
Hispanic	9 (7%)
Insurance	
Medicaid	26 (20%)
Ryan White	63 (49%)
Medicare	21 (16%)
Private	16 (13%)
CD4 Count [mean]*	415
Viral Load [median]*	275
Viral Load [mean]*	53,341

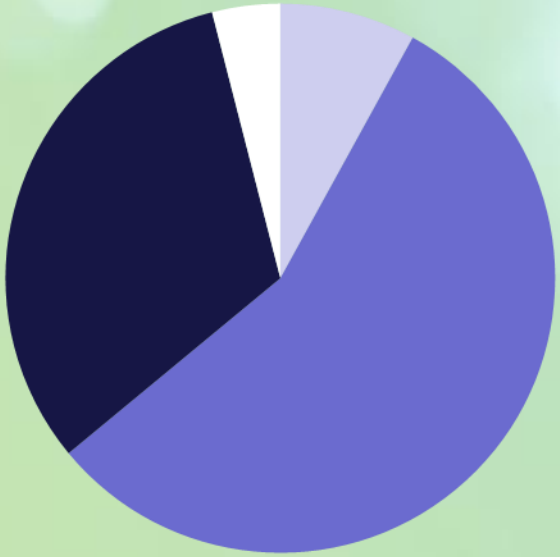
* Last value on record for patient

Intervention Results

Intervention

127 (99%) Patients

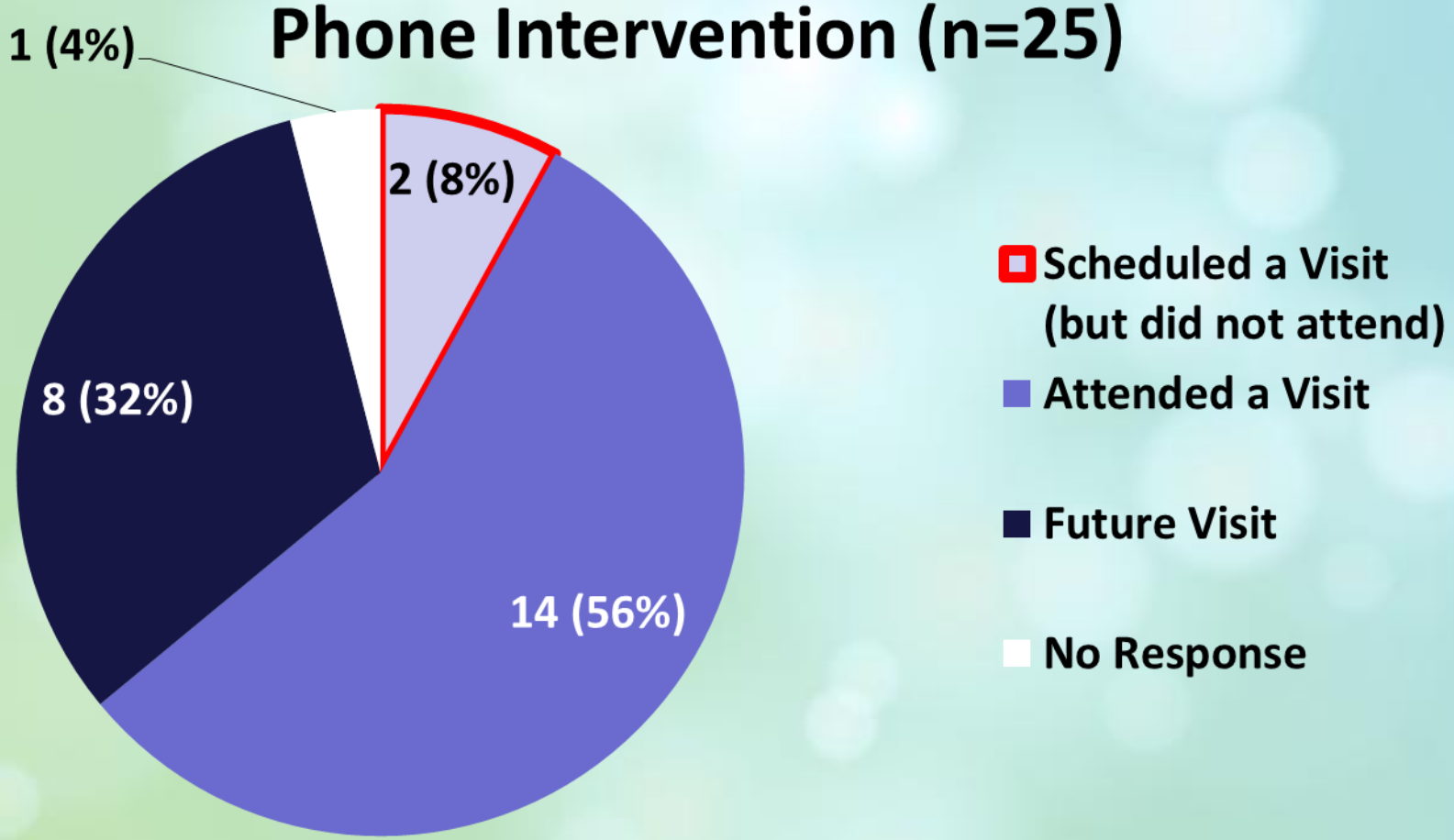
Phone Intervention (n=25)



Phone and Letter Intervention (n=88)

Phone, Letter, and Home Visit Intervention (n=14)

