



Finding and Re-engaging Un-retained Patients in San Diego, CA

UNIVERSITY OF SAN DIEGO MEDICAL CENTER - OWEN CLINIC

Ryan White Part C grantee and San Diego HIVQUAL-US Regional Group participant, University of San Diego Medical Center - Owen Clinic, has operated as the HIV-specific program for the University of San Diego Health System since 1982, serving 2,922 unique patients in 2010. The Owen Clinic includes both primary care services as well as specialty clinics that address related health issues such as lipid disorders and anal dysplasia.

The Owen Clinic's Continuous Quality Improvement (CQI) Committee meets twice per month to improve service delivery. The CQI Committee chose **retention in care as their priority for 2010** for its direct association with HIV-patients' virological success and mortality. By **defining un-retained patients as those who had at least one visit during the calendar year but a gap in visits of six months or more from the last attended visit**, the Owen Clinic discovered that **as many as 478 patients were not actively engaged in care** in 2009.

In response, the Owen Clinic began its first-pilot project for one month in summer 2009 with the goal of improving rates for patient retention. Using part-time assistance from experienced outreach workers, the project achieved minimal success by returning to care only twenty-five (5.2%) of the total 478 un-retained patients. Additionally, participating staff were unable to reach 161 (34%) patients by either phone or mail. An enhanced strategy was then deemed necessary to meet the goals of the Owen Clinic's CQI Committee.

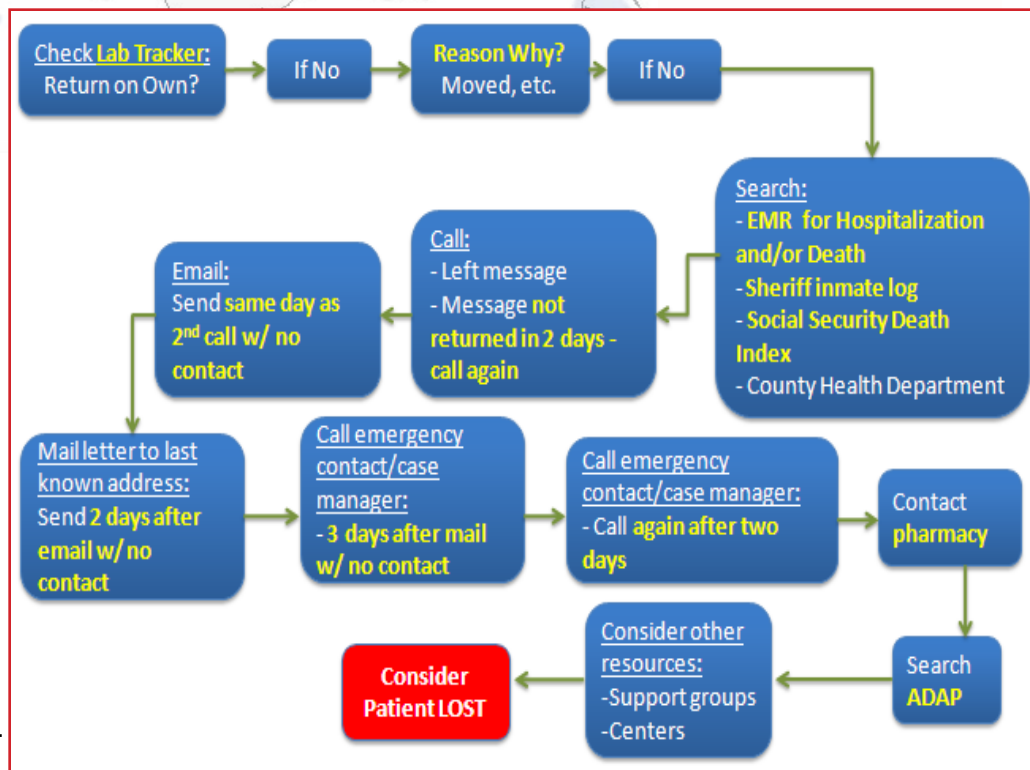
The Patient Unable to Follow-up: Found! (PUFF) quality improvement project began as year-long, California Human Dignity Foundation grant-funded activity on February 1, 2010 with dual aims: to increase the rate of patient retention and to better understand clients' perspectives and possible barriers to their active engagement in care. In particular, the Owen Clinic team identified **locating those patients lost-to-follow-up as the most significant challenge to re-engagement**. To that end, the CQI Committee

devoted several meetings to brainstorming potential algorithms for patient outreach, databases to be used to search for out-of-care individuals and patient-reported needs.

As a first step, newly-hired and part-time PUFF specialists were trained to navigate three electronic health databases (LabTracker, PCIS, and EPIC); a scheduling program (IDX); and adherence and enrollment processing databases (ADAP, etc.). This position was designed to build upon a specialist's previous **experience in phone solicitation, database management and customer service** so that he or she might effectively track un-retained patients and address those issues that impede consistent and active engagement in care. PUFF specialists received additional information related to health and substance use education as well as opportunities to shadow various team members including front desk staff, medical assistants, phone operators and triage nurses.

Next, PUFF specialists collaborated with the CQI Committee, including the Associate Medical Director, to develop and test tools to be used to find and track un-retained patients. As a result, the **PUFF toolbox** was generated with several key components, as shown on the next page.

