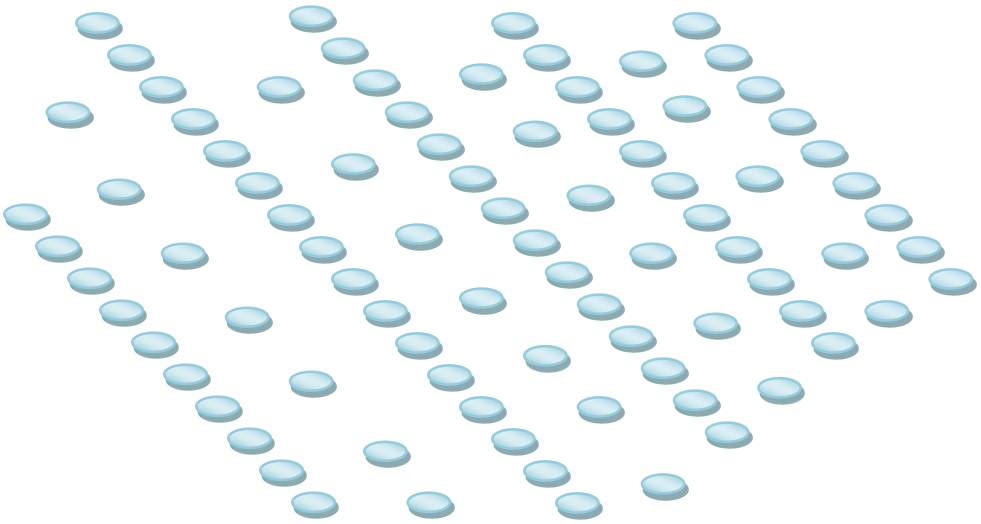
Appointment Procedures

NYLinks Implementation Manual



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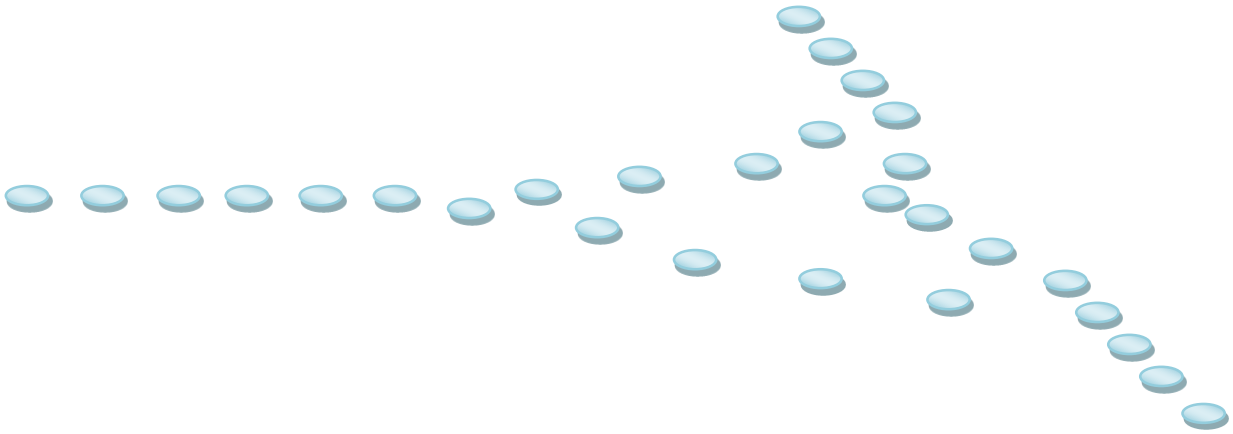
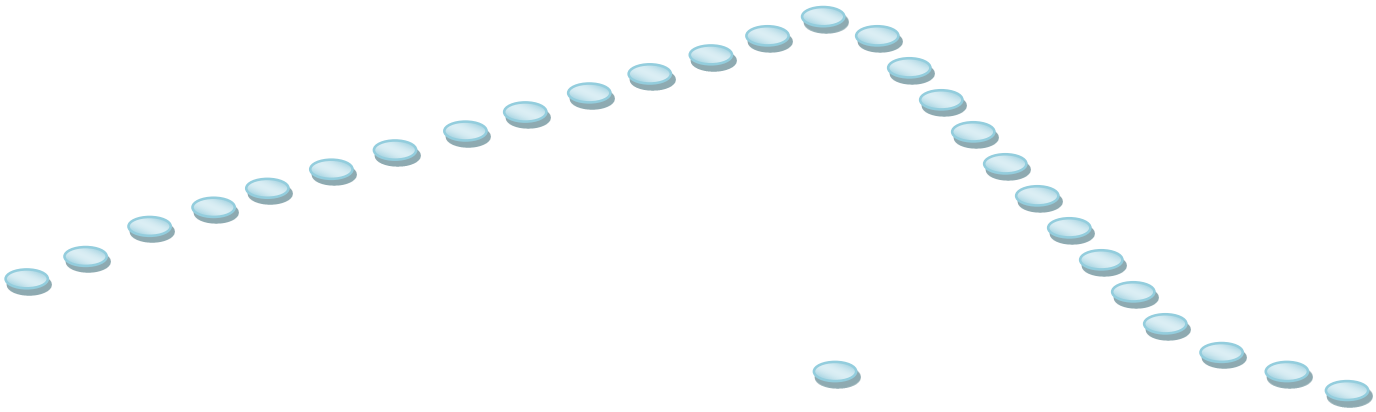


