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The provision of cell phones as a recruitment and retention strategy for people who inject drugs enrolling in a randomized trial

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Abstract

Background—Studies of drug-using populations often restrict enrollment by limiting participation to those with a working telephone. It is unknown whether supplying phones could broaden recruitment and sustain retention among an urban population of people who inject drugs (PWID). We compare the feasibility of offering pay-by-month phones to gift card compensation as part of an ongoing randomized controlled trial of hospitalized PWID.

Methods—Participants were recruited from inpatient services at an urban hospital in Boston, MA to participate in an ongoing randomized trial testing a motivational interviewing (MI) intervention. Participants who did not have their own phone at the time of enrollment were offered a pay-by-month phones as compensation for study participation.

Results—Eighty-one participants met study criteria, were enrolled, and completed the study at the time of analysis. We used a generalized estimating equation to compare the overall likelihood of attending interviews during the 12-month follow-up period. Participants receiving phones tended to have lower mean educational attainment (11.4 years vs. 12.1 years), were significantly

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Contributors

Dr. Stein designed the study. Catherine Stewart conducted the literature searches, summaries of previous related work, and wrote the first draft of the manuscript. Dr. Anderson undertook the statistical analysis and also wrote a section of the first draft of the manuscript. Drs. Stein, Liebschutz and Herman, as well as, Hannah Kopinski, Inga Holmdahl, and Julia Keosaian, provided critical input to multiple drafts of the paper. All authors contributed to and approved of the final manuscript.

Conflict of Interest

All authors declare that they have no conflicts of interest.

(Fisher's exact $p < .001$) more likely to report homelessness during the past 90-days (86.7% vs. 37.3%), and were significantly less likely (Fisher's exact $p = .044$) to be employed (3.3% vs. 20.4%) compared to those receiving gift cards. Participants in each group were equally likely to attend follow-up interviews during the study (83.3% vs. 88.3%, $p=0.53$).

Conclusion—Offering phones as a compensation method allows recruitment of a more disenfranchised population without impacting study retention and therefore may improve generalizability of study results.

Keywords

Injection drug use; Longitudinal; Retention; Tracking; Recruitment

1. Introduction

Longitudinal studies of persons who inject drugs (PWID) show that attrition most commonly occurs due to frequent incarceration, time spent in treatment facilities, hospitalizations, death due to drug-related health problems, and continual address and phone number changes (McKenzie et al., 1999; Scott, 2004). To minimize attrition, investigators employ three primary strategies: enrollment restrictions, extensive outreach, and the provision of a variety of incentives to improve retention.

Investigators restrict enrollment by limiting study participation to those who can provide a working telephone number, a current address (Kleschinsky et al., 2009) and/or at least one additional collateral contact (Hansten et al., 2000). While improving the likelihood of follow-up, this strategy may disqualify the most impoverished and disenfranchised PWID from receiving and testing interventions, limiting study generalizability and these individuals' access to potential benefits from study participation.

Retention efforts after enrollment have included collecting addresses and phone numbers for a large number of collateral contacts as well as detailed contact information from the participants themselves (Cepeda et al., 2010; Leonard et al., 2003). Additional mechanisms to optimize follow-up involve providing additional remuneration for the participant such as mugs, basic toiletries, raffle prizes, and monetary bonuses for completing all assessments (Boys et al., 2003; Cepeda et al., 2010; Des Jarlais et al., 2005; Lankenau et al., 2010; Ojo-Fati et al., 2017), compensation for collateral contacts for passing along messages to participants (Cottler et al., 1996), mailings such as birthday cards, appointment cards, and thank you cards (Boys et al., 2003; Cepeda et al., 2010; Festinger et al., 2008; Leonard et al., 2003; Scott et al., 2004), searching online public and private databases to locate participants (Bolanos et al., 2012; Boys et al., 2003; Kleschinsky et al., 2009; Mitchell et al., 2015), field tracking (Kleschinsky et al., 2009; Ojo-Fati et al., 2017), and meeting participants in convenient interview locations (Lankenau et al., 2010). Other investigators hire dedicated retention staff or hire PWID or ex-PWID who have ongoing relationships in the community as outreach workers (Boys et al., 2003; Cepeda et al., 2010; Cottler et al., 1996; Lankenau et al., 2010; Ojo-Fati et al., 2017; Scott et al., 2004) who wear casual clothing to enhance approachability (Lankenau et al., 2010). Email has been cited by many studies as an effective and economical form of retention (Bolanos et al., 2012; Mitchell et al., 2015).

