An Intervention Strategy to Engage and Retain Patients in HIV Primary Care

Date: 8/24/2010

Time: 4:00 PM - 5:00 PM

Location: Washington 1

Speakers: Amy M. Sitapati, MD; UCSD

Moderator: Michelle Browne

20 Years of Leadership
A LEGACY OF CARE

Disclosures

Amy M. Sitapati, MD; UCSD has no financial relationships or family members with commercial interests to disclose.

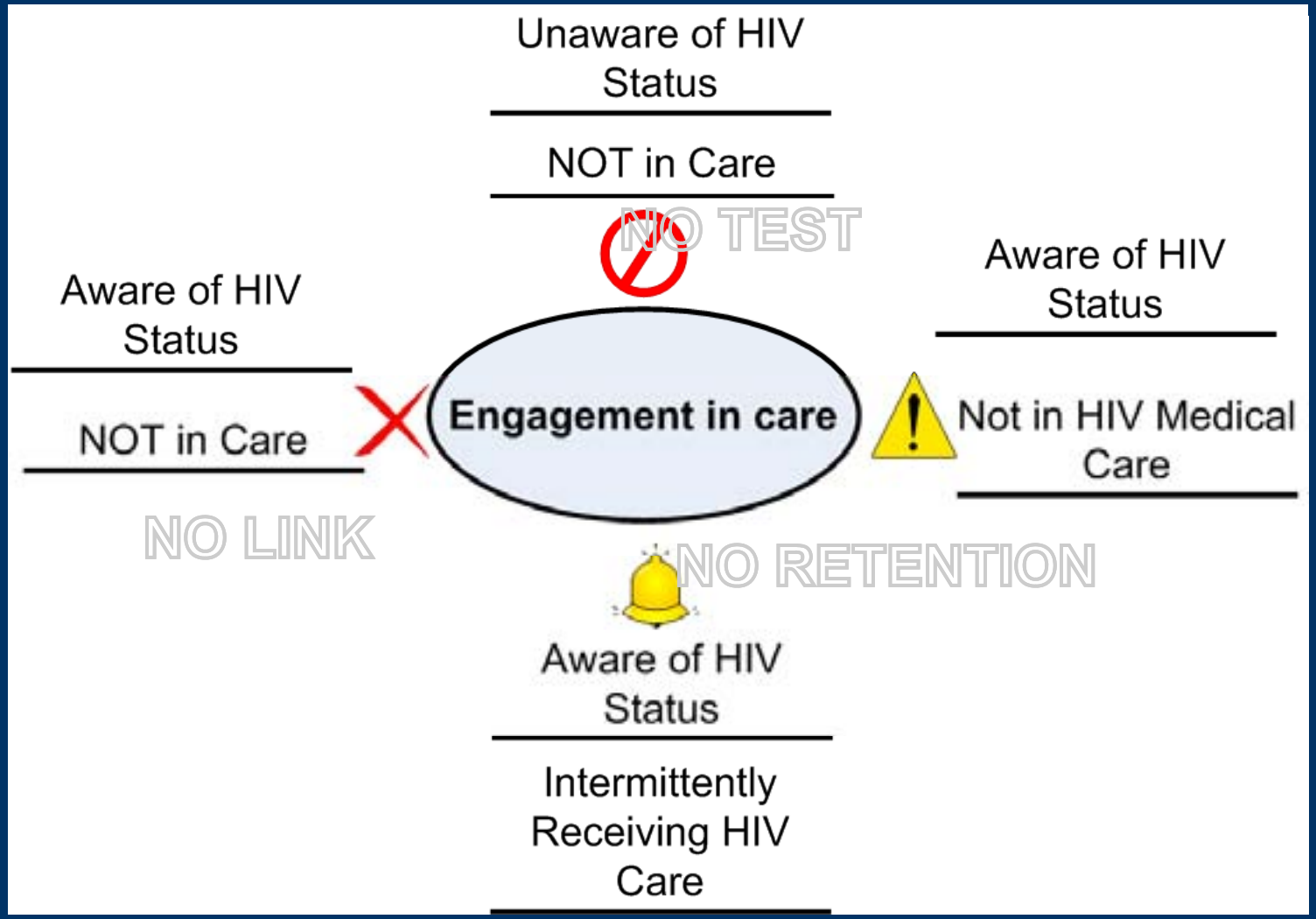
HRSA Education Committee Disclosures
HRSA Education Committee staff have no financial interest or relationships to disclose.