Table of Contents



A. What is the NYLinks Appointment Procedures intervention?

The NYLinks Appointment Procedures intervention focuses on implementing systematic and targeted appointment reminders and other processes related to helping patients keep their medical appointments and helping facilities follow-up after missed medical appointments. The intervention utilizes a number of mechanisms and approaches, and can even be implemented at agencies that have some form of appointment reminders already in place. Appointment procedures serve to: a) alert patients of their upcoming appointments in order to reduce no-show rates and retain patients in HIV care; and b) provide follow-up if a patient misses an appointment. Reminders of upcoming appointments are systematically and consistently sent to all patients via their preferred method of delivery (home phone, cell phone, SMS, email, etc). Likewise, follow-up communication for missed appointments is systematically sent to patients who have missed appointments. These communications can occur via an automated system, electronically or using human resources (staff, volunteers, interns). Follow-up for missed appointments occurs for up to five working days or until the patient schedules another appointment. For the purpose of this intervention, appointments referenced are medical appointments with a practitioner who has prescribing privileges.

B. Target population

All HIV-infected patients. However, if resources are limited, efforts may be focused based on frequency of patient no-show, disease status, recent laboratory results (e.g., low CD4 or high viral load), the timing of the most recent visit and other barriers that put the patient at higher risk for missing appointments.

C. Core elements of the intervention

This section describes the essential components of the intervention. The core elements are critical to the success of the intervention and must be implemented exactly as designed. If one or more of the core elements is altered or dropped, the intervention will be compromised, resulting in reduced effectiveness of the intervention.

It is important to take into consideration the policies and procedures related to patient contact that may already exist within the organization. All cases where there are conflicts between these policies and procedures and the core components should be looked at to see whether or not adaptation to policies and procedures is possible.
The core elements of the NYLinks Appointment Procedures intervention are as follows:

I) Appointment Reminders

A) Patient contact information and preferred communication method is up-to-date

- Confirm or update the contact information on a regular basis or at each visit for all HIV-infected patients with upcoming medical appointments. Allow patients the option to include information for a secondary contact, i.e., family member, friend.