More recently, studies have provided electronic debit cards that can be loaded remotely to compensate a participant if a survey was conducted via phone (Des Jarlais et al., 2005; Lankenau et al., 2010). Studies have also recently been promoting the use of social networking sites to track and contact difficult-to-reach participants (Bolanos et al., 2012; Mitchell et al., 2015). Many of these efforts involve significant additional costs beyond standard participant incentives, difficulties in obtaining IRB approvals, and require extensive study time, effort, and specialized training.

Allowing interviews to be completed by telephone (Boys et al., 2003; Lankenau et al., 2010) has also been shown to increase study retention. However, only considering the ownership of a cellphone at the time of enrollment may be insufficient; the possession of cell phones by participants who are homeless or transiently housed may not be particularly helpful due to a lack of minutes and phone loss or theft (Mitchell et al., 2015). These problems also interfere with retention even when a participant is provided with a toll-free number to reach the research team (Lankenau et al., 2010). However, it is unknown whether supplying cell phones could broaden recruitment and sustain retention among an urban PWID population. This study provides detailed information on a strategy to engage people who inject drugs, who are hospitalized and do not have phones, in clinical research by providing pay-by-month cell phones as a part of study involvement. We compare retention rates of those receiving phones to those receiving traditional gift card compensation for participants in a 12-month clinical trial.

2. Methods

2.1. Study Design

The SKIN Study is an ongoing randomized trial testing the effectiveness of a motivational interviewing-based educational intervention to reduce bacterial infections among hospitalized PWID. For this analysis, we describe the procedural aspects of providing cell phones as incentive and compare study retention at each of the six follow-up assessments for participants who receive study cell phones versus those who receive standard gift card compensation.

2.2. Study Participants

Beginning in January 2014, participants were recruited from all inpatient clinical services (medicine, surgery, OB/GYN) at Boston Medical Center (BMC), a safety-net hospital serving a predominantly urban and underserved population in Boston, Massachusetts. Potential study participants were identified through a medical record review of all admitted patients in the prior 24 hours (72 hours on Monday morning). Study staff attempted to approach all potential participants (all hospitalized persons who inject drugs) as identified in the EMR for a face-to-face interview with a short screening questionnaire. Eligibility criteria included recent injection drug use (at least three days out of the week prior to hospital admission), English comprehension, the ability to return to BMC for follow-up, at least two additional contacts with valid phone numbers, and no known upcoming prison sentence or a planned move from the region. Prior to the initiation of the cell-phone protocol that is the focus of this analysis, eligibility criteria also required the participant have a valid phone

number. After the cell-phone protocol was initiated, individuals either had to have their own valid phone number or accept the study cell phone, which provided them with a valid phone number. All study procedures were approved by the Boston University Medical Center Institutional Review Board.

2.3. Data Collection

Trained research assistants obtained informed consent from eligible hospitalized participants, administered a 90-minute baseline questionnaire and skills demonstration assessment of the participants' skin and needle cleaning habits, and collected a urine sample for toxicology testing. After completing the baseline interview, participants were randomized to either an intervention or assessment-only arm. Participants in the intervention arm received the motivational, educational skin hygiene intervention; these participants received a second booster session 1 month after hospital discharge. Follow-up assessments of study outcomes (bacterial infections, unsafe injection habits) were scheduled at 1 week and 1, 3, 6, 9 and 12 months. With the exception of the 1-week phone interview, the remaining follow-up interviews took place in person either at BMC or in a public place easily accessible to the participant; telephone interviews occurred when participants could not attend the in-person interview. In person follow-up assessments lasted 30–60 minutes.

2.4. Phone Protocol

Implementation of a cell phone compensation protocol was put in place four months after the start of the trial because 24% of those screened during the first four months were excluded based on the valid phone number requirement. Therefore, participants in this analysis included all those who were enrolled between May 2014 and October 2015, allowing for 12-month follow-up data. The cell phone protocol removed the eligibility requirement of having a working phone number prior to enrollment. Participants without phones who were otherwise eligible to enroll in the study were given a study cell phone in lieu of gift card compensation for completing study interviews. Participants with a working phone were offered the choice between the gift cards or a study cell phone.

For the baseline assessment, participants in the gift card compensation cohort received \$20 in gift cards to local area supermarkets or pharmacies. Compensation increased by \$10 at each follow-up assessment with the exception of the 12-month interview, at which participants were compensated \$100 in gift cards. Additionally, at all assessments, participants in both phone and gift card groups received passes for public transportation (i.e., subway, bus). Participants also received \$5 gift cards to a chain of coffee shops for keeping in contact with the study team between assessments. The total potential compensation was \$447.