Intervention Results



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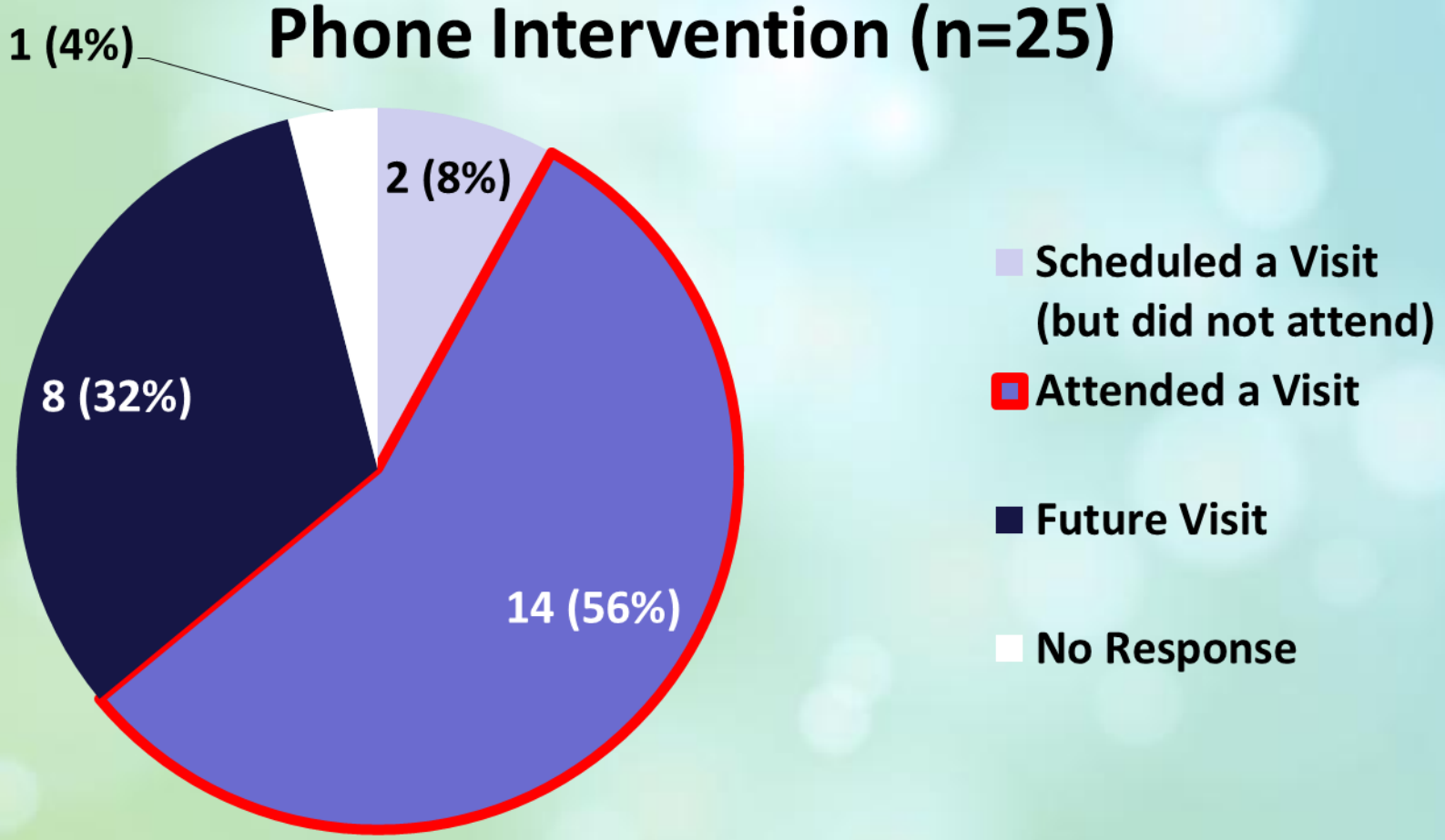

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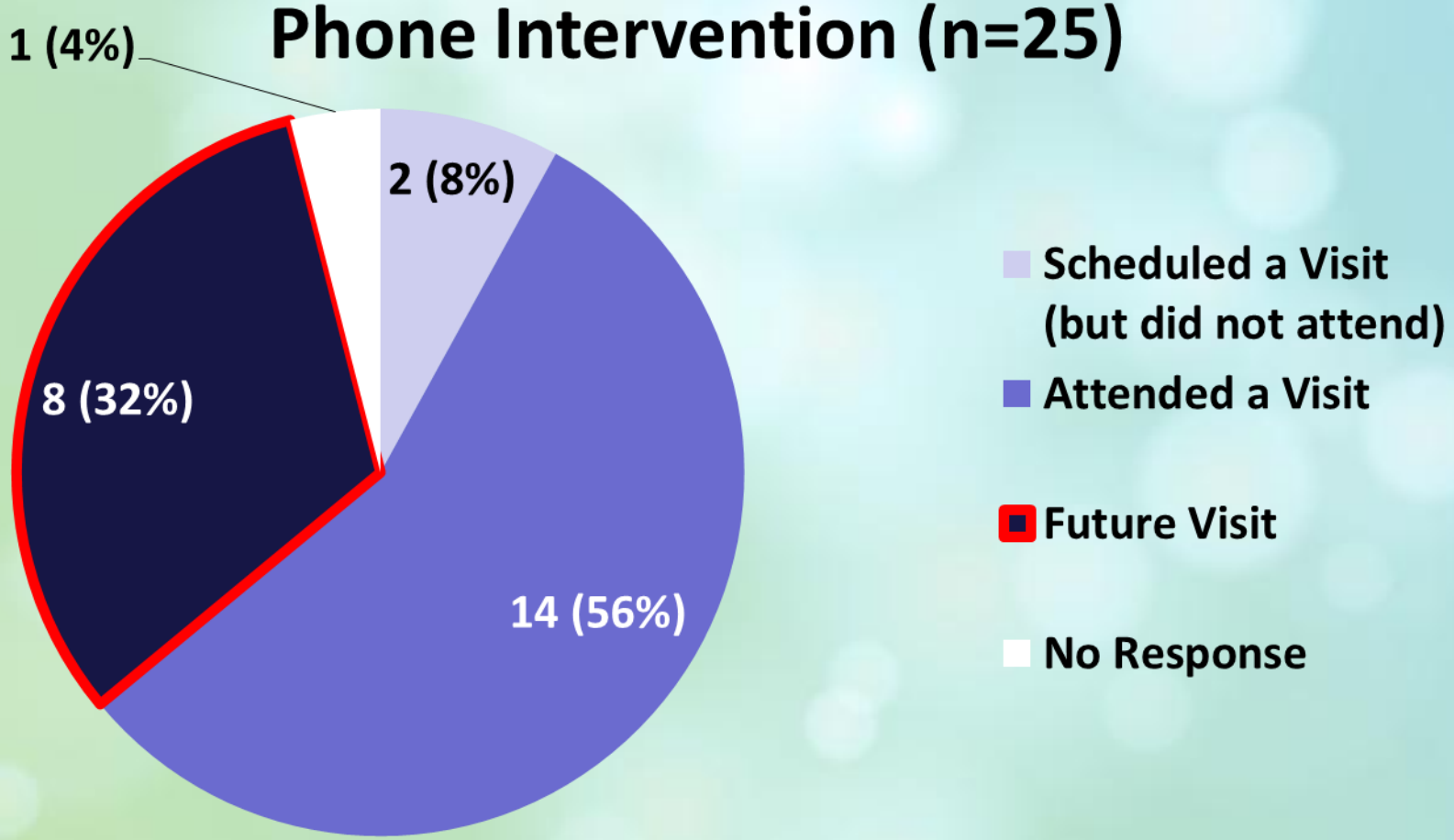

