Challenges experienced in linking TB and HIV patients back to care: Post Call Center Project Review

M Motloung [(1)]; VJ Riddles [(1)] & H Mahomed [(2,3)]

The Health Foundation [(1)]; Cape Metro Health Services[(2)] and University of Stellenbosch[(3)]

PHASA 2023
TRANSFORMING RESEARCH TRANSLATION-
REIMAGINING
PUBLIC HEALTH EVIDENCE, POLICIES, AND PRACTICE

transform translate

PHASA
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BACKGROUND

- HIV and tuberculosis (TB) retention in care is a challenge in the Cape Town Metropolitan District.
- Patients classified as lost to follow up (LTFU) has increased risk of mortality and transmission of disease in the community (fig. 1 & 2).
- To improve TB and HIV linkage to care, the Cape Metro established a call center to contact patients who have disengaged and encourage returning to care.

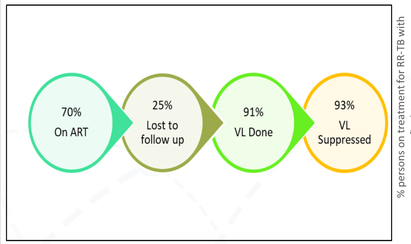


Fig. 1 Data Source: 95-95-95 HIV Treatment Cascade PHDC Mar 2023 (using 2yr threshold

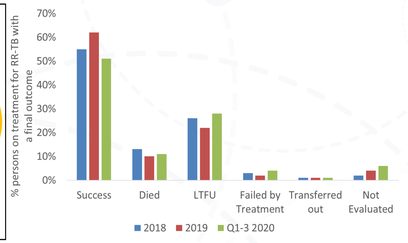


Fig. 2 RR & MDR Treatment Outcomes (long and short regimen—combined)

OBJECTIVES

- Trial the use of electronic tools (Single Patient Viewer) in identifying and addressing impacted populations
- Engage with those who have disengaged with their treatment (as reflected in health information systems)
  - Encourage returning to care
  - Understanding why they disengage
  - Improve systems and tools around TB and HIV retention
- Assess whether telehealth in this context provided a positive impact on the overall metrics
- Provide a recommendation on whether this is an appropriate activity to continue with in addressing linkage to care and disengagement

METHODOLOGY

- Transitioning a previous COVID-19 Call Centre to addressing HIV and TB LTFU
  - **5 callers** – make calls and record feedback
  - **Administrative Manager** – manage team on daily/weekly/monthly basis
  - **Data Support** - Report on what the overall feedback reflected and manage work distribution
- An SMS was sent to the patients first and called 3 times at different times of the day.
- Calling with clients to encourage returning to care / Identify challenges in our information / recording feedback (if any) – including where this is not available.
- Patients who needed counseling or were experiencing issues were referred to Substructure community-based services.

RESULTS

QUANTITATIVE DATA

- The average HIV patients that are not reachable is 72% and for TB patients 84% (fig 3).

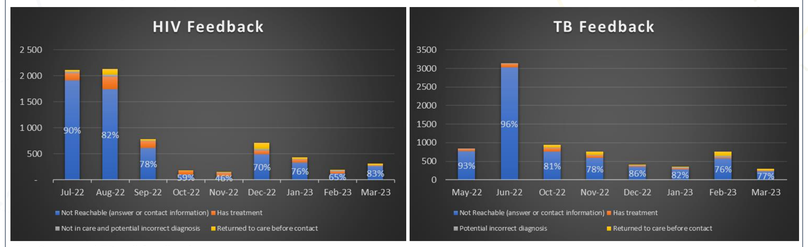


Fig. 3 HIV and TB call feedback

- Between January – March 2023, an average of 17% of HIV LTFU patients and an average of 27% of TB LTFU patients return to care to care without being reached (Table 1&2).

Table 1. HIV LTFU feedback breakdown: January – March 2023

Description (HIV LTFU 2023)	January		February		March	
Total Patients Attempted	**456**	**100%**	**195**	**100%**	**316**	**100%**
No phone number available	**6**	**1%**	**10**	**5%**	**6**	**2%**
Successfully reached	**94**	**21%**	**61**	**31%**	**26**	**8%**
Already in care/has treatment	59	63%	37	61%	12	46%
Needle stick injury	5	5%	15	25%	6	23%
Deceased	21	22%	5	8%	5	19%
Encouraged to return to clinic for care	9	10%	4	6%	3	12%
Not successfully reached	**324**	**71%**	**114**	**59%**	**253**	**80%**
No. does not exist	51	16%	13	11%	10	4%
Wrong number	26	8%	6	6%	8	3%
No answer/voicemail	247	76%	95	83%	235	93%
Returned to care before contact	32	7%	10	5%	31	10%
Returned to care after contact	19	20% (4%)	8	13% (4%)	0	0
Returned to care – not successfully reached	74	23% (16%)	20	18% (10%)	7	3% (2%)

Table 2. TB LTFU feedback breakdown: January – March 2023

Description (TB LTFU 2023)	January		February		March	
Total Patients Attempted	**351**	**100%**	**776**	**100%**	**296**	**100%**
No phone number available	**22**	**6%**	**52**	**7%**	**4**	**1%**
Successfully reached	**56**	**16%**	**84**	**11%**	**35**	**11%**
Already in care/has treatment	23	41%	26	31%	20	57%
Completed treatment (self-reported)	0	0	6	7%	1	3%
Deceased	6	11%	14	17%	2	6%
Encouraged to return to clinic for care	18	32%	27	32%	4	11%
Not aware of diagnosis – encourage to return	9	16%	11	13%	8	23%
Not successfully reached	**260**	**74%**	**525**	**70%**	**222**	**76%**
No. does not exist	6	2%	55	11%	24	11%
Wrong number	9	4%	22	4%	9	4%
No answer/voicemail	245	94%	448	85%	189	85%
Returned to care before contact	13	4%	115	15%	35	12%
Returned to care after contact	6	11% (2%)	15	18% (2%)	8	23% (3%)
Returned to care – not successfully reached	77	30% (22%)	120	23% (15%)	38	17% (13%)

QUALITATIVE DATA

PATIENT FACTORS
- Patient refusing to take treatment even after counseling.

SOCIAL DETERMINANTS OF HEALTH
- Homelessness
- Substance abuse
- Not having money to go to the healthcare facility
- Not having time to go to the healthcare facility because they are working

STIGMA AND DISCRIMINATION
- Patients do not want the people they live with to know that they have HIV and or TB.

HEALTHCARE FACILITY FACTORS
- Bad experience from the PHC

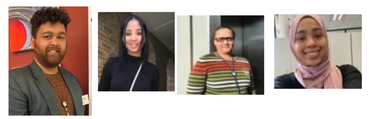
CONCLUSION

- There is a very low yield of reaching patients who are lost to follow-up for 8 weeks or more.
- Lost to follow-up patients return to care by their own decisions.
- Social determinants of health plays a huge role in the patient's linkage to care.
- Incorrect contact information creates a challenge with any telehealth interventions and for tracing patients by the community health services to link them back to care.
- Quality improvement intervention needed to improve accuracy of patient contact information.

ADVOCACY MESSAGE

- Gaining public trust is a key factor in addressing the impact of broader social issues on individual health decisions
  - Treatment adherence
  - Contact and address information
  - Returning to care
- Social determinants of health and stigma plays a role in lost to follow-up, intersectoral approach is needed.

ACKNOWLEDGEMENTS



Call center team (from left to right):
Luigi Perez (Data analyst)
Jade Solomon (Call agent)
Nasley Abrahams (Call agent)
Maryam Davids (Call agent)

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