The monetary value of the phones and phone plans was approximately equivalent to the value of the compensation received by the gift card group (\$526 per year if maintained for 12 months). Participants received a flip-phone and an unlimited talk and text plan to be paid on a monthly basis by the study. After the final interview the participant could keep the cell phone, but the study team no longer paid the plan. Participants receiving cell phones did receive \$5 gift cards as incentive to update their contact information between study

interviews (maximum \$45) as well as \$32 in transportation cards through the course of the study. Additionally, participants receiving cell phones were allowed an unlimited number of replacement phones (\$16 per replacement phone). If participants lost, broke, or had a cell phone stolen, they were required to visit the study office to receive a new cell phone. The study team suspended phone service immediately upon learning of the loss or theft of a phone until the participant came to the office to receive a replacement handset, at which time phone service was reactivated.

If a participant purchased his or her own cell phone during the course of the study and the staff member was able to verify that the phone was active, then the participant could be switched from the phone plan to the gift card plan (N=18). Conversely, a participant could be switched from the gift card plan to the cell phone plan upon request at any point during the study (N=10). Typically, these participants had lost access to their own phone and a cell phone was offered as compensation. For this manuscript, participants who switched groups (phone to gift card or gift card to phone) were excluded from the analyses (N=28).

Participants compensated with a cell phone were required to contact the study team at least once a month to maintain the phone plan; two weeks prior to the date of the next phone plan payment, a research assistant contacted the participant via voicemail and text as a reminder. The research assistant could also review the participant's phone account to check the call/text history for time of last use. If the phone had not been used recently the research assistant assumed the participant either no longer had their phone (or charger) or was in a facility where phone use was not allowed, thus triggering a call to the participant's collateral contacts for updates on the participant's whereabouts.

If a participant approached the end of the scheduled interview window and did not contact the study team and an upcoming release from a restricted residential situation could not be confirmed, the research assistant suspended the participant's phone plan. The research assistant could reactivate the phone plan at any time if the participant got back in touch with the study team. A participant phone tracking log was created to track monthly plan start dates, phone suspension and reactivation dates, reasons for phone suspension, and the number of replacement phones received by each participant.

2.5. Participant Tracking Procedure

Staff members completed standard tracking with all participants enrolled in the study. As an interview window approached, participants were reminded of their assessment date and time. If the phone number was inactive, the research assistant then sent an email to the participant (if applicable) and a letter to the participants' home address (if applicable). If the research assistant reached a voicemail, s/he left a message. If the participant could not be reached, the research assistant began calling the alternate contacts listed on the Locator Information form. If no additional information on participant whereabouts could be gleaned from these contacts, the research assistant then called correctional institutions in the area and checked online inmate databases and obituaries. These efforts continued 1–2 times weekly until the participants' interview window ended; tracking for the next interview began thereafter.

2.6. Analytical Methods

We report descriptive statistics to summarize the characteristics of the sample. We present subgroup means ($\pm$ SD) or counts and percentages to compare substantive differences between comparison groups. Because of the small sample size and skewed distributions, we use the nonparametric Wilcoxon rank-sum test to test the statistical significance of between-group comparisons on continuous variables and Fisher's exact test when comparing group differences on categorical variables. We estimated a generalized estimating equation (GEE) to compare the overall likelihood of attending interviews during the 12-month follow-up period. We used bias-corrected and accelerated (BCa) (Efron, 1987) bootstrap resampling with 5,000 replications to estimate 95% confidence interval estimates for the odds ratio comparing those who received a phone with those who received gift cards. In this small sample, exploratory analysis Type II error is potentially as egregious as Type I error, and we note associations that suggest substantively interesting between group differences even if the p-value is not significant at the conventional .05 level.

3. Results

3.1. Characteristics of the Sample

Between May 2014 to October 2015, study staff screened 423 potential participants and identified 191 participants as eligible. Of the eligible participants, 136 (71.2%) were consented. The most common reasons for lack of consent included participant refusal to participate (n=26) and hospital discharge (n=12). Of the 136 participants who gave informed consent, 22 did not enroll in the study because they left the hospital against medical advice before completion of the baseline (n=5), were discharged from the hospital before completion of the baseline (n=6), determined they would not be able to return for follow-up (n=2), reported injection rates lower than the study eligibility threshold (n=4), or refused participation after consent (n=5). Of the 114 remaining enrolled participants, 112 had completed the study by October 2016 when analysis occurred. Analysis was conducted with participants who were retained within their original compensation group for the duration of the study; those who switched between groups (n=28) were excluded from analysis. Additionally, three participants who had their own phones but requested cell phones as compensation were also excluded. Analyses were conducted with participants who had reached the 12-month interview (n=81).