- Up-to-date patient contact information, including patient name, phone number(s), mailing address(es)
- Up-to-date confirmation of patient's preferred method of contact, including phone, email, sms, standard mail, alternate contact, relative, friend, etc.
- If the contact information or the preferred method of contact is not up-to-date, take steps to confirm or update the patient's contact information and preferred method of contact

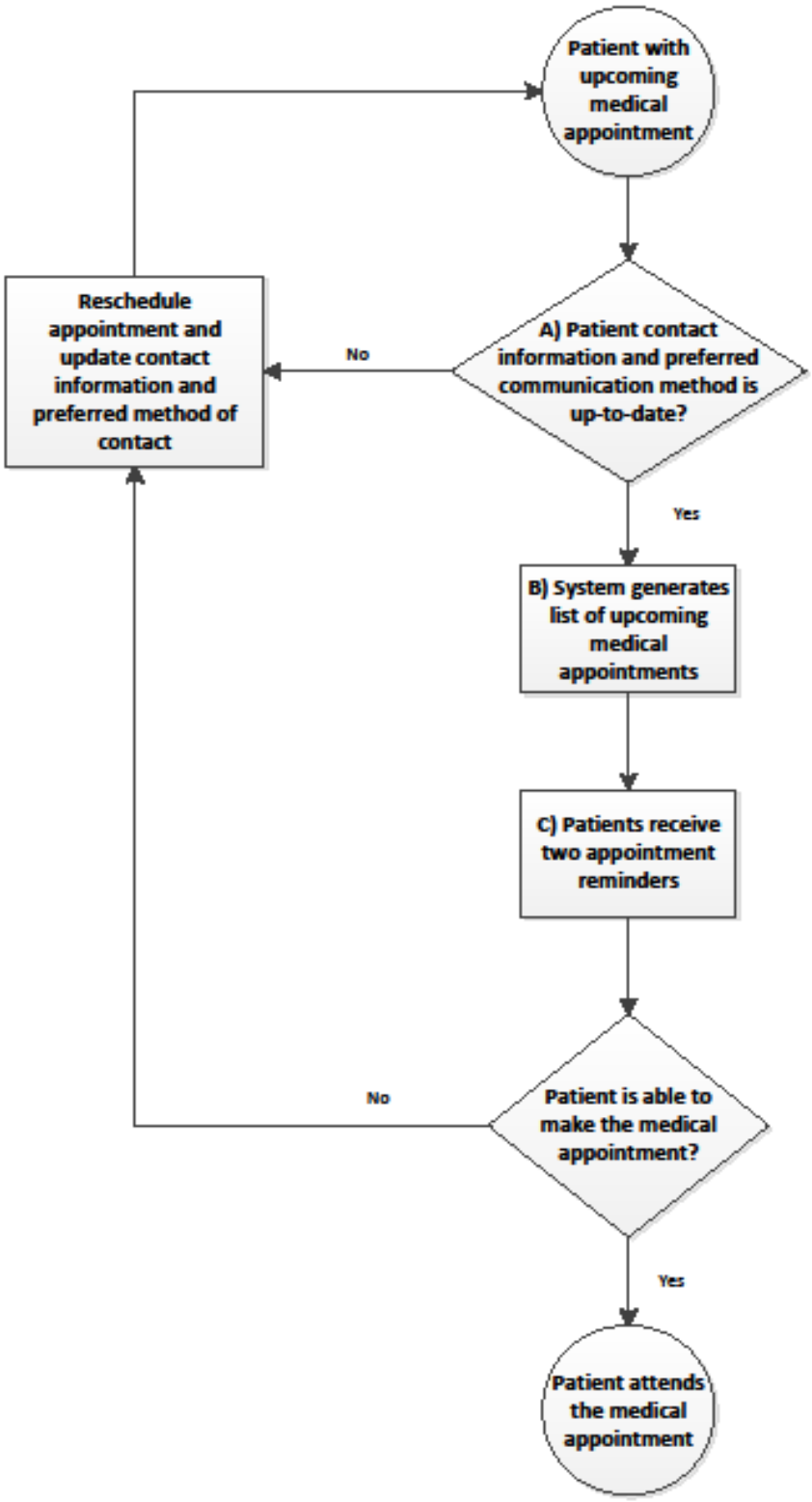
B) System generates list of upcoming medical appointments

- Generate regular lists of HIV-infected patients with upcoming medical appointments . These lists will be used in making reminder calls or loading names into an automated call system. At a minimum the list should include: patient name, preferred method of contact, phone number, date of appointment.