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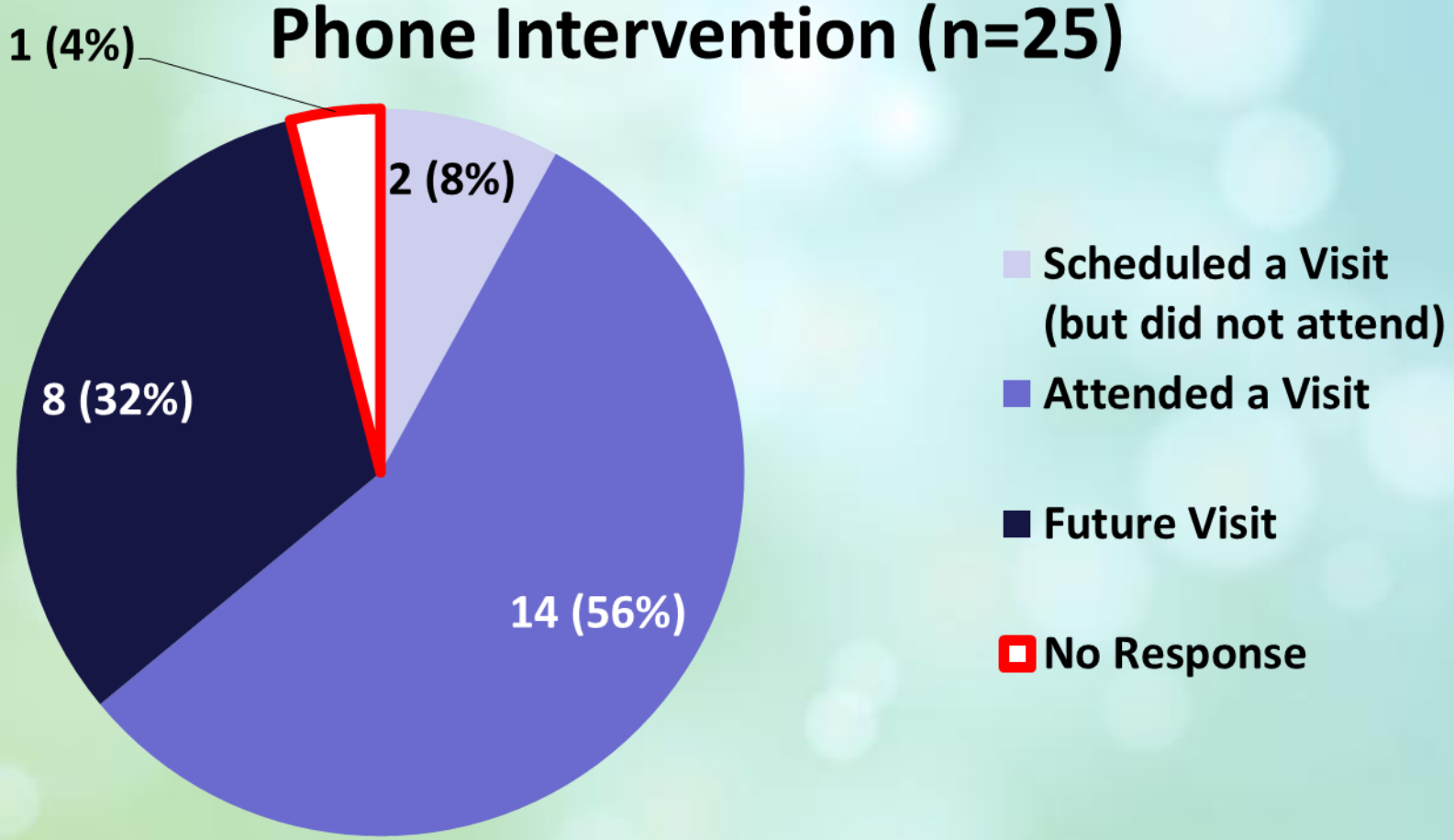

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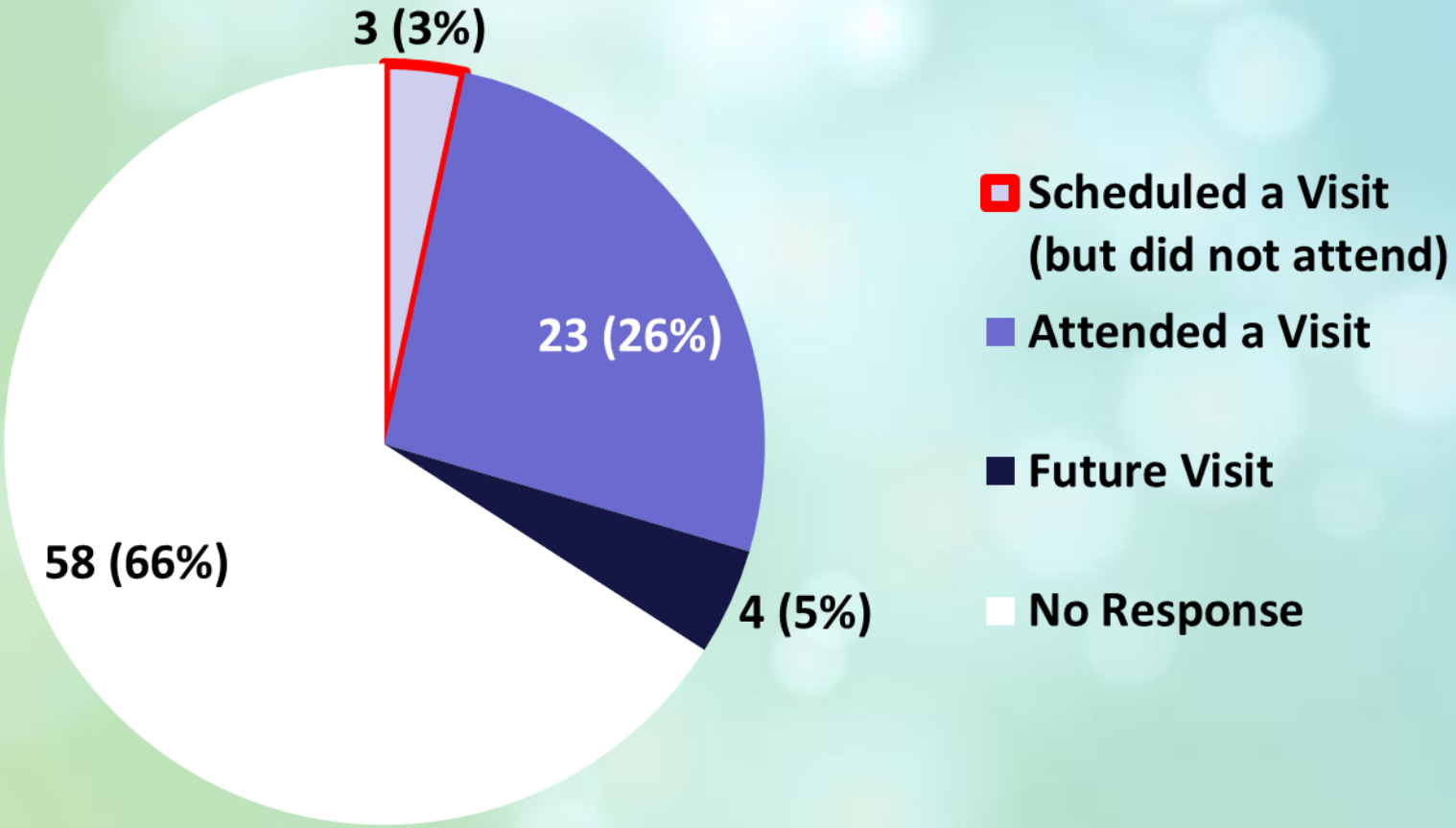

