# Retaining Patients Living with HIV/AIDS Through Friendly Outreach Cards

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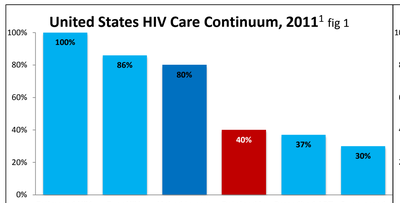
## Introduction and Background

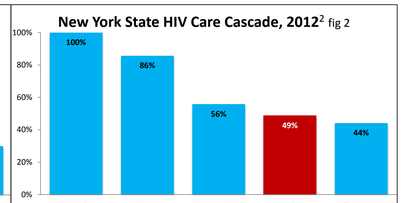
The Institute for Family Health is a Federally Qualified Health Center serving over 90,000 patients at 27 locations throughout New York State. Annually, approximately 1,000 people living with HIV/AIDS (PLWHA) receive primary care and psychosocial services through the Comprehensive Outpatient Medical Practice And Support Services Program (COMPASS.) This intervention took place at Family Health Center of Harlem, where COMPASS serves about 375 PLWHA.

Retention in care improves the health of PLWHA and reduces the number of new HIV infections. The National HIV/AIDS Strategy, and national, state and local treatment cascades highlight retention activities as vital in our fight against HIV/AIDS. Nationally, 40%[1] of people living with HIV/AIDS are considered retained in care. In New York State, 49%[2]; in New York City, 54%[3]; and at the Family Health Center of Harlem, our 2013 retention rate was 84%.

**United States HIV Care Continuum, 2011**[1] fig 1




**New York State HIV Care Cascade, 2012**[2] fig 2




In 2013 our routine retention efforts involved attempting 3 consecutive calls followed by a final letter to all patients who missed appointments.
For our 2013 Continuous Quality Improvement (CQI) project we identified patients at risk of falling out of care (those seen by our medical providers in past 6 months but not seen in the past 3 months.) We outreached with 3 call attempts followed by a final letter as well. For these patients at risk for falling out of care who were contacted through our 2013 CQI project, 24% kept their next scheduled appointment or scheduled and then kept a new appointment.

## Definitions

- New York State HIV clinical guidelines: Clinicians should schedule routine monitoring visits at least every 4 months for clinically stable PLWHA.
- Centers for Disease Control Retention Measure: Patient attended 2 or more HIV medical care visits in the 12 months following initial care. (fig.1)
- New York State Retention Measure: patient received 2 HIV related lab tests at least 3 months apart. (fig.2)
- Institute Retention Measure (as defined by HIVQUAL): patient has attended at least 1 HIV medical care visit in the first 6 months of the year, and at least 1 in the second 6 months of the year, and those visits are at least 60 days apart. New patients seen after July 1st are removed from analysis.

## Objective

In 2014, 90% of COMPASS patients receiving primary care at The Family Health Center of Harlem will be considered retained. This objective was made into our 2014 CQI project.

## Methods

- Engaged patients at December 2013 Consumer Advisory Board (CAB) meeting to re-evaluate outreach and retention strategies.
- CAB members requested outreach materials that were less clinical and more "loving" containing "terms of endearment."
- Initial drafts of the 2014 outreach card were completed by a collaboration between a patient and staff member.
- The final card was developed by COMPASS staff and the Institute Communications Department

## Methods

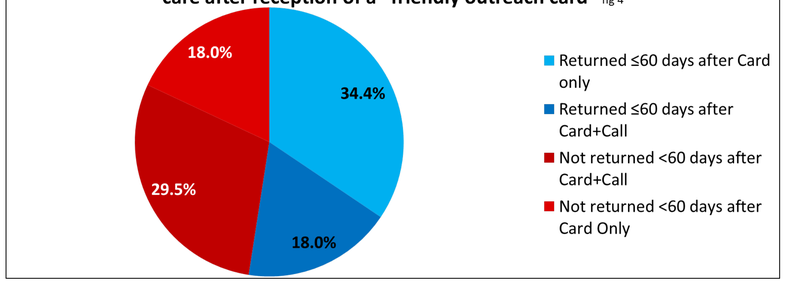
- Based on CAB member feedback, the "friendly outreach card" was created.


fig 3. "Friendly outreach card" sent to patients; front, inside, and back views

- On a rolling monthly basis, the Electronic Medical Record (EMR) generated a report listing patients at risk of falling out of care.
- Identified patients were mailed the "friendly outreach card."
- We reviewed patients sent "friendly outreach cards" at 60 days to see if they had returned to care.
- List of patients sent "friendly outreach card" was sent to program staff to encourage collection of qualitative data (patients response to card).

