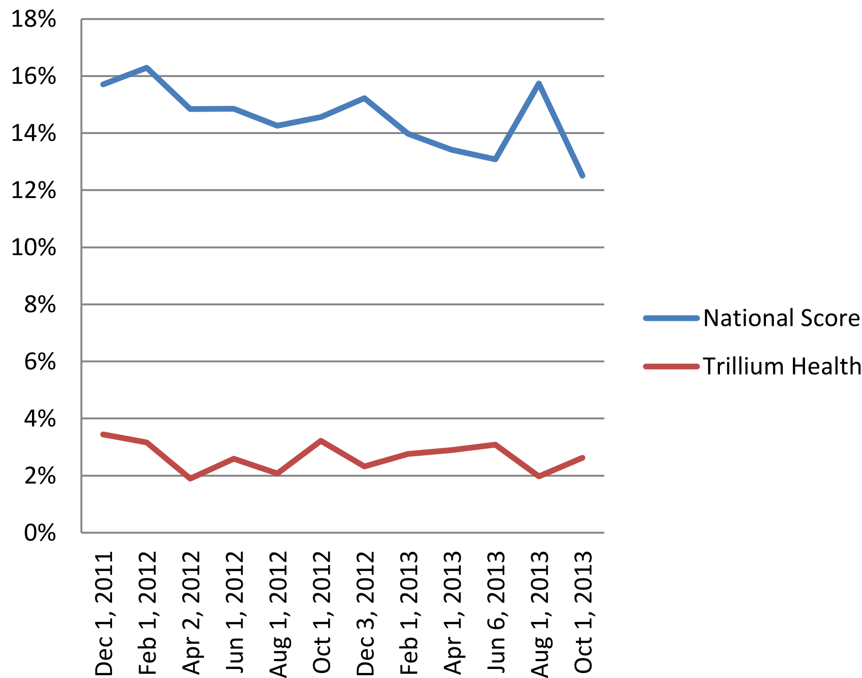
Linkage and Retention Update

December 4, 2013

Sharing Results with Stakeholders

- Board update every quarter
  - all 4 In+Care measures
  - Consumer representative on the Board
- Funders
  - AI Site visits
  - RW Site visit

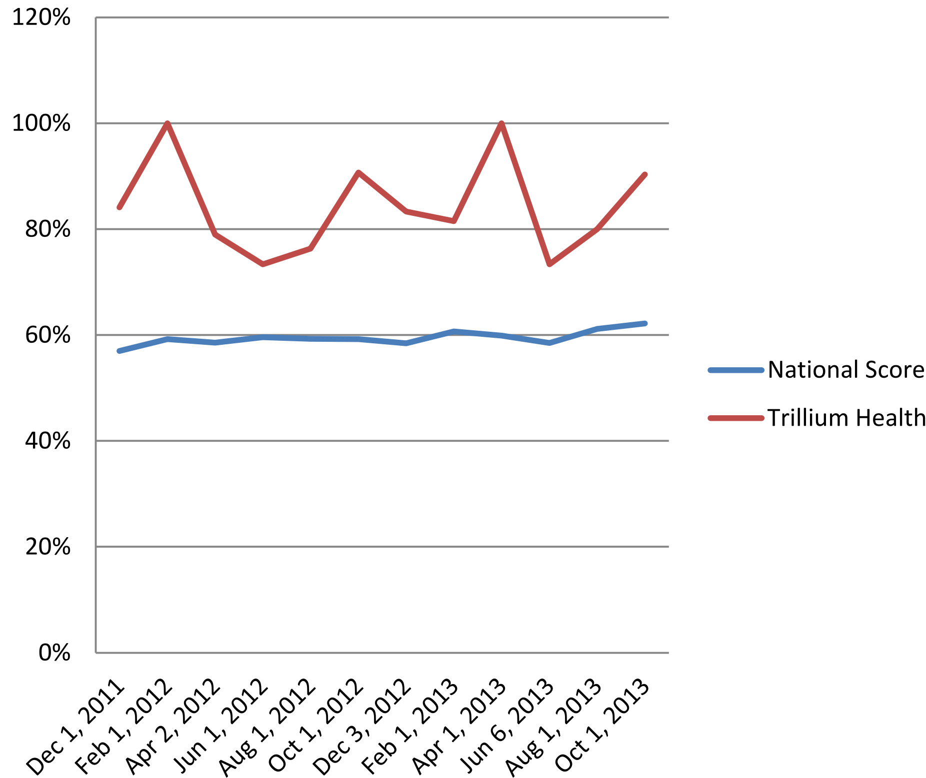
Clinic Outcome Measure



Gap Measure: % of HIV patients, regardless of age, who did not have a medical visit with a provider with prescribing privileges in the last 180 days of the measurement year