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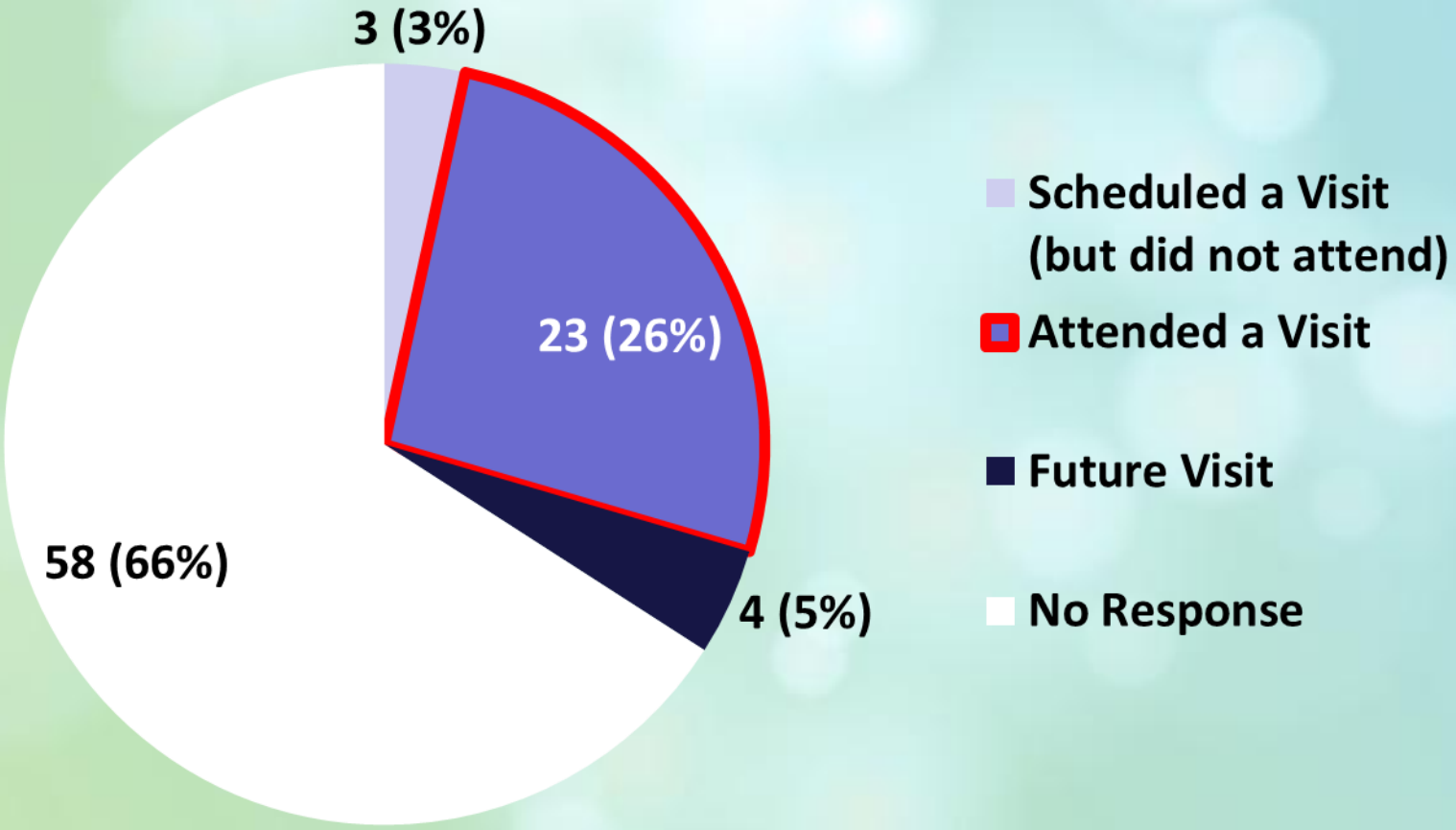