In order to measure the success of the PUFF project in increas-

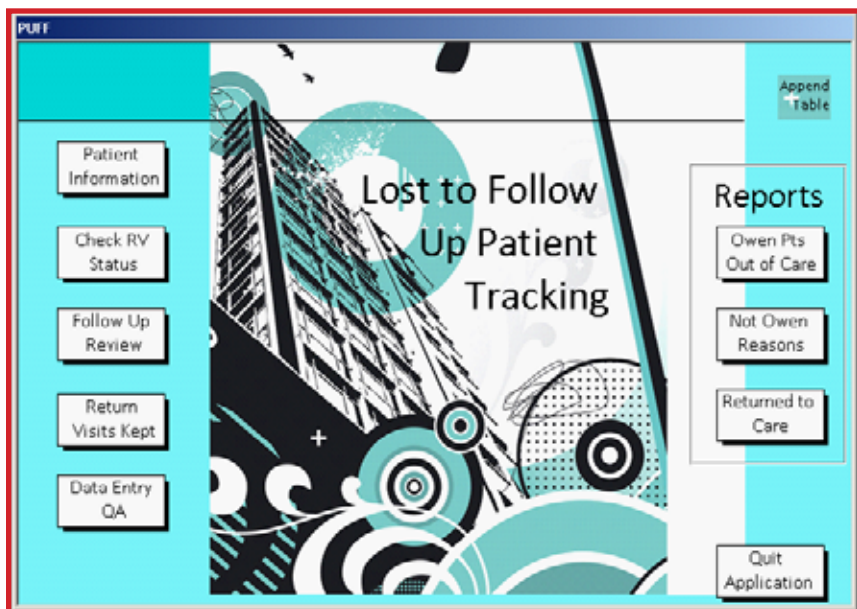


Source: UCSD Medical Center - Owen Clinic

| PUFF TOOL BOX | |
|--|--|
| Algorithm to locate lost patients (see previous page) | |
| Stigma-free script to be used during contacts | |
| Customized lost-to-follow-up Microsoft Access database | |
| Private secure phone line for patients to reach staff regarding scheduling | |
| “Staying in Care” materials (flyers, brochures) to be posted in areas of the community with high rates of homelessness | |

Source: UCSD Medical Center - Owen Clinic

ing the number of retained patients, the CQI Committee **calculated the percentage of individuals brought back into care after a six-month gap following their last recorded visit.** 478 patients were identified as eligible for tracking and targeting by PUFF specialists after six months. The results of PUFF specialist intervention and PUFF toolbox use are summarized in the table below.



Source: UCSD Medical Center - Owen Clinic

Among the strategies implemented to locate patients, PUFF specialists routinely monitored the **Social Security Death Index** and electronic medical record for deaths and/or hospitalizations while also **calling twenty pharmacies to find patients’ last date of refill and most up-to-date phone numbers.** When possible, PUFF specialists **left messages** with the pharmacy to then be **relayed to patients upon their next refill.**

| RESULTS: 478 patients targeted by PUFF | |
|---|---------------|
| Returned on their own | 24.7% (n=118) |
| Returned to care as a result of PUFF interventions | 18.6% (n=89) |
| In care elsewhere | 28.5% (n=136) |
| Still Owen Clinic patient though no return visit recorded | 12.6% (n=60) |
| Expired | 5.4% (n=26) |
| Otherwise lost or unreachable | 10.3% (n=49) |

Source: UCSD Medical Center - Owen Clinic

last date of refill and most up-to-date phone numbers. When possible, PUFF specialists **left messages** with the pharmacy to then be **relayed to patients upon their next refill.**

The CQI Committee performed a more in-depth analysis of those patients who did not return to care either on their own or following outreach by a PUFF specialist. First, of those 136 patients grouped as “in care elsewhere”, the CQI Committee sought to determine why they had left the Owen Clinic. Seventy-five (50.3%) had moved out of the area while thirty (20.1%) cited changes to insurance coverage as a reason for changing clinics. Only two individuals (1.3%) reported they “did not like Owen Clinic”. The CQI team also considered if any patient demographic characteristics contributed to the PUFF specialist’s success by comparing the race/ethnicity, age and gender of those patients “lost” or unreachable to those with which they did make contact, with little variation between both groups.

For next steps, the CQI Committee hopes to find additional grants and dedicated funding streams in order to reinvigorate and permanently systematize the PUFF Project. The Owen Clinic also would like to design an enhanced data collection method for the PUFF toolbox to more efficiently determine which barriers may have contributed to disengagement in care and to identify better contacts within the larger community to direct care coordination. New interventions such as **text messaging visit reminders and a barriers-to-care entry field within the Owen Clinic’s EMR** are currently under consideration as additions to the PUFF toolbox.

The final results of the PUFF Project are still under analysis. The Owen Clinic’s collaborative and multi-disciplinary approach to quality improvement has made a positive impact upon the rates for retention as well as the overall health outcomes of their HIV patients.

HIVQUAL-US is supported through US Department of Health and Human Services, Health Resources and Services Administration.

For more information on HIVQUAL-US or the HIVQUAL-US Briefs, please contact Amanda Bowes at acb11@health.state.ny.us.

Announcement: the National Quality Center, 2011 In+Care Campaign

The National Quality Center (NQC) is working in preparation for the launch of the 2011 National Campaign, entitled In+Care. The focus is on retention: re-engaging consumers that are lost-to-care



as well as helping consumers to stay in care.

Performance measures for retention in care are currently under development to be submitted by participating clinics bi-monthly.

NQC consultants will be

available to participants to provide technical assistance and supporting materials specific to quality improvement in retention in care. A formal announcement is forthcoming.

For further information regarding NQC’s In+Care National Campaign on retention, please contact Clemens Steinböck at cms18@health.state.ny.us.