Data submitted bimonthly to a national database

Clinic Outcome Measure

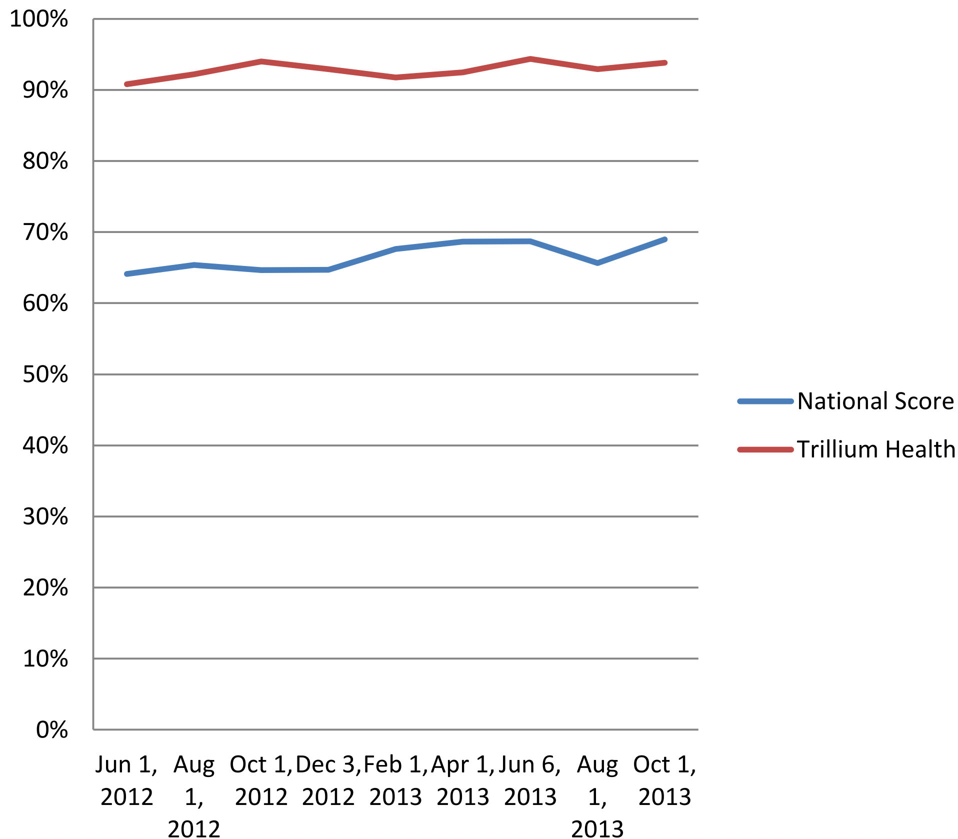


Patients Newly Enrolled in Medical Care: % of HIV pts, regardless of age, who were newly enrolled with a medical provider with prescribing privileges who had a medical visit in each of the 4-month periods in the measurement year

Note: The reason for the variability in the Trillium result is due to the small number of patients in the denominator.