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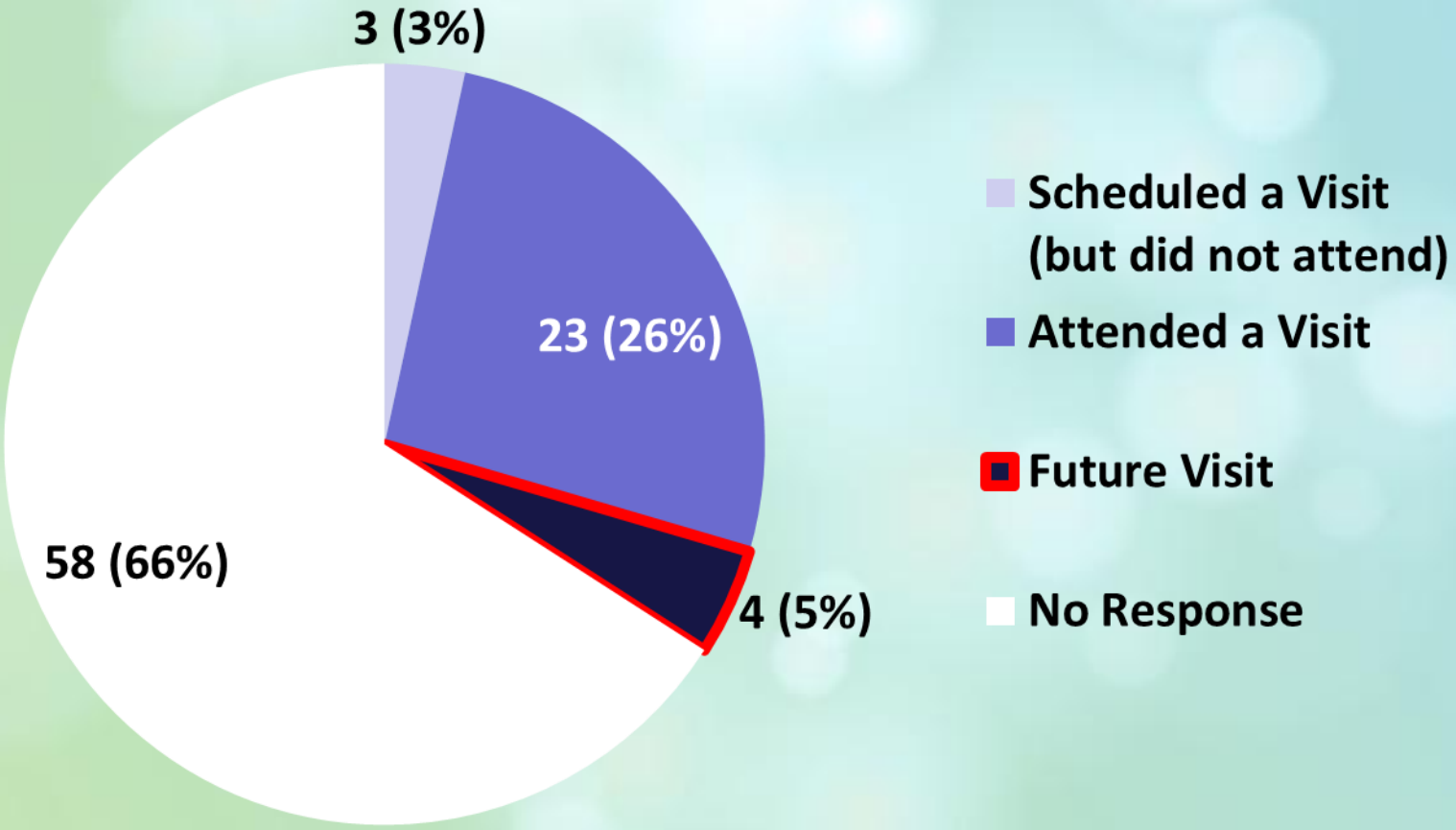

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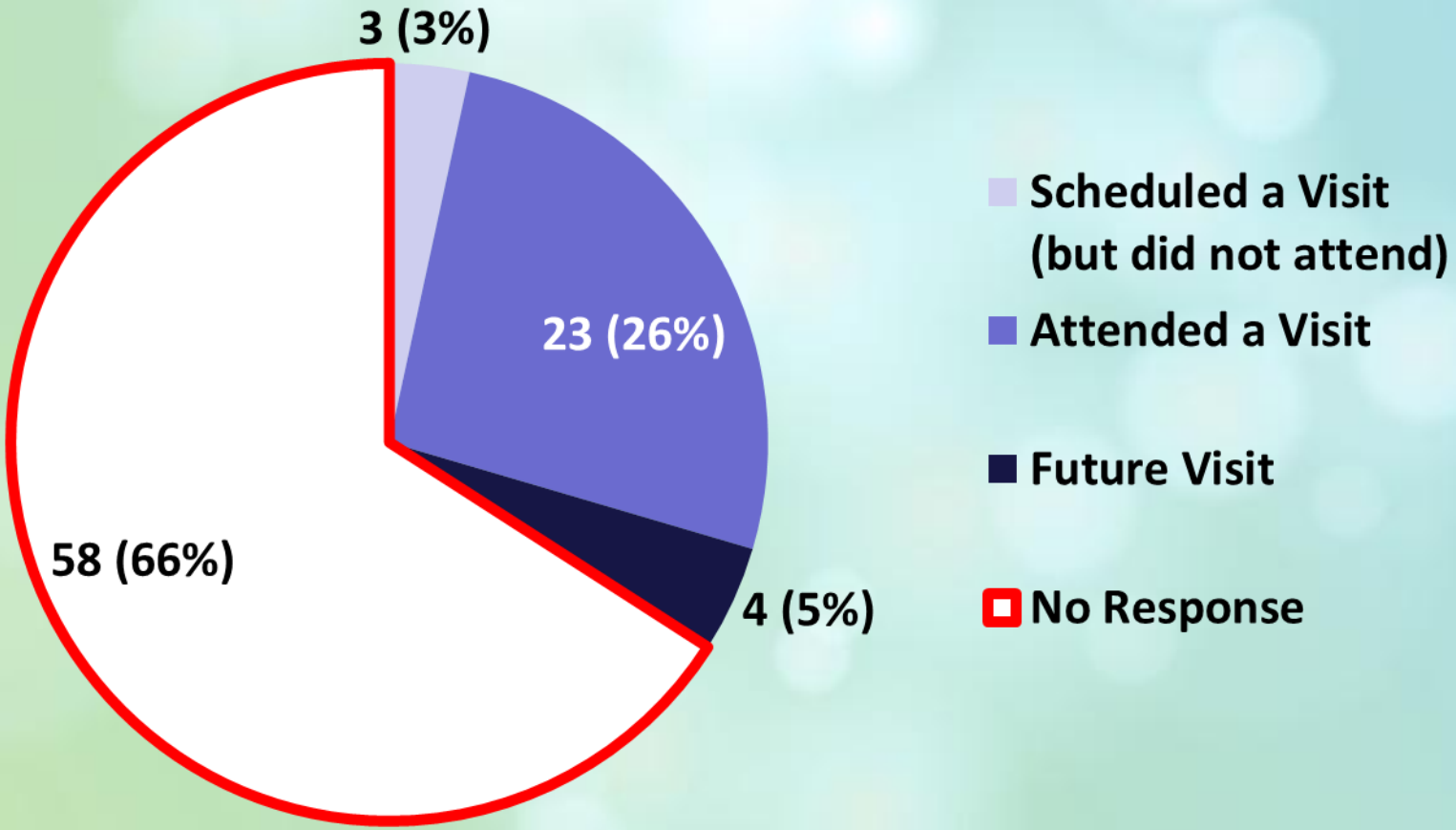