C) Patients receive two appointment reminders

- Provide each patient with at least two reminders of upcoming medical appointments; No more than 5 business days in advance of the appointment and then 1-2 business days prior to the appointment. The frequency and timing of these reminders will be determined by the program and consistent for all patients.
  - Reminder messages include a message concerning whom to call within the organization in case the appointment needs to be rescheduled
  - Reminder messages include a statement about the importance of keeping up with medical appointments to patient's health
  - If the patient is not able to make the medical appointment, assist the patient with rescheduling appointments

The flowchart on the next page illustrates the necessary steps to remind HIV-infected patients about their upcoming medical appointments:



II. Missed Appointment Follow-up

A) System generates list of patients with missed medical appointments

- Generate daily lists of patients who missed their medical appointments

B) Patient contact information and preferred communication method is up-to-date

- Confirm or update the contact information for HIV-infected patients who missed their medical appointments. Allow patients the option to include information for a secondary contact, i.e., family member, friend.
  - Up-to-date patient contact information, including patient name, phone number(s), mailing address(es)
  - Up-to-date confirmation of patient's preferred method of contact, including phone, mailing, friend, etc.

C) Reach out to patients with missed medical appointment

- When a patient misses an appointment, daily contact attempts are made to the patient for five working days or until the patient reschedules an appointment
  - Include a statement about the importance of keeping up with medical appointments to patient's health
  - Include a message concerning whom to call within the organization to make an appointment

D) If a patient is reached within the five working days a medical appointment should be made for that day or the next if at all possible.

E) If a patient can not be reached after five working days of daily contact attempts:

- Document efforts used to reach the patient—case file, EMR, health record, etc.
- Conduct internet-based searches for persons whose address may have changed
- Contact outreach staff, if they exist, to try to locate the patient.

D. Adaptable elements of the intervention

Unlike the core elements of an intervention which must be implemented exactly as designed, adaptable elements are activities and delivery methods that are optional and can be tailored to meet the specific needs of an agency without compromising the integrity of the intervention.

The adaptable elements of the NYLinks Appointment Procedures intervention are as follows:

Appointment Reminders

- The staff representatives who conduct the appointment reminders may vary.
- Agencies with enough IT infrastructures may want to consider automated reminder procedures for some of the reminder processes above.
- Staff may meet with patients in order to try to remove barriers to keeping appointments such as lack of transportation or need for peer support.

E. Length of time the intervention is delivered to each client

- *Appointment Reminders:* ongoing for each appointment
- *Missed Appointment Follow-up:* daily contact attempts for up to five working days from the missed appointment or until the patient reschedules the appointment

F. Staffing requirements/roles and responsibilities

Patient Enrollment: general administrative staff involved in patient consent processes
Patient Contact Information Confirmation: general administrative staff, case manager, patient navigator or anyone else involved in checking-in patients or patient registration
Appointment Reminders: general administrative staff, automated calls, social workers, care team members (case managers, physicians, nurses, patient navigators, etc.)
Missed Appointment Follow-up: general administrative staff, automated calls, social workers, care team members (case managers, physicians, nurses, patient navigators, etc.)

G. Staff training

Staff training will be necessary in the following areas:

1. How to identify patients with upcoming appointments and patients with missed appointments and generate lists for use in making reminder and follow-up calls.
2. Data systems related to automated calls (if automated calls are used).
3. How to locate people using internet resources.
4. How to document the results of reminder calls.
5. How to maintain the Referrals/Appointments tracking log with information on follow-up call activities and results.
6. Delivery of affirming reminder and follow-up messages.
7. Patient/healthcare confidentiality.
8. Client re-engagement and outreach strategies.

