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The Community Outreach Specialist's role in re-engaging patients

AIDS Care/Care Management

June 26, 2013

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Background

- AIDS Care's journey to improve retention in care began in January 2009 as an identified need in the redesign of our weekly Case Management (interdisciplinary) meeting
- By the time we started submitting data to In+Care, we had respectable retention results (our baseline):
  - Gap Measure – 3.44%
  - Medical visit frequency – 90.8%

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Background

- Our “Patients newly enrolled in care” measure was a less desirable 84%, but a causal analysis revealed that in most cases there was a reasonable explanation for the gaps in care.
- With no expectation of improving on the 90.8% medical visit rate, we continued to improve the quality of our response to “lost-to-care” patients.

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Improvement Project Goal

- To develop the role and use of Community Outreach Specialists as members 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 and Community Health Initiatives staff.
- Target Population: lost-to-care patients identified by Front Office staff or in weekly Care Management meeting

Improvement Project Team Members

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

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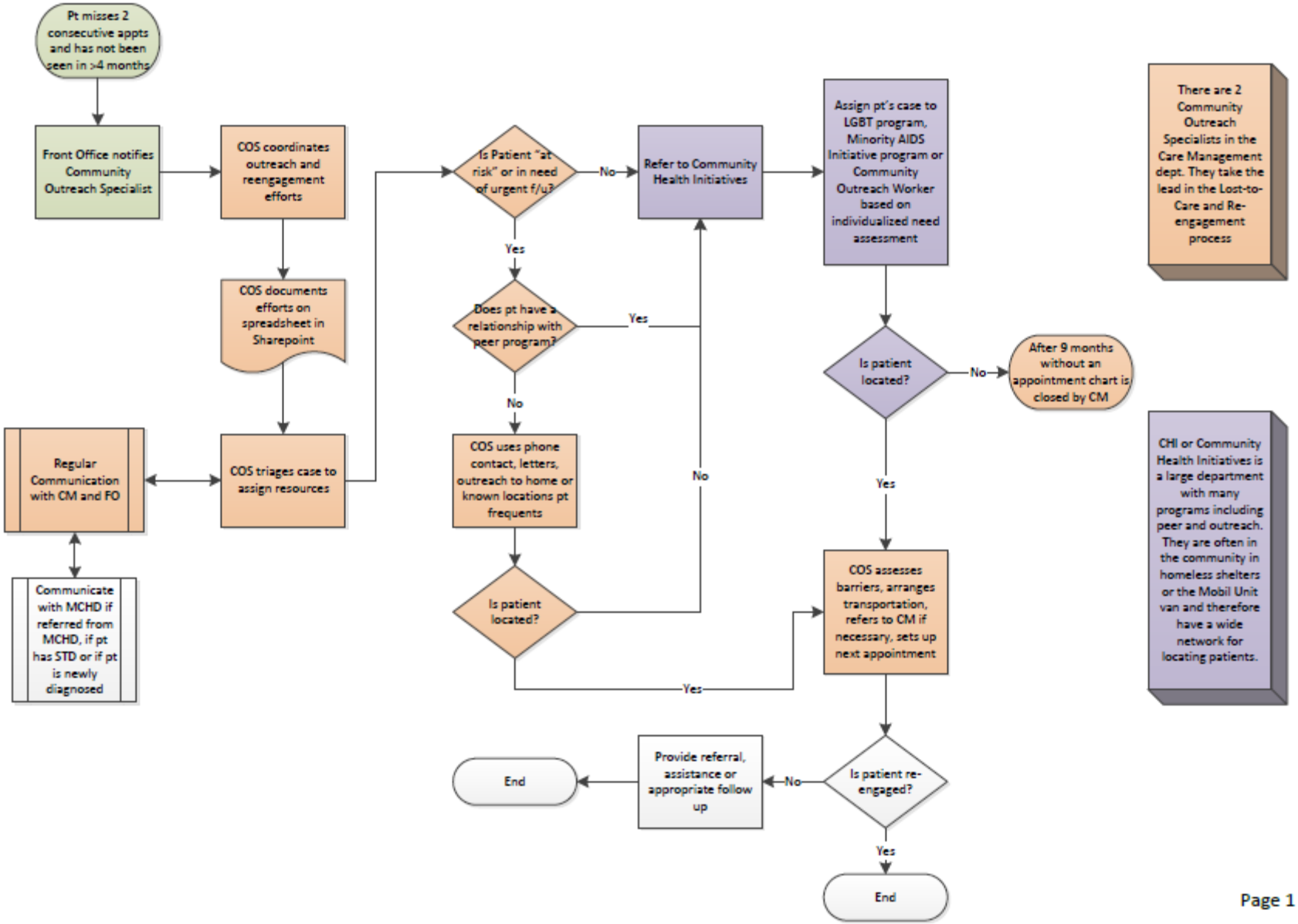