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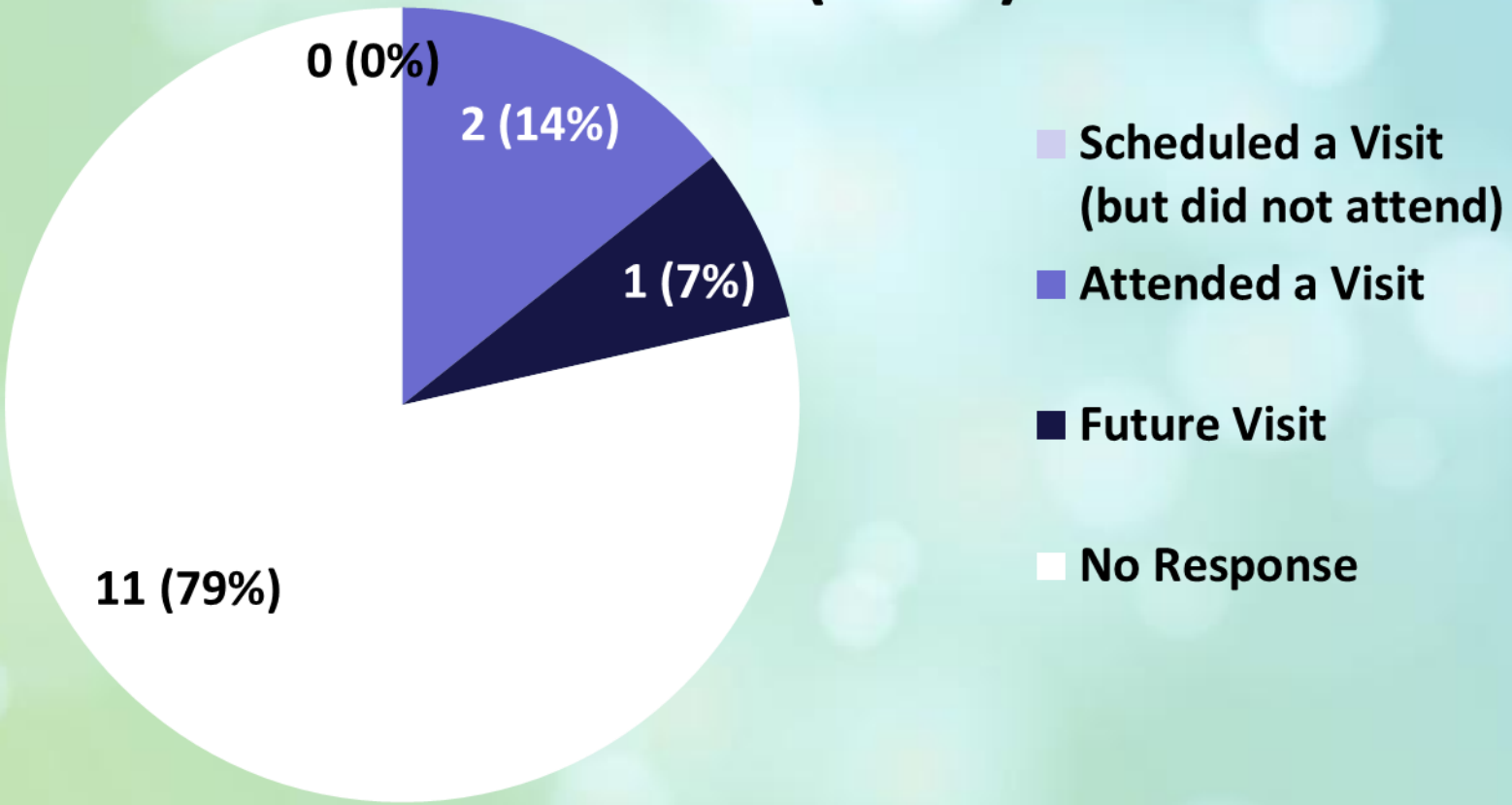

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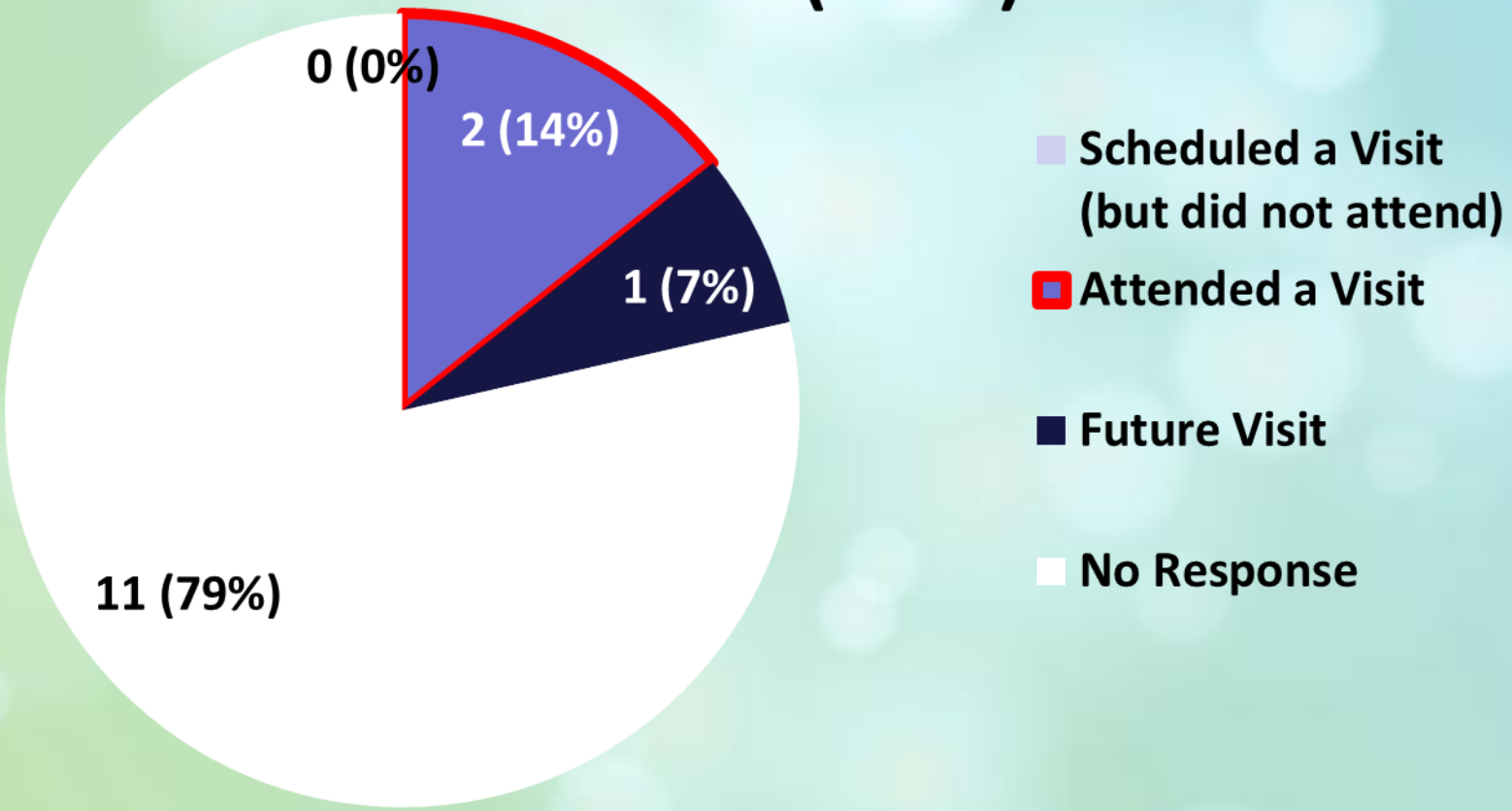

