



**The Clinic Is Open**

**The Team Is Ready**

**Where are the Patient's**

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**AIM:** To discuss why patient's miss appointments and often become lost to follow up.

**Discussion:** What is lost to follow up?



- **Regular medical care is essential to prolonged life.**
  - **Improving general health**
  - **Reduction of opportunistic infections**
- **Medical management should begin as soon as possible after diagnosis and continue throughout the disease course.**
- **Adherence to appointments is essential in management of HIV. Missed appointments have been directly linked to negative clinical outcomes example: inability to suppress HIV-1 RNA levels (viral loads).**

**Adherence is the degree to which behavior coincides  
with medical or health advice  
(Haynes, 1979)**

- Advice includes:
  - Scheduling appointments
  - Returning for appointments
  - Filling Prescriptions
  - Following medication instructions
- **Friendlund/Williams**  
Identified adherence as the greatest barrier to overall therapeutic success.



## Several studies have been done into failure to attend rates.

- Kissinger & Colleagues (1995)
- Found 15% no show rate
- Higher incidence in IVDU
- ↑ level of immune compromise.
- Catz et al 1995
- Found 36% no show





## **(Dunbar-Jacob 1995)**

Identified that patient's suffering from chronic illness that threatens psychosocial functioning or requires complex long term care have

An ↑ risk for medical non-adherence

## **HIV – now considered as a chronic illness**

- Patient's appointment adherence is the crucial step towards improving treatment and achieving good health.
- Diagnosis – development of a treatment plan
- Time spent on patient education are all wasted if a patient is non-adherent or lost to follow up.
- Medical care for HIV is most effective when surveillance and services are initiated early and maintained over time.



## Hippocrates once wrote:

- Patients often lied about seeing their doctor and taking their medication.
- It seems attendance has been a long time issue in healthcare



## Reasons for no show/lost to follow up

1. Heavy/frequent use of alcohol results in: ↑ high risk behaviors and interferes with HIV care. (appointment attendance and medication adherence)
2. Mental Illness - results in compromised coping skills.  
Higher incidence of missed appointments (can be as high as 25%)  
Many researchers have identified mental illness associated with HIV  
Cognitive impairment may be related to mental illness/IVDU or HIV

Gomez et al 1999 found a substantial amount of HIV patient's require psychiatric intervention. This study examined HIV/psychiatric illness → Assessment on entry to the clinic with the goal of ↑ adherence



## Reasons for no show/lost to follow up



### 3. IVDU – also ↑ risky behavior

Study by US Department of Health showed a recent history of crack cocaine/IVDU accessed care only 36% versus 63% of those not currently involved in drug use.

## Reasons for no show/lost to follow up

- Lack of Readiness



Fear – apprehension of the unknown.

Patient's health beliefs eg. Medicine man in

First Nation's culture.



## **Fear and Stigma**

- Fear is a barrier to care
- Fear of being seen
- Fear of the unknown
- Discrimination and stigma – are still a large part of HIV

## **Age/Gender/Social Situation**

- Homeless
- Distance from clinic - weather conditions
- Female/male
- Unemployed versus employed
- Ethnicity
- Social – family situations, no ride, death in family, babysitting

# CD4 COUNTS

Higher CD4 counts

Are a prediction of  
missed appointments



## Studies have shown

- Younger age
- Minority status
- Less sense of illness
- Lower perceived social support



# Benefits

- To benefit from HIV care regimens persons living with HIV/AIDS must first adhere to outpatient medical appointments
- Not only ID clinic but u/s, ophthalmology and psychiatry, etc
- Early screening for STD's
- Appropriate initiation of HAART
- Prevention of complications of HIV
- ↓ number of opportunistic infections



# AFTER IDENTIFYING ALL OF THE INVOLVED FACTORS – WHAT DO WE NEED TO DO?

- Reminders – letters/phone call - ? Time period prior to appointment
- Missed appointment letters
- Arrange rides, help with instructions of correct address
- Leave walk in slots open
- Keep in contact – build patient confidence, patient trust and confidentiality – warm and friendly manner
- Ensure patient understands the clinic policies
- Does the patient have the ability to contact the clinic
- Provide return to clinic appointment cards with the clinic contact number on the card

# Be Flexible if Possible

- On diagnosis see patient along with the social worker for an entry interview and allow enough time

## Attempt to use all available sources

- Family Physician
- Social Services
- Outreach workers
- Other Community Resources ??
- Public Health eg: Street Project

**In Saskatchewan HIV Case Management Pilot Project – provides funding to public health agencies. The project is dedicated to the group of patient's who are lost to follow up and the difficulties to meet their own needs.**

**The Project Objective:**

- identify newly diagnosed patient's**
- put them in touch with the local clinic asap and help the patient keep in touch with the clinic**
- assist identified clients to attend scheduled appointments**
- increased focus on psycho-social needs**

# Goal

- Decrease no show rate
- Decrease lost to follow up client's
- Improve relationship between care providers and clients