CME Staff Disclosures
Professional Education Services Group staff have no financial interest or relationships to disclose.

Workshop Goals: Developing the tools for Improved Engagement

- Brief review of definitions & impact
- Knowing your own retention
- A dedicated personnel for retention
- Calls, calls, calls
- Pharmacy as an untapped link
- SUMMARY of patient experiences

Stages of Engagement



Adapted: Cheever, Clin Infect Dis, 2007

Factors associated with

Access to file paperwork

Workshop Goals:
Tool 1: Knowing your data

How do you calculate retention?

Do you know your retention rate?

How often do you collect it? And from what sources?

Retention calculation:

2 provider visit in past year

---

1 provider visits in past year

(within 2 different 6 month periods)

Exclusion: new entry of care in past 6 month period

Our post Open Access Retention

Year 2009 was 85.1% to 83.5 % in Year 2008.

Pts w/ one visit 1/1/2009 - 6/30/2009	2,339
Pts w/ one visit 7/1/2009 - 12/31/2009	2,447
Pts seen in both 1st and 2nd half of 2009	1,994
Our 2009 Retention Rate	85.3%

Recognition of a need

20 Years of Leadership
A LEGACY OF CARE

Collaborative Pilot: Owen Clinic and the AVRC Bridge Program targeted approximately 400 patients

Lost to Follow Up Pilot Summary-May - July 2009

Outcome	#	% of Total
Deceased	1	0.4%
Insurance	27	10.7%
Incarcerated	6	2.4%
Moved out of Area	15	5.9%
In Care - No Longer Owen Patient	19	7.5%
Returned to Owen	25	9.9%
*Unable to Reach/Phone Disconnected	160	63.2%
Total	**253**	**100.0%**

***The demographics of the 160 patients that could not be reached were compared to the general Owen population.**

3 month project stopped with loss of funding; 160 missing

20 Years of Leadership
A LEGACY OF CARE

The Unengaged List: Inclusion Criteria

- ✓ HIV+
- ✓ At least one clinic visit in past 12 months
  Excluded subspecialty and consult only visits
  Over 6 months since last clinic visit