H. Resources required for implementing the intervention

Resources required for the implementation of this intervention mostly revolve around staff time and effort.

1. Training time to orient staff to procedures, tools, and how to collect process measures.
2. Staff time to:
    - inform the patient of this procedure through the consenting and re-consenting process.
    - Create lists (or generate reports of) of upcoming and missed appointments
    - Make reminder calls, and locate clients with inaccurate contact
3. Materials and/or funding to provide written appointment reminders, transportation for home visits.

Optional – subscription to an automated call system to make the reminder and follow-up calls. Training on how to manage the automated calling system is required if a subscription for such a system is purchased.

I. Implementation

Prior to implementing this intervention the following requisites are needed:

- Adequate data systems need to be in place to
  - frequently generate the necessary patient lists
  - track the necessary patient data fields, such as preferred communication method
  - track patient appointments over time

Patient Enrollment

- Revise enrollment processes to include a one-sentence description of the appointment procedure process to inform patients and set expectations
- All new patients understand the appointment procedure process

Patient Contact Information

- Establish a process where patients can confirm/update their contact information at each visit
- Establish a mechanism by which patients can confirm or update their preferred method of contact at each visit

Appointment Reminders

- Provide the patient with reminders of upcoming appointments in the following ways:
  - At the moment a medical care appointment is scheduled, make sure the patient is aware of the date and time in writing
  - Patients receive two reminders by preferred contact method (home phone, cell phone, SMS, email) prior to each scheduled appointment:
    - Five business days prior to the scheduled appointment
    - One business day prior to the scheduled appointment
- Ensure patient has relevant resources to attend the appointment (e.g., transportation, accompaniment)
- Log an entry for each appointment scheduled such that patients with multiple appointments in a measurement period will appear more than once in the tracking tool for that period
- Assist with rescheduling of appointments when necessary
  - If the appointment is rescheduled and is within 48 hours of the date of contact, an appointment reminder is at the discretion of the provider. No record is created in the tracking tool
  - If the appointment is rescheduled and will occur in more than 48 hours from the date of contact, the provider should log an entry in the tracking tool for the scheduled appointment and conduct two reminder calls as per the core elements of the intervention
- Document result of reminder call
  - Patient confirms appointment
  - Patient reschedules appointment
  - Patient not reached

- Message left (The point of attempted contact is to speak with the patient and not to leave a message so while this may need to be captured it does not end the contact attempt process)
- Message left (The point of attempted contact is to speak with the patient and not to leave a message so while this may need to be captured it does not end the contact attempt process)

Missed Appointment Follow-up:

- Assist with scheduling and rescheduling of appointments when necessary
  - Staff informs the patient what to do if they cannot make an appointment. This advice will de-stigmatize the issue of missed appointments and will put tools in the patient's hand and will set their expectations. (e.g., "we understand that things come up and that you might not be able to make a scheduled visit for some reason. The most important thing is that you call this number and reschedule right away. Also, if you miss a visit, you might get a call from us.")
- When a patient misses an appointment:
  - The missed appointment will be documented on the Appointments Procedures Tracking tool (Appendix A)
  - Subsequent contact to the last listed address are not warranted if it becomes apparent that the patient has permanently moved; transferred care; died; or is no longer interested in services from the organization
  - Daily contact attempts are made to the patient starting the day of the missed appointment
  - Contact attempts should be made at different times of the day to better make contact with patient for up to five working days or until the patient schedules another appointment
- Conduct internet-based searches for persons whose address may have changed:
  - After five working days of calls.
  - Internet searches may be warranted at any point where phone and other efforts seem unproductive.
- Possible internet resources include, but are not limited to:
  - http://a072-web.nyc.gov/inmatelookup/
  - http://nysdoccslookup.doccs.ny.gov/
  - http://www.411.com/
  - http:// DeathIndexes.com
  - http://www.intelius.com/
  - http://vitalrec.com/
  - http://ssdi.rootsweb.ancestry.com/
  - http://www.lexisnexis.com/terms/privacy/data/people.asp
  - http://www.zabasearch.com/
- Document all patient re-engagement activities on the Referrals/Appointments Tracking Log