Among these 81 participants, 30 were enrolled in the phone protocol, and 51 received gift cards (Table 1). Participants averaged 38.4 (11.1) years of age, and 45.7% were female, 60.5% were non-Hispanic Caucasian, 22.2% were African-American, 14.8% were Hispanic, and 2.5% were of other ethnic or racial origins (Table 1). Mean years of education was 11.8 (2.07), and 13.9% were employed either part- or full-time. Most (92.6%) reported that opiates were their primary injection drug; the rest identified cocaine. Thirty (37.0%) participants reported no phone access at baseline, 2 (2.5%) reported access to a landline only, 21 (25.9%) had access to a cell phone, and 28 (34.6%) had access to a smartphone.

Participants receiving a phone were somewhat more likely to be female (66.7% vs 47.1; $p=.11$), less likely to be non-Hispanic Caucasian (50.0% vs 66.7%; $p=.09$), and tended to have

lower mean educational attainment (11.4 years vs 12.1 years; $p=.14$). Participants receiving a phone were significantly ($p < .001$) more likely (86.7% vs 37.3%) to report being homeless during the past 90-days than those receiving a gift card, and they were significantly less likely (3.3% vs. 20.4%; $p = .044$) to be employed either part- or full-time. Among participants receiving a gift card, 2 (3.9%) had access only to a landline, 19 (37.3%) had access to a cell phone, and 30 (58.8%) had access to a smartphone. Participants receiving a phone did not have access to any phones at enrollment.

3.2 Retention

Between group differences in rates of follow-up were small, directionally inconsistent across time points, and did not approach statistically significant levels at any time point (Table 2). In total, participants who received a phone missed 89 (49.4%) of a possible 180 follow-up assessments while those receiving gift cards missed 148 (48.4%) of 306 possible assessments. Using GEE, we estimated that differences in the expected odds of attending follow-up during the entire 12-month assessment period were trivially small; the estimated odds of attending follow-up assessments was 1.04 (95%CI 0.59; 1.76) times higher for participants receiving a phone than for participants receiving a gift card.

Table 3 lists reasons participants were not assessed during follow-up. Not being able to reach the participant accounted for 56.1% of the missed assessments in the total sample with 55.1% of participants receiving a phone and 56.87% of participants receiving a gift card missing assessments ($p=.64$).

Of the 30 participants in the phone cohort, 25 required phone suspensions during the course of study participation. Out of 25 phone suspensions, 16 phones were suspended because we could not reach the participant. Phone suspension prompted nine of the 16 participants to return to the study office to have the phone reactivated without further effort from the research staff. This made it possible for RA's to conduct a follow-up interview with formerly 'lost to contact' individuals. Of the remaining 9 phones suspended, 3 were suspended because the participant became incarcerated and could no longer utilize their phone, 3 withdrew from the study, and 3 died. Seven participants in the phone cohort (23.3%) and 15 participants in the gift card cohort (23.5%) returned for all follow-ups and maintained contact with study staff throughout the study. Nineteen participants received at least one replacement phone during the course of study participation. The average number of replacement phones was 4 for those participants who required a replacement cell phone.

3.3 Retention Effort

Research staff attempted to contact participants in two ways. The first was direct participant contact, which included any direct contact attempt made between study staff to the participant, such as texts or phone calls/voicemail regardless of outcome (phone inactive, straight to voicemail, invalid number, incorrect number, etc.). Additionally, any in-person contact with the participant (apart from assessment visits), any communication with jails/facilities concerning the participant, and any letters or emails sent by study staff to the participant or by the participant to study staff were included in the direct participant contact

category. The second category of retention efforts included any attempt at contacting the participant's collateral contacts.

Alternative contacts included phone calls, texts, and letters to those persons reported by the participant at the time of recruitment as persons who might know how to reach the participant if s/he could not be reached by study staff. Overall, participants within the cell phone cohort required an average of 24.5 direct participant contact attempts and 4.7 alternative contacts attempts during the 12 months of study participation. In comparison, the gift card cohort required an average of 21.4 direct participant contact attempts and 6.6 alternative contacts attempts to be retained.