Data submitted bimonthly to a national database

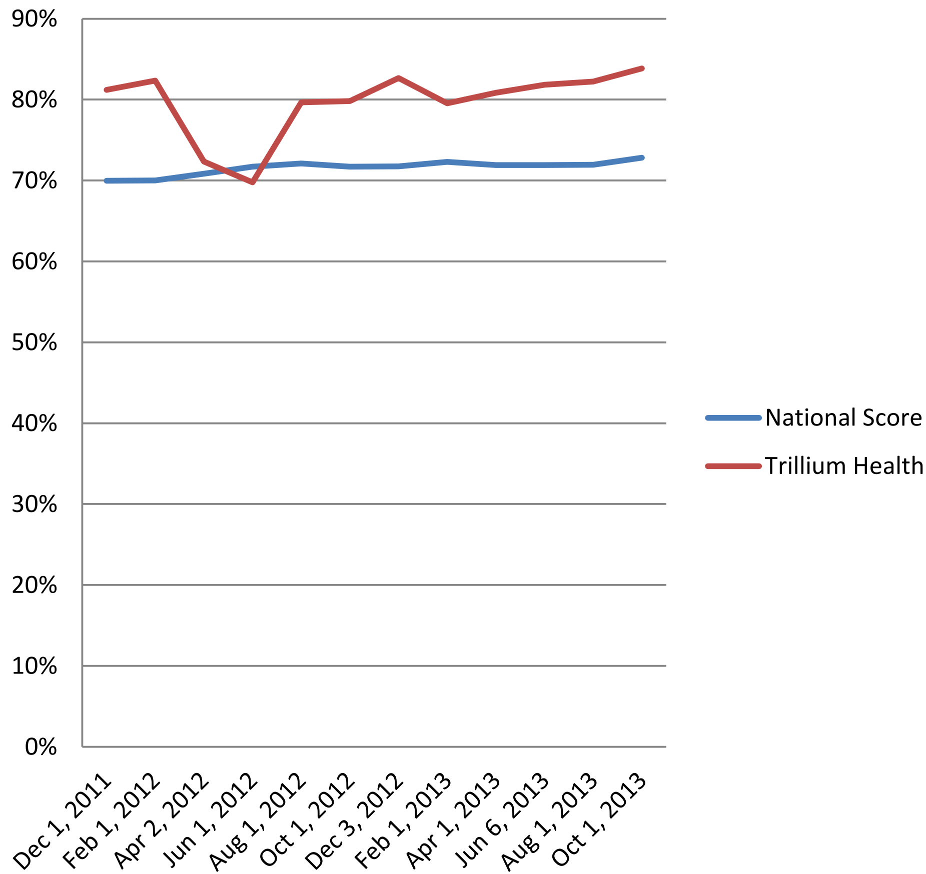
Clinic Outcome Measure



Medical Visit Frequency: % of HIV pts, regardless of age, who had at least one medical visit with a provider with prescribing privileges in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits

Data submitted bimonthly to a national database

Clinic Outcome Measure



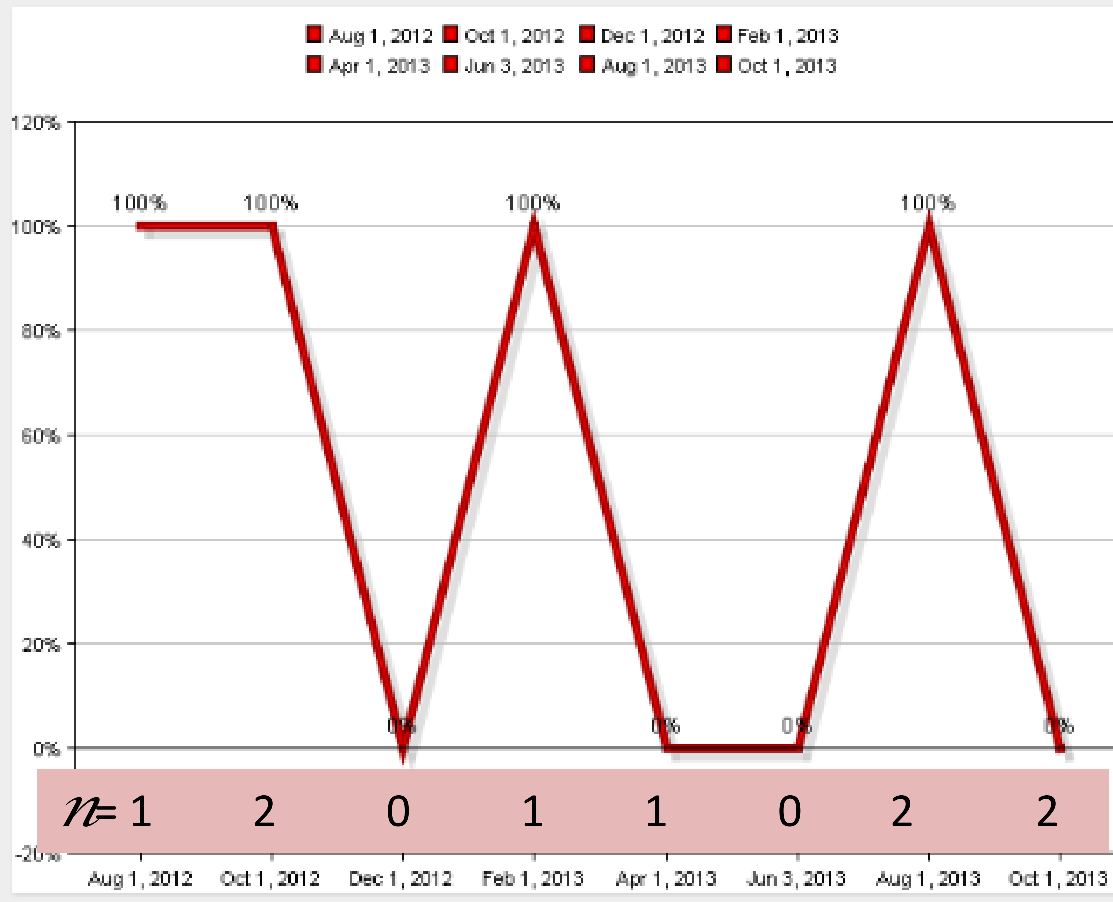
Viral Load Suppression: % of HIV pts, regardless of age, with a viral load less than 200 copies/mL at last viral load test during the measurement year