  - ✓ 478 patients identified

Creation of Project PUFF: Patients unable to follow-up…FOUND

One person can make a difference

Objectives: outreach interventions engaging HIV patients back into primary care

Aimed to get patients unable to follow up back into care

Develop innovative methods to target the 53% unable to reach by telephone alone

Determine methods to prevent future loss to follow up

Workshop Goals:
Tool 2: Creation of a new Job

Previous phone political/non-profit work

HIV science and research exposure

Volunteer in community

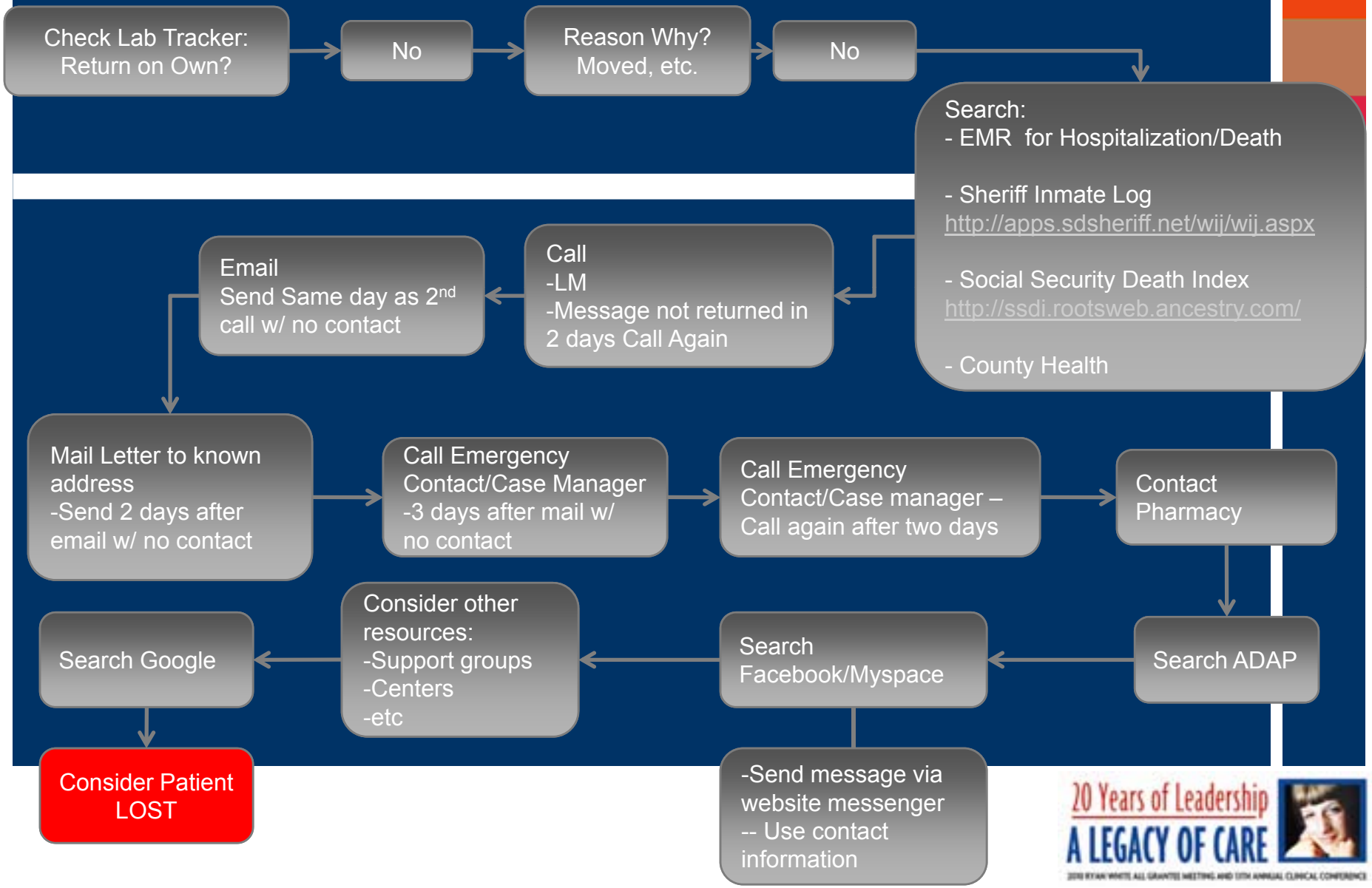
Read articles on background

Cross-training to navigate barriers:

- 4 system training & all staff roles (MA/ desk/ phones/ adhere/ enroll/ edu/ case mgt)