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Ways to Attempt Contact

- Phone Calls
- Check local inmate listings
- Letters Home
- Emergency Contact (if applicable)
- Check managed care organization
- Other Service Providing Agencies (if applicable)
- Home visits
- Collaborate with Community Health Initiatives staff to find patients in known neighborhood

Date, name, who is referring, reason, language, provider

CHI Grant (may be useful contact if pt isn't found)

Color-coded status for reengaged, continuing efforts or closed

A	B	C	D	E	F	G	H	I	J	
DATE	PATIENT NAME	Referral Made By:	Level of engagement- Re-engagement/ Lost-to-care	Language	CHI Grant	PROVIDER	Referral Type- complete P- Pending C- Cancelled	1- Yes they re-engaged in medical care 0- No- did not re-engage	COS working with Patient	Notes GREEN – REENGAGED YELLOW- CONTINUING FOLLOW UP RED – CANCELLED/ CLOSED/ REFERRAL COMPLETION
3/15/12		Julian	Re-engagement	English		Schaefer	Yes	1	Lilly	Home visit
6/13/12		Madison	Re-engagement	English		Corales	yes	1		Phone
7/1/12		Front Office	Re-engagement	English		Mancenido	Yes	1	Lilly	Home visit
7/1/12		Honnick	Re-engagement	English		Mancenido	Yes	1	Lilly	Phone
8/9/12		Tomicka	Re-engagement	Spanish		Mancenido	Yes	1	Lilly	Home visit
9/6/12		Honnick	Re-engagement	English		Mancenido	Yes	1		Phone
9/6/12		Front Office	Re-engagement	English			Yes	1		Phone
9/7/12		Brown	Re-engagement	English		Mancenido	yes	0		Unable to reengage
9/8/12		Seffens	Re-engagement	English			yes	1		Phone
9/12/12		Front Office	Re-engagement	English			p	0	CM Jill	
9/13/12		Front Office	Re-engagement	English		Corales	yes	1	Lilly	Home visit
9/18/12		Front Office	Re-engagement	English		Corales	yes	0	COS Lilly	Closed due to relocation
9/18/12		Front Office	Re-engagement	English			yes	0	Jordan	Unable to reengage
9/24/12		Jackson	Re-engagement	English	Woman		yes	0		Refused to engage
10/3/12		Front Office	Re-engagement	English			Yes	1	Jordan	Letter
10/15/12		Front Office	Re-engagement	English			Yes	0	Lilly	Deceased
10/15/12		Front Office	Re-engagement	English	MSM		Yes	1	Jordan/ Lilly	Reengaged on his own after reengagement attempts (phone)
10/17/12		Front Office	Re-engagement	English			Yes	1		Reengaged on his own after reengagement attempts (phone)
10/19/12		Front Office	Re-engagement	English			Yes	1		Reengaged on his own
10/24/12		Front Office	Re-engagement	English			yes	0	CM DEB	Transferred care
10/25/12		Front Office	Re-engagement	English			p	0		
10/30/12		COS	Re-engagement	English		Mancenido	yes	0	CM Julian	Closed due to incarceration
10/30/12		COS	Re-engagement	English		Mancenido	yes	0	Jordan	Transferred care
10/30/12		COS	Re-engagement	English	Hetero	Mancenido	yes	0	Jordan	Unable to reengage
10/30/12		COS	Re-engagement	English		Corales	yes	0		Unable to reengage
10/30/12		COS	Re-engagement	English		Mancenido	yes	0	CM Julian	Unable to reengage
11/8/12		CM Tanya	Re-engagement	English		Corales	yes	1	Lilly	Home visit
11/14/12		CM Abby	Re-engagement	English	**Hetero**		**yes**	**1**	Lilly	Home visit
11/30/12		CM Julian	Re-engagement	English	Hetero	Valenti	yes	1	Lilly	Phone
11/30/12		CM Tanya	Re-engagement	English	Woman	Mancenido	yes	1		Phone
12/10/12		CM Julian	Re-engagement	English	MSM	Mancenido	p	0		
12/17/12		CM Tanya	Re-engagement	English	Hetero	Schaefer	p	0		
1/11/13		CM Nicole	Re-engagement	English	Hetero	Mancenido	yes	1	Lilly	Home visit
1/17/13		CM Julian	Re-engagement	English	MSM	Mancenido	p			
		Front Office	Re-engagement	English	MSM		Yes	1		Reengaged by CM
		Front Office	Re-engagement	English		Schaefer	yes	1		Reengaged by CM
		Front Office	Re-engagement	English		Mancenido	yes	0	Jordan	Transferred care