J. Data to be Routinely Collected and Reported

Process measures

Process measurements are an assessment of intervention related activity connected to a desired outcome. This type of measure involves basic counts of intervention related procedures. For example, the number of patients who were referred to a program, the number of staff trained etc. Process measures are used to identify areas where improvements can be made during implementation of an intervention or as a tool in on-going monitoring of an intervention. The NY Links team has developed process measures that will be used in the statewide evaluation of this intervention. A data collection tool has been developed to aid providers to systematically track process measure information (Appendix A). This tracking tool should serve as a guide and is not required to be used as long as the provider has an alternative tracking method in place. The tracking tool is designed to be used electronically but may be printed for manual record keeping. All providers implementing this intervention will be expected to collect and report process measure data to the NY Links evaluation team on a monthly basis. Data should be reported by the 15th day of each month (or the next business day if the 15th falls on a weekend). Providers should develop a schedule to perform routine quality assurance on the data to ensure that information is being collected and recorded accurately and frequently.

The following naming convention may be used for the log in Appendix A to track process measures monthly.
Filename: Appointment procedures tracking tool_MMYYYY.xls
where MMYYYY represents the 2-digit month and 4-digit year of the data contained in the file.

The Appointment Procedures intervention may span more than one monthly reporting period. For example, a patient may become eligible for the intervention at the end of a calendar month and would require tracking into the next month. The tracking tool is intended to be a dynamic roster of patients. Therefore, patient information for persons without a contact disposition outcome should be carried from one monthly tracking period to the next until a contact outcome disposition is achieved or until the end of the two-week intervention period.

Aggregate process measure data will primarily be used in the statewide and multi-state evaluation. In order for providers to report aggregate data to the NY Links team, process measure data should be collected and recorded for each patient affected by the intervention and then aggregated as a total for all patients every month. For example, whether or not a patient missed an appointment would be aggregated into the total number of patients with missed appointments. This would be recorded along with the total number of patients with scheduled appointments during that month.

Many of the patient-level data elements for the process measures described below may already be routinely collected by providers. These include patient name, unique patient identifier and the date the patient came in for a service. Although patient-level data will not be reported to the NY Links evaluation team, all data elements that would need to be tracked to accurately report aggregate process measure data is provided below. Optional data elements are also suggested for providers who are interested in gathering additional information for their intervention. **No patient identifiers should be included in any aggregate data process measure report that is sent electronically to the NY Links evaluation team.** The following data

elements will need to be collected *each month* to create process measures for the Appointment Procedures intervention:

Patient-level data elements:

- Patient name (unique identifier)
- Appointment date
- Date of first reminder call/contact
- Date of second reminder call/contact
- Total number of reminder calls/contacts

For patients with missed appointments, patient level data to collect are:

- Date of missed appointment
- Date and type of first and last call/contact
- Total number of calls/contacts made
- Contact status (i.e., contacted, contact not attempted, unable to locate during the intervention period)
- Outcome (i.e., appointment rescheduled, refused any care, referred elsewhere)
- Date of rescheduled appointment

Aggregate data elements:

- Total number of patients with a scheduled appointment
- Total number of appointments
- Total number of appointments with two or more calls/contacts
- Total number of patients with missed appointments
- Total number receiving any contact
- Total number of patients with a rescheduled visit

Outcome measures

Outcome measures are used to evaluate the results of the intervention. They also help to identify whether current activities, processes and procedures are working to create the desired outcomes. The NY Links evaluation team will be using NYC and NYS HIV surveillance data to monitor the outcome and impact of implemented interventions on linkage, retention and viral load suppression across the state. Surveillance data will not be available to individual programs to assess the impact of the intervention at their facility. Although not required to be reported as part of the NY Links evaluation, it is highly recommended that providers collect outcome measures to assess whether the changes implemented have resulted in improved outcomes. Please note that one patient with multiple appointments during the month may be counted more than once.