4. Discussion

Studies of persons who inject drugs face numerous retention challenges. We have described an innovative method for retention in a trial of out-of-treatment PWID by offering a cell phone with prepaid monthly plan. Cell phone compensation not only allowed recruitment of participants with high rates of homelessness, lifetime incarcerations, and unemployment – the study was able to recruit 52 participants who would otherwise not have been eligible for study participation – it also demonstrated an equivalent retention rate to the group that did not require phones.

The follow-up rates at all time points remained disappointingly low in this trial of hospitalized PWID. This population has proven difficult to track following hospital discharge, even when medication-assisted treatment for opioid use is offered as part of post-discharge planning, thereby reducing illicit drug use (Liebschutz et al., 2014). Research staff utilized many retention strategies used by other research groups including collecting detailed collateral contact information for the participant, searching public online databases, compensation for transportation to the study site, and allowing interviews to be completed by telephone or in convenient interview locations outside of the research office.

Still, there are many likely reasons why the overall study retention was low. Recruitment was conducted through an urban safety-net hospital; persons who inject drugs frequently travel from various parts of the city/state to take advantage of the many benefits provided by a safety net hospital as well as the many treatment facilities in the area. Once they have received treatment, many return to where they live which may not be within a reasonable distance for study related activities and makes these participants more difficult to retain. We are also one of a handful of studies recruiting from a hospital inpatient service. Participants may agree to be in the study while hospitalized for many reasons (boredom, being drug-free in the moment, and reasoning that they “might as well earn some money”), but once they have been discharged from the hospital their willingness to participate may wane. Homelessness may also have played a role in low study retention. Homeless individuals are generally categorized as hard to contact (Scott, 2004) and retain due to the transient nature of the population, and they are often excluded from clinical trials (Davis et al., 2002; Young et al., 2006). We did not exclude homeless individuals during recruitment so as to increase the generalizability of our findings, but as a result our retention rates may have suffered. The chaotic lifestyles of persons who inject drugs also lead to alienation from personal networks

and weakened social support (Scott, 2004). Support systems reported to the study team may be comprised of transient drug “friends” and family members who fall out of touch during periods of drug use, and this may make it difficult for study staff to use collaterals to help find study participants. Additionally, substance-using populations are known to have high rates of co-occurring mental health problems such as depression and PTSD (SAMHSA, 2015), which may reduce participant interest in ongoing contact with study staff (McCauley et al., 2012). Finally, participants often entered zones of unreachability, such as jails, prisons, and residential treatment centers, where cell phones are not usable. Cell phone and gift card compensation participants were both lost within these “zones of unreachability” as the implementation of the phone protocol was not able to remedy loss to follow-up when participants entered these settings for prolonged periods. Being able to communicate with study participants in these settings requires up-front agreements with the managers of these sites (e.g., release of information protocols). In large cities, the substantial number of such sites makes up-front agreements daunting for research studies to arrange.

Our study had several limitations. First, we recruited from a single inpatient facility in Massachusetts. This facility is a safety net hospital and by definition serves all patients regardless of ability to pay, which draws a population with low socioeconomic status. Our retention results may not be generalizable to PWIDs recruited from the community or in outpatient settings. Second, we used a particular set of retention techniques. Other investigators, using other incentives or strategies, such as going to the participants’ reported home address to find that person or using social media to contact participants, might have led to different findings.

Although this protocol required study staff to frequently suspend participant cell phone plans when the participant did not keep in contact and replace phones often when they were lost or stolen, the provision of cell phones allowed especially vulnerable participants to be retained at equal rates to a standard retention compensation plan and required a similar number of contact attempts (direct participant contact and alternative contacts) to retain them in the study. Homeless and unemployed individuals have been found to be the most difficult subgroup to track (Cottler et al., 1996; Davis et al., 2002; Scott, 2004; Young et al., 2006; Ziek et al., 1996) and therefore the near-equivalence in contact attempts between groups is striking because the cell phone cohort was significantly more likely to report homeless nights and significantly less likely to be employed either full-time or part-time.

In this urban sample of PWID, the provision of cell phones in place of traditional gift card compensation allowed an important segment of hospitalized PWID that would not have otherwise been eligible to participate in a longitudinal intervention study. We have offered the first step in how to expand recruitment of people who inject drugs regardless of their current contact information. Awareness of the effort spent in tracking and determining new ways to improve retention could inform future investigation with this vulnerable and transient population.