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Results

20 of 37 patients referred to COS in a 10 month period were re-engaged

- 7 were engaged by phone
- 7 were engaged by Home visit (one found on the street by CHI staff)
- 1 was engaged by letter
- 3 engaged on their own
- 2 engaged by Care Manager

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Results

12 of these 37 referrals were closed

- 5 were unable to engage “total contact lost”
- 3 transferred care elsewhere
- 1 incarcerated (from Monroe County jail census)
- 1 relocated
- 1 deceased (googled pt’s name and found obit)
- 1 declined care

5 of 37 are ongoing attempts to re-engage

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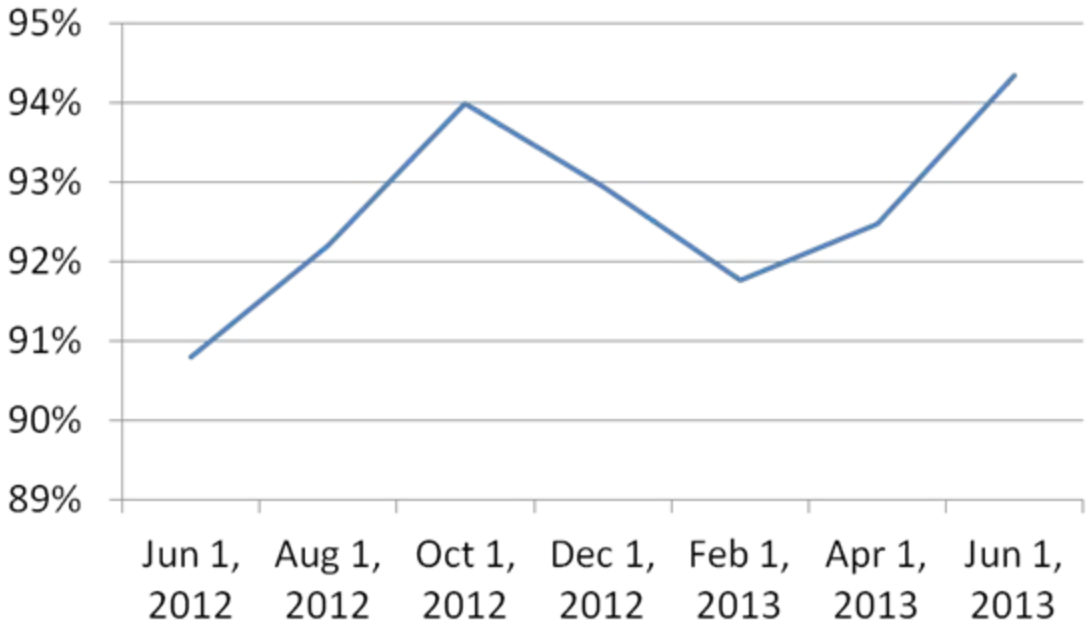
Medical Visit Frequency



% 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

Patient #1 – Address unknown

Patient was in clinical trials lost to care. Clinic did not have an updated phone number. When COSs were informed, patient needed to be seen by that week. COSs completed a home visit to last known address. Patient no longer lived there but the current resident knew who the patient was. Current resident called and stated that a woman named “Lilly” was looking for him and gave the patient a phone number to contact. Patient contacted Lilly that week and was able to get reengaged in care. Patient provided Lilly with updated address and phone number. Patient stated that he was preoccupied with the ending of a relationship, moving and patient missed his appointment due to job and was unsure of how to contact the office to reengage.