## Findings

**Return to care (≤60 days) rates for patients at risk of falling out of care after reception of a "friendly outreach card"** fig 4




- 83 Patients at risk of falling out of care were involved in 2014 CQI Project.
  - 14 ineligible for analysis due to <60 days elapsing after card was sent
  - 8 ineligible for analysis cards returned to sender
- 61 remaining patients at risk of falling out of care were analyzed.
  - On average there was 23 days between when the card is sent and return to care of those patients who returned to care ≤60 days after sending a "friendly outreach card."
  - 54% of patients returned to care ≤60 days after receiving a "friendly outreach card."
- The 61 patients were broken into two groups, those who received a call from the clinic unrelated to the 2014 CQI and those who did not.
  - Of those that only received a card, 66% returned to care ≤60days after sending a "friendly outreach card."
  - Of those that received a card and a call 38% returned to care ≤60days after sending a "friendly outreach card."
- 7 patients returned to the clinic >60 days after sending the "friendly outreach card." They are counted as not returned to care in the above analysis.
  - Combined return to care rate (≤60 days & >60 days) was 64%
- Some of the positive qualitative data includes these comments made by the patients and their families:

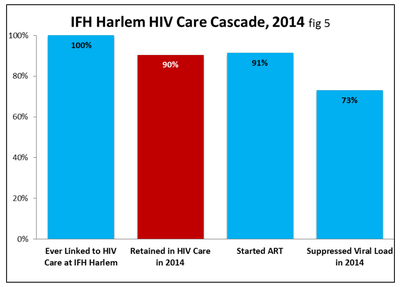
  "*Dr. Hewitt sent me a card, so I came in*!" The patient also brought the card in with them.

  "*Yes, I like the card and that's what made me come in*."

  A 50 year old patient's mother called to schedule him an appointment , she stated it was because she received the card.

## Conclusions

**IFH Harlem HIV Care Cascade, 2014** fig 5




This 2014 CQI outreach and retention project targeted patients at risk of falling out of care. In 2014 we saw our overall retention rate improved from 84% from 2013 to 90.4% for 2014, surpassing our goal.

Our return to care rates (≤60 days) for our patients who were at risk of falling out of care reaching 54% and a combined (≤60 & >60 days) return to care rate of 64%.

Working off of suggestions from our Consumer Advisory Board (CAB) we were able to institute an effective retention program that was more "loving" and less clinical than previous outreach methods.

Our patients responded positively to the cards indicated by both our qualitative and quantitative data. We had an increase in our overall retention rate, as well as a high and swift return to care following mailing of the "friendly outreach card."

## Discussion & Implications for Practice

How we could have improved the 2014 CQI project:

- Starting sooner. The patient request for more caring communication was in development until the early third quarter when the first round of cards were sent.
- Using consistent process metrics across 2013 & 2014 CQI projects. Our 2013 CQI project measured if patients kept their next appointment or scheduled and kept an appointment. Our 2014 CQI project looked at if the patient returned to the clinic within 60 days.
- Having a control group. If we continued the 2013 retention effort for a random control group throughout 2014 and use the 2014 metrics for returned to care, or looked historically and gathered our 2014 metrics on the 2013 data, we would have greater ability to compare our efforts.
- Greater consistency with other outreach efforts. Our general outreach and retention efforts for patients who missed appointments changed on 20 October 2014, in the middle of our project.

For future projects we may look at the group of patients not retained and see if they have shared characteristics that will accurately predict who is most at risk.

Implications for practice:

- Continue sending "friendly outreach cards" to patients at risk of falling out of care.
- Continue asking for feedback from patients and our CAB to generate ideas for continuous quality improvement.
- Consolidate all of our retention and outreach efforts into a unified series of steps with consistent documentation at each step.

## Sources

1. *Vital Signs: HIV Diagnosis, Care, and Treatment Among Persons Living with HIV - United States, 2011*. (2014). CDC.
2. *National HIV/AIDS Strategy Measures and the Cascade of Engagement in Care, 2012*. (2014). Aids Institute - New York State Department of Health.
3. *New York City HIV/AIDS Surveillance Slide Sets, 2012*. (2014). New York: New York City Department of Health and Mental Hygiene.