Here is a suggested list of data elements to construct outcome measures that can be used to monitor the progress and success of this intervention *each month*:

Patient-level data elements:

- Did patient keep appointment, if not
- Was patient contacted?
- Was the appointment rescheduled?

Aggregate data elements:

- Total number of patients with scheduled appointments
- Total number of patients with kept appointments
- Total number of patients with missed appointments
- Total number of patients with missed appointments that were rescheduled

Calculations possible from the aggregate data elements:

Percent of patients with missed appointments = 100 X (Total No. of patients w/missed appointments ÷ Total No. of patients with a scheduled appointments)
Percent of patients with missed appointments that were rescheduled = 100*(Total No. of patients w/missed appointments that were rescheduled ÷ Total No. of patients w/missed appointments)

K. Assessing fidelity to the intervention

In program evaluation, fidelity examines the extent to which an intervention is conducted as it was originally designed. Monitoring fidelity ensures that specific elements of an intervention are implemented according to protocol. This maximizes the effectiveness of the intervention and the likelihood of seeing the desired outcome.

To monitor the fidelity of the Appointment Procedures intervention, the NY Links staff will conduct 2-3 site visits. The first visit will occur shortly after implementation of the intervention to help identify if the core components are being implemented or delivered as planned. This will allow for early corrections and improvements to be made if it is found that a provider has deviated from the essential elements of the intervention. An additional session or two will be conducted to assess if fidelity is maintained over time. This is essentially a time where technical assistance can be provided to any implementation site that needs it.

Fidelity will be assessed through the following methods:
For persons with scheduled appointments, NY Links staff will determine if:
1) All patients received two calls prior to their appointment date
2) The number of attempts made to reach patients with missed appointments using other modes of communication is recorded

NY Links staff can review the agency's tracking tool with implementing staff to assess fidelity of the intervention. For example, tracking logs can be reviewed to determine if patients are receiving the appropriate number of appointment reminders using the patient's preferred method of contact. For patients with missed appointments, the tracking log can be used to determine if the patient is receiving the appropriate contact follow-up. For example, for

patients with missed appointments the dates of the first and last contact attempt combined with the total number of attempts show that patient contact was attempted for up to five days.

L. Acronyms and key definitions

NYC DOHMH – New York City Department of Mental Health and Hygiene
NYS DOH – New York State Department of Health
PLWHA – People living with HIV/AIDS
SMS – Text messaging

M. NYLinks staff contact information

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N. References

- NYC Department of Health and Mental Hygiene, Bureau of HIV/AIDS Prevention and Control, Care, Treatment, and Housing Program. Care Coordination Manual. Updated May 2013
- Van Velthoven et al. Scope and effectiveness of mobile phone messaging for HIV/AIDS care: A systematic review. Psychology, Health & Medicine. 2013. 18(2):182-202
- Perron et al. Reduction of missed appointments at an urban primary care clinic: a randomized controlled study. BMC Fam Pract. 2010 Oct 25, 11:79
- Kliner et al. Using no-cost mobile phone reminders to improve attendance for HIV test results: A pilot study in rural Swaziland. Infect Dis Poverty 2013, June 14; 2(1): 12
- Hahim et al. Effectiveness of telephone reminders in improving rate of appointments kept at an outpatient clinic: A randomized control trial. J A Board Fam Prac. 3, 2001,pp 193-196

O. Appendices

Appendix A. Appointments Procedures tracking tool
Appendix B. Readiness Assessment Tool