Data submitted bimonthly to a national database

in care

NYLinks

Linkage to Care



Engagement- the "funky outliers"

- One had labs drawn but no-showed for the new patient appointment. COS and CHI are pursuing him.
- The other has just sort-of vanished.
- Next submission (12/2/13) is 0%, an n = 1.
- A college student out in Geneseo who wanted to work with his own PCP. MCDPH (Kim Smith) verified that he did link to care- but not within thirty days.

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Improvement Project Goal

- To develop the role and use of Community Outreach Specialist as a member of the Care Management department to re-engage patients not retained and lost to care. The COS position, which began March 2012, is a bridge between Front Office staff, Care Managers, Community Health Initiatives staff and the Community
- Target Population: lost-to-care patients identified by Front Office staff, from monthly census (pts not seen in 6 months), or at daily morning huddle.

Outreach – Re-engagement – Lost-to-care Process

Pt misses 2 consecutive appts and has not been seen in >4 months

Front Office notifies Community Outreach Specialist

COS coordinates outreach and reengagement efforts

COS documents efforts on EMR flowsheet

COS triages case to assign resources

Regular Communication with CM FO and CHI (Newly dx'd)

Communicate with MCHD if referred from MCHD, if pt has STD or if pt is newly diagnosed

Is Patient "at risk" or in need of urgent f/u?

No

Yes

Does pt have a relationship with peer program?

Yes

No

COS uses phone contact, letters, outreach to home or known locations pt frequents

Is patient located?

No

Yes

Refer to Community Health Initiatives

Can CHI be helpful?

Yes

No

Weekly Interdisciplinary Team Meeting

After 4 attempts

Assign pt's case to LGBT program, Minority AIDS Initiative program or Community Outreach Worker based on individualized need assessment

Is patient located?

No

Yes

After 9 months without an appointment chart is closed by CM

COS assesses barriers, arranges transportation, refers to CM if necessary, sets up next appointment

Is patient re-engaged?

Yes

No

End

Provide referral, assistance or appropriate follow up

End

There is 1 Community Outreach Specialist in the Care Management dept. She takes the lead in the Lost-to-Care and Re-engagement process

CHI or Community Health Initiatives is a large department with many programs including peer and outreach. They are often in the community in homeless shelters or the Mobil Unit van and therefore have a wide network for locating patients.

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Outreach Results

- 14 referrals for patient retention
  - 5 are in current "open" status (still searching for them)
  - 1 has scheduled an appointment (still waiting to see if he's going to come)
  - 6 are Re-engaged
  - 2 transferred services
  - 0 have been "unable to locate"

Outreach changes

- One COS was promoted to CM, therefore there is only one person in this position
- Our Health Homes Care Management has an outreach component
- Improved Care Management reassessment has improved re-engagement without need for COS

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Other changes

- The weekly Clinical Care Management meeting was replaced with 2 types of meetings
- Morning Huddle
  - all Clinical and representative CM staff
  - Anyone can bring up retention concerns
- Friday Interdisciplinary Meeting -2 agenda items
  - retention
  - complex cases

Friday Interdisciplinary Meeting

Clinical Meeting Patient Retention 12/06/2013

Patient: CM: Provider: Last Visit: Number of missed Visits:	Action plan:	Last Note:
Patient: CM: Provider: Last Visit: Number of missed Visits:	Action plan:	Last Note:

- COS (Community Outreach Specialist) provides updates on patients with active referrals
- Address barriers that have been discovered
- Team shares information regarding patient to be shared that could be useful (i.e. favorite hangout, friends , previous address).
- CHI is a part of this meeting too and are able to provide updates on the individuals they follow.