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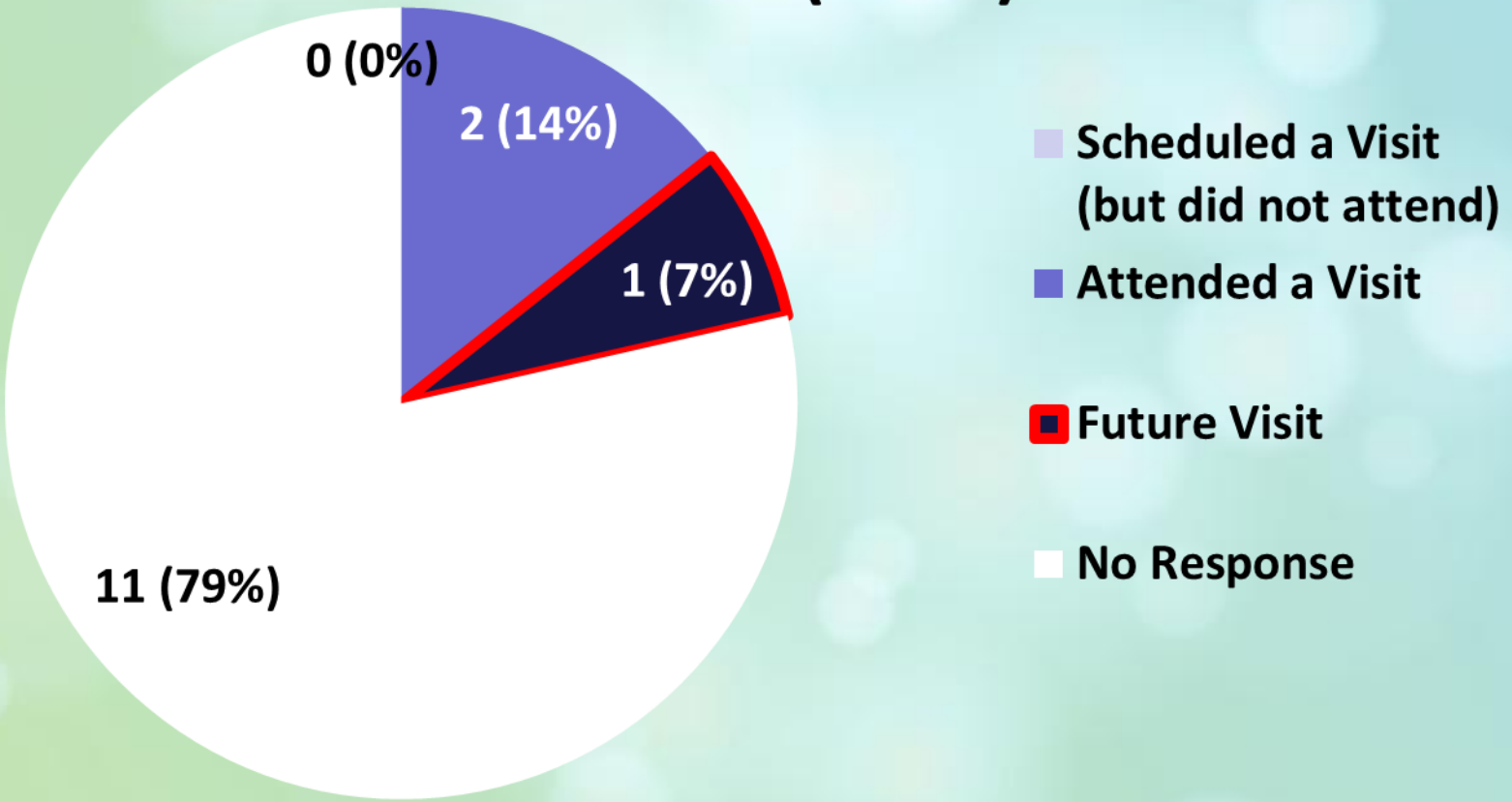

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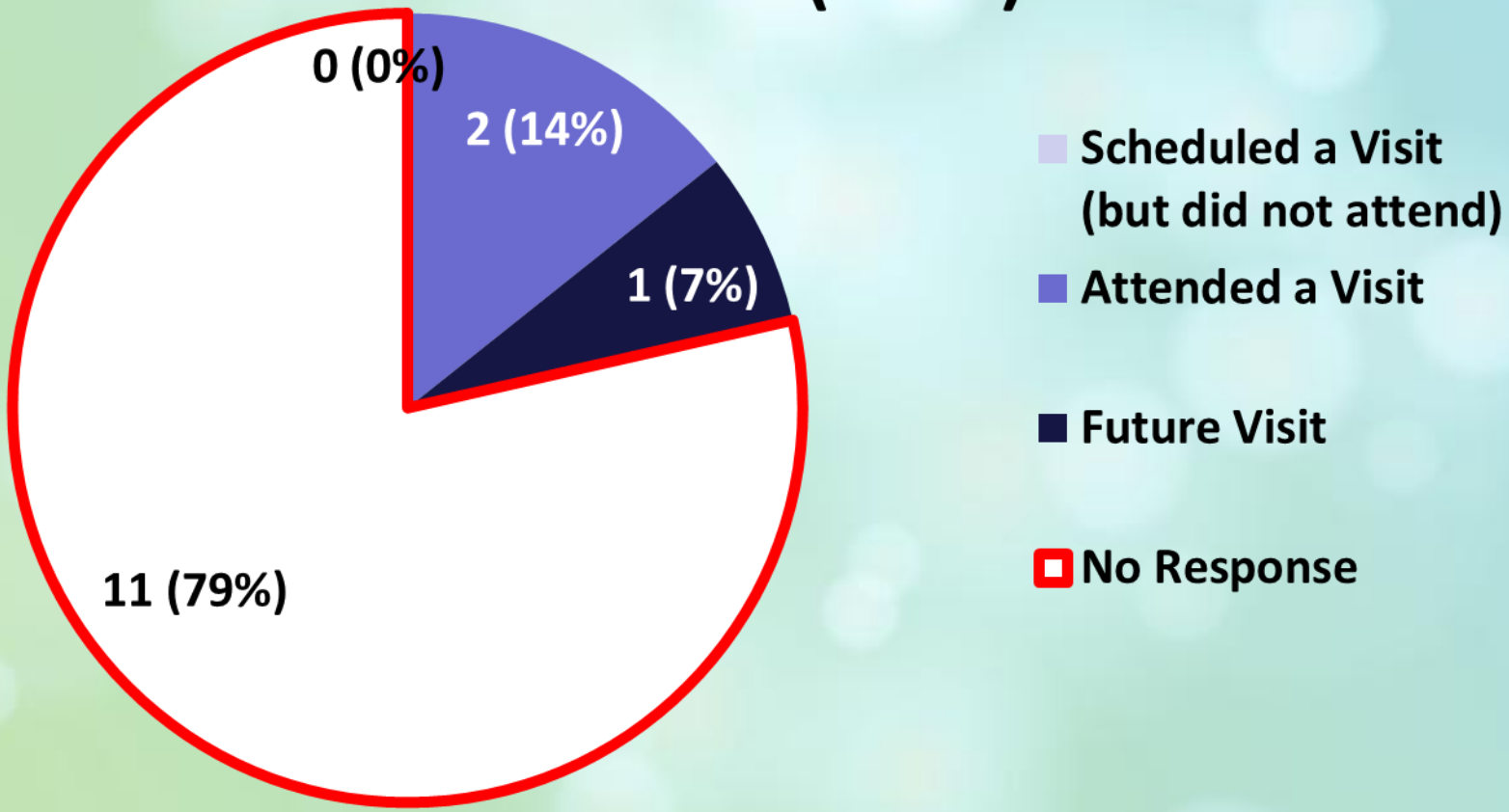