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Highlights

- Examined cell phones as compensation for injection drug using participants.
- Cell phones as compensation allowed inclusion of otherwise ineligible participants.
- May improve generalizability through recruitment of a more vulnerable subgroup.
- The cell phone and gift card compensation groups were retained at similar rates.
- Cell phone compensation may improve recruitment/retention in transient populations.

Table 1

Background Characteristics by Phone Status.

	<i>Mean (± SD) or n (%)</i>			
	Sample (n = 81)	Phone (n = 30)	Gift Card (n = 51)	(p =)^a
Age	38.4 (± 11.1)	40.6 (± 10.9)	37.1 (± 11.1)	.160
Gender (Female)	39 (45.7%)	20(66.7%)	24 (47.1%)	.109
Race/Ethnicity				
Caucasian	49 (60.5%)	15 (50.0%)	34 (66.7%)	.093
African-American	18 (22.2%)	11 (36.7%)	7 (13.7%)	
Hispanic	12 (14.8%)	4 (13.3%)	8 (15.7%)	
Other	2 (2.5%)	0 (00.0%)	2 (3.9%)	
Yrs. Education	11.8 (± 2.07)	11.4 (± 2.50)	12.1 (± 1.75)	.143
Any Homelessness	45 (55.6%)	26 (86.7%)	19 (37.3%)	< .001
Employed Part/Full Time	11 (13.9%)	1 (3.3%)	10 (20.4%)	.044
Caregiver for Child < 15	3 (3.7%)	0 (0.0%)	3 (5.9%)	.292
Primary Inj. Drug: Opiates	75 (92.6%)	26 (86.7%)	49 (96.1%)	.187
# Injections Past 90 Days	391.0 (± 481.7)	351.5 (± 291.0)	414.2 (± 566.3)	.926
# Incarcerations (Lifetime)	6.82(± 9.70)	9.93 (±13.8)	4.99 (± 5.50)	.208
Died During Assessment	6 (7.1%)	3 (9.1%)	3 (5.9%)	.675
Phone				
No Access	30 (35.7%)	30 (100.0%)	0 (0.0%)	< .001
Land Line Only	2 (2.3%)	0 (0.0%)	2 (3.9%)	
Cell Phone	19 (23.5%)	0 (0.0%)	19 (37.3%)	
Smart Phone	30 (37.1%)	0 (9.0%)	30 (58.8%)	

^aNonparametric Wilcoxon rank-sum z-test for differences in rank-ordered distributions or Fisher's exact p for differences in categorical background characteristics.

Table 2

Follow-Up Rates by Phone Status.

Assessment	Sample (n = 81)	Phone (n = 30)	Gift Card (n = 51)	(p =) ^a
Week 1	58 (71.6%)	21 (70.0%)	37 (72.6%)	.804
Month 1	40 (49.4%)	15 (50.0%)	25 (49.0%)	1.00
Month 3	43 (50.6%)	15 (50.0%)	26 (51.0%)	1.00
Month 6	30 (37.0%)	13 (43.3%)	17 (33.3%)	.476
Month 9	35 (43.2%)	14 (46.7%)	21 (41.2%)	.650
Month 12	45 (55.6%)	13 (43.3%)	32 (62.8%)	.108
Attended 1+ Assessments	70 (86.4%)	25 (83.3%)	45 (88.3%)	.525

^aFisher's exact p.

Table 3

Reasons for Missing Assessments by Receiving a Phone or a Gift Card – total number of missed assessments within each category

		Received	
	Sample	Phone	Gift Card
Could Not Reach Participant	133 (56.1%)	49 (55.1%)	84 (56.8%)
Spoke w Participant (Timed Out)	32 (13.5%)	9 (10.1%)	23 (15.5%)
Hospitalized	4 (1.7%)	0 (0.0%)	4 (2.7%)
Residential Treatment	10 (4.2%)	3 (3.4%)	7 (4.7%)
Moved	5 (2.1%)	3 (3.4%)	2 (1.4%)
Incarcerated	20 (8.4%)	12 (13.5%)	8 (5.4%)
Deceased	17 (7.2%)	7 (7.9%)	10 (6.8%)
Withdrew	15 (6.3%)	6 (6.7%)	9 (6.1%)
Refused	1 (0.4%)	0 (0.0%)	1 (0.7%)
Total Missed Assessments	237 (100.0%)	89 (100.0%)	148 (100.0%)