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Daily Morning Huddle

- Began May 2013
- 15 minutes at 8:45 AM
- Facilitated by nursing
- Attended by providers, treatment adherence, care management, behavioral wellness, dietitian, Pharm D, front office

Continued

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Daily Morning Huddle

- Every day each provider/clinician receives an automatically generated e-mail with pre-planning information for patients on their next day schedule
- A report based on the rules is run for each patient scheduled to come in that day to identify needed labs or procedures
- The report also includes recent log notes that might identify problems with insurance, housing, transportation or missed appointments

Patient Name

Gender Identity flowsheet – new and needs to be populated

Indentifies as: PLEASE FILL OUT DEMOGRAPHICS FLOWSHEET

Last BMI: 18.2454

Offer patient portal access

Portal Patient: Not a Portal User

Identify patients needing intervention

For date: 8/22/2013

Last Viral Load: <40 (Copies/mL)

Last CD4 Count: 1215 (/uL)

Last HgbA1c:

APPOINTMENTS FOR: 8/22/2013

Provider	Appointment Type	Reason	Time
Mancenido, Michael D.	Established	Follow Up 30 min	**11:00 AM**
Dean, Grace M	Estab	Nutrition Follow Up	**1:30 PM**
Hurley, Christine	Estab	ACTG 30	**11:30 AM**

This patient has multiple appts today. List helps with tracking that all appts are kept

PATIENT RULES:

Overdue | Coming Due

Last Test Date	Due Date	Rule
9/18/2012 3:16:03 PM	12/18/2012	Comprehensive Metabolic Panel every 3 months
9/18/2012 3:16:04 PM	12/18/2012	CBC once a year for patients with Hypertension
9/18/2012 3:16:04 PM	12/18/2012	CBC with Diff every 3 months in HIV patients
9/18/2012 3:16:04 PM	12/18/2012	CD4 every 3 months for HIV patients
9/18/2012 3:16:04 PM	12/18/2012	Viral Load every 3 months for HIV patients
	8/22/2013	EKG for all patients with HTN, once if not previusly performed
	8/22/2013	TETANUS / DIPHTHERIA required every 10 years for all adult patients
	8/22/2013	Urine creatinine once a year for all patients with HTN
	8/22/2013	Urine microalbumin once a year for all patients with HTN
9/18/2012 3:16:04 PM	9/18/2013	CBC with Diff once a year

This table is based on rules in the EMR established for pt based on dx, gender, age

This report is run for all scheduled patients the day before their visit. It is used at the huddle to prepare for actions to be taken.

Continued next page

Continuation of previous page. Three most recent log notes are printed out.

This may help identify recent concerns a well as missed appointments.

RECENT LOG NOTES:

Note Date Created	TEXT
8/6/2013 10:06:08 AM	P: spend down I: CM sent receipts to Medicaid team 40 in amount of $309 to meet spend down for
7/24/2013 2:10:00 PM	Patient left a voice mail regarding her home-delivered meals stopping. Writer tried to contact patie
7/23/2013 12:14:34 PM	Writer called the patient and left a message to contact our office and reschedule missed appt. with

Next Steps – Enhancing the Patient Experience

- The patient plan for each patient scheduled is printed out the day before the appointment
- Patient is engaged in med reconciliation and updating demographics
- Patient is encouraged to jot down questions for the provider
- Timely information is added as needed, ex., "Time to get your flu shot", as a way to communicate with all patients in the clinic.

Patient Plan

Patients are given their plan at check-in. They are asked to review the med list, complete demographics and think about questions they want to ask their provider.

APPOINTMENTS FOR: 11/13/2013

Provider	Appointment Type	Reason	Time
Schaefer, William J.	Established	CD 4 Monitoring Visit 20 Min	2:00 PM
Nurse	Established	Pain Assessment (Intial)	1:30 PM

List all appointments

MEDICATIONS:

Brand	Dose
Celexa	40mg Tablet
Gabapentin	600mg Tablet
Isentress	400mg Tablet
Loratadine	10mg Tablet
Lorazepam	1mg Tablet
Methocarbamol	750mg Tablet
Norvir	100mg Tablet
Oxycodone/Acetamin	10mg/325mg Tablet
Premarin	0.625mg Tablets
Prezista	800mg Tablet
Singulair	10mg Tablet

ALLERGIES:

Allergy	Effect
Latex	Moderate
Penicillins	Moderate abdominal pain, rash

List meds and allergies

PLEASE CONFIRM THE FOLLOWING INFORMATION.....	On File	Correct?
Legal Gender (**Male / Female**)	F	
Gender Identity (**Male / Female / Transgender / Gender Queer / Other**)	<NONE>	
Sexual Orientation (**Heterosexual / Gay / Lesbian / Bisexual**)	<NONE>	
Are you transgender? (**NO / M->F / F->M**)	<NONE>	
Who is your Primary Care Physician?	<NONE>	

Patient asked to add missing demographics and confirm information

What would you like to discuss with your Provider today?

Provider Notes

Patient can write questions to prepare for the visit

*** Please Return Pass to Front Desk BEFORE Leaving ***