Client #2 – Leave a note

Client was unengaged and patient's Care Manager believed that she had begun using again. COSs went to patient's apartment. Patient was believed to be home but did not answer the door. COSs wrote a generic note stating "My name is Jordan. I missed you today when I stopped by. Please give me a call at (585)210-4131. Thank you."

By the time the COSs returned to the office, there was a voicemail from the client who reengaged with Care Manager. A few months later, the Care Manager was unable to contact client, so writer attempted to contact client and after reviewing the jail census, COS determined that client was in jail.

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Patient #3 – Check everywhere

Patient solely received HIV medical care in our clinic (not primary care). Patient became lost to care and clinic had no updated releases on file and no emergency contact listed. After some follow-up care, COS found patient's obituary. Clinic was not notified of patient's passing because we are not his primary care provider. Medical provider was capable of confirming patient's passing.

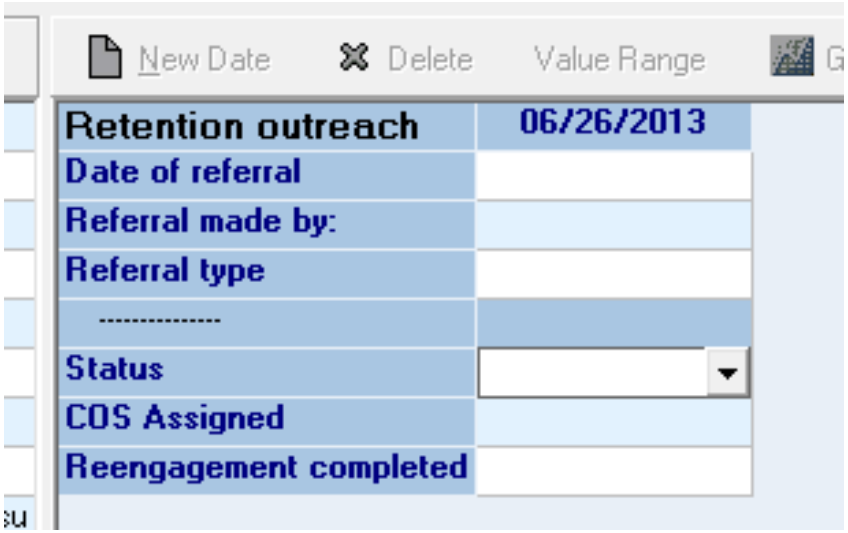
Patient #4 - Be persistent

Patient receives only HIV care at our clinic and frequently did not show to his appointments. COS attempted to reach patient several times by phone and mail with no response. COS went to patient's home and left a very simple note at door asking "please call". Patient called COS next day and updated contact information. COS discussed need for follow up with HIV provider and appointment scheduled .

Patient did not show for initial appointment scheduled. COS called patient regarding the missed appointment and scheduled a meeting just with the COS. Patient did show! COS discussed patient's life and priorities and scheduled one more appointment with Care Manager and provider. Patient did show to his appointments after this so far.

Next Steps

- In place of stand-alone spreadsheet to track lost-to-care, a flow sheet is available in each patient's EMR chart and a report has been written to pull aggregate data



Improved tracking

Retention Outreach

6/21/2013 8:00:06 AM

Open

Referal Date	First Name	Last Name	Referral Made By	Referral Type	Language	Provider	COS	Reengagement Date	# Phone	# Letters	# Visits	Total Outreach	Last Out Reach Note Text
04/30/2013	B	L	Lucia Colindres Vasquez Assoc. Dir. of care management and Outreach	Lost to Care	English	Schaefer, William J	Lilly Flores		1			1	P: Outreach phone call I: Writer called patient and left message to please contact writer. Contact information was left in the message. F: wait for patient to call back
	D	H	Abigail Quinones CM	Health Homes initial contact	English	Schaefer, William J	Lilly/Jordan						P: OUTREACH: Home Visit I: COS Jordan Johnson and Writer went to patient's home address today. No one answered the door after knocking and ringing the door bell. The Television was on and a very young child could be seen in the living room. However no one came to answer the door. No note was left as it still unsure whether this is the patient's actual address at this time. F: Writer will follow up with CM Abby Q.

Scheduled Appointment

Completed

Refused to Re-Engage

Report pulls the Outreach log notes from the EMR

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Overarching Lessons Learned

- All members of the clinic, care management, community initiatives and even informatics/IT staff can play a role in the organization's retention efforts
- The improvement never stops