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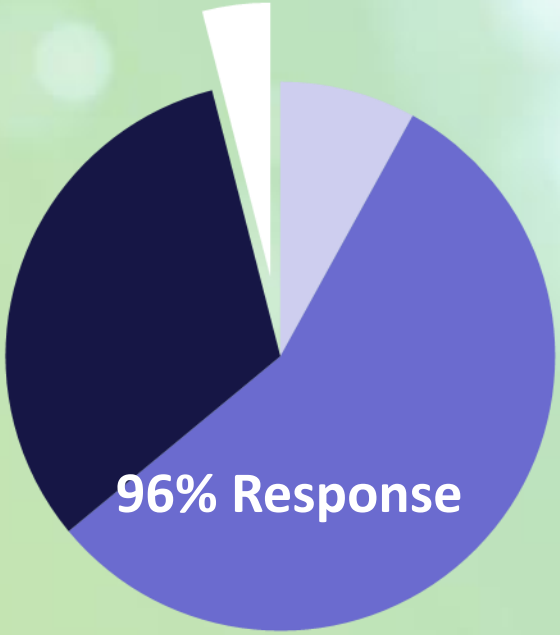

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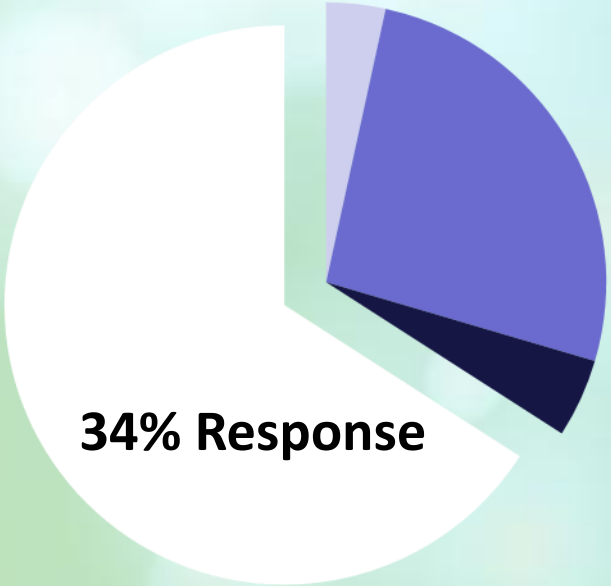

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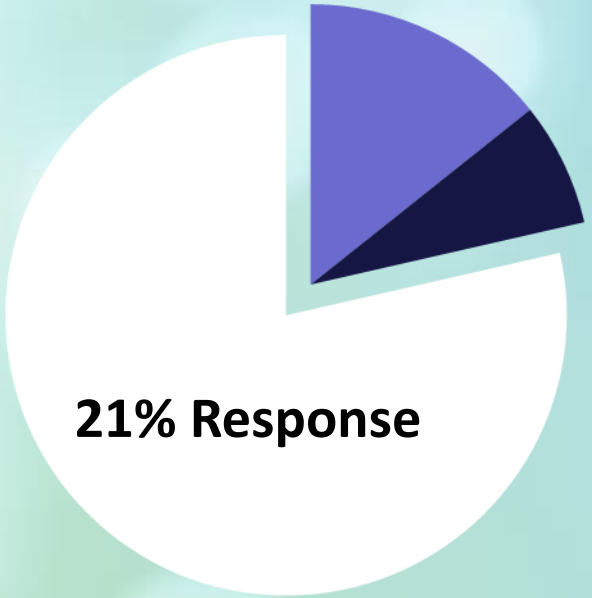

Group Characteristics

	Response (n=57)	No Response (n=70)
Age (years)	43	40
Male	38 (67%)	53 (76%)
African-American	49 (86%)	51 (73%)
Insurance		
Ryan White	25 (44%)	37 (53%)
CD4 Count [mean]*	391	438
Viral Load [median] *	588	262
Viral Load [mean]*	42,962	54,781

* Last value on record for patient

Group Characteristics

	Phone (n=25)	Phone and Letter (n=88)	Phone, Letter, Home Visit (n=14)
Age [mean] (years)	45	42	31
Male	19 (76%)	64 (73%)	8 (57%)
African-American	19 (76%)	70 (80%)	11 (79%)
Insurance			
Ryan White	10 (40%)	43 (49%)	9 (64%)
CD4 Count [mean] *	490	409	338

* Last value on record for patient

Conclusions

- Many of the patients identified were not in need of reengagement
  - 45% transferred care, died, or were incarcerated
- Overall response in 45% of those fallen out of care
  - Suggests that contact with outreach coordinator may be an effective intervention
- Groups were similar
  - Response and non-response groups similar to each other and the poorly retained population as a whole

Limitations

- Lab markers do not represent current HIV disease status in poorly retained patients
- Categorization was time intensive and may have been the result of an intervention
- Time elapsed since last appointment may limit intervention effectiveness
  - Risk of inaccurate contact information increases with time

Future Directions

- **Which barriers most often impact retention in care for our patients?**
- **Which retention interventions are most cost-effective?**
- **How do we reach patients that were never linked to care?**

Questions???