Workshop Goals:
Tool 3: Making algorithms/flyers

Flow diagram for re-engagement

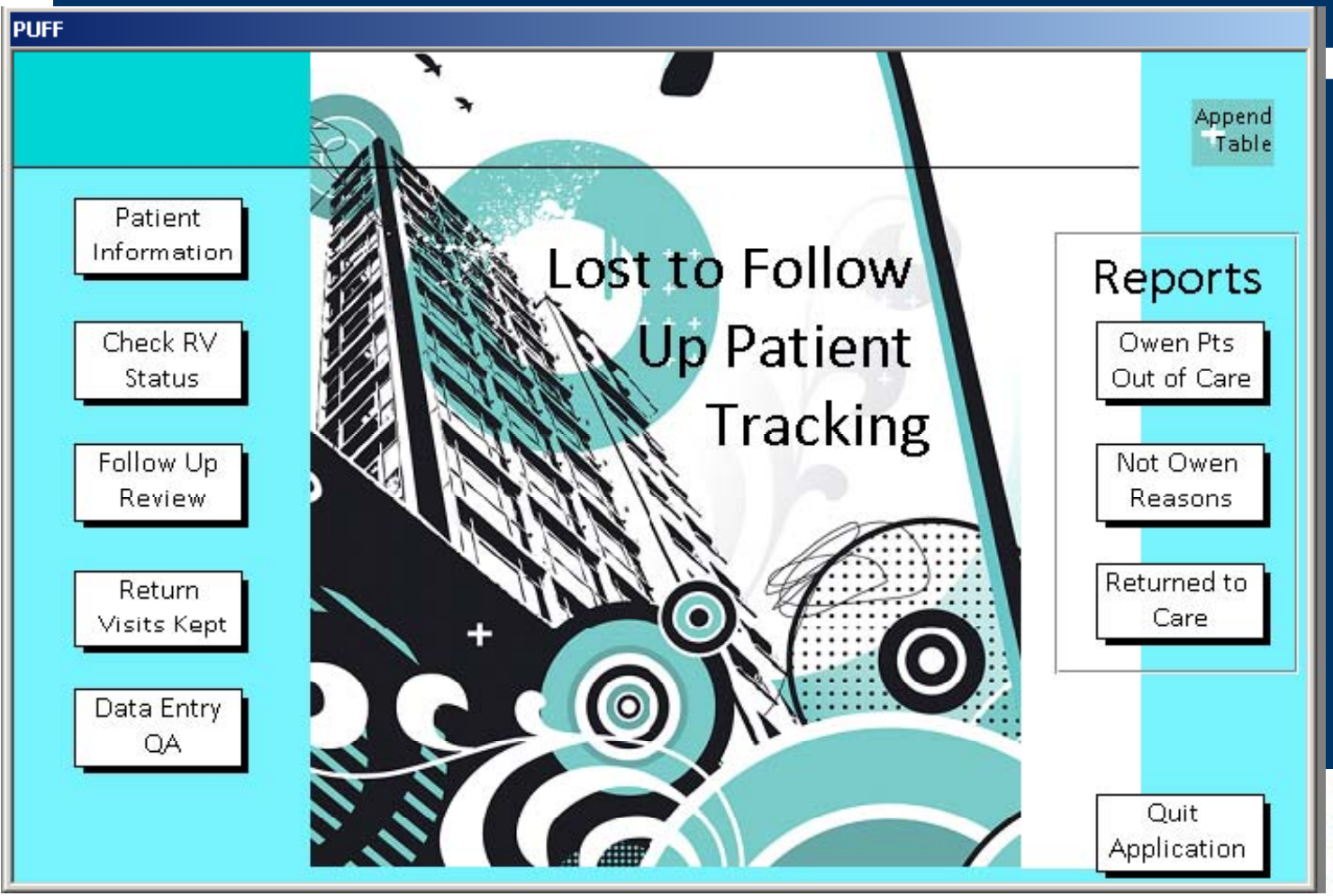


20 Years of Leadership
A LEGACY OF CARE

Flyer creation

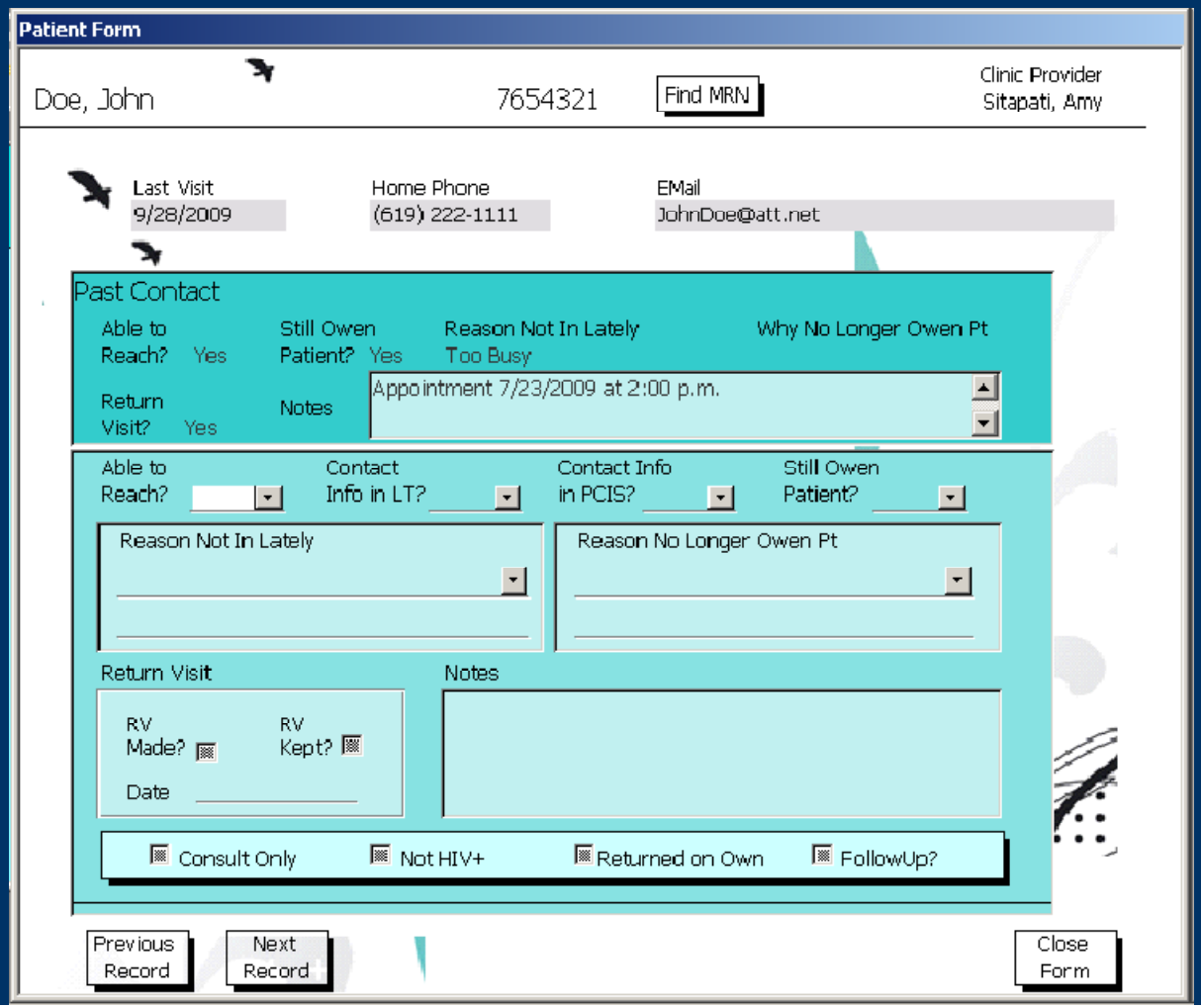
20 Years of Leadership
A LEGACY OF CARE

Workshop Goals:
Tool 4: Track in Access database



20 Years of Leadership
A LEGACY OF CARE

PUFF: Access: patient search



Workshop Goals:
Tool 5: Calls, calls, and calls

Dedication of a singular VIP phone line with after hours messages

Many calls to same phone when appeared to be correct; then called frequently to leave messages

Got to know the client from chart/phone

Patient calls and outreach:

A. No hx prolonged absences or missed visits. Always did 3 to 4 month F/U. He just forgot.

B. Pt has new insurance; recovering from met cancer, contacts Dr. by phone; RW; many cancels & no shows

C. Phone #'s bad in 2 databases; letter returned; medical records detail govt persecution perception; needs to renew RW/ADAP

D. Phone #'s in PCIS and LT and IDX no good; moved to New Orleans per case manager

Workshop Goals:
Tool 6: Untapped pharmacy link

61/70 lost patients with e-prescribing

Called 20 pharmacies, looking for:

- Date of last refill
- Newest phone #
- Other pt info
- Message left at pharmacy for pt upon next refill
- "Please call your doctor's office at the Owen Clinic to schedule an appointment xxx-xxxx" (PUFF program phone #)

Workshop Goals:
Tool 6: Pharmacy link results

20 different pharmacies contacted
- 19/20: provided info last refill date, contact # and other
- 10/20 (50%): accepted provider messages
- 1/20 did not share info, but called 10 pts (8 bad #/2 msg)

33/61 pts had phone numbers shared
- 22/33 were already listed in our EMR; 1 new bad #
- 10/33 were new good contact numbers

4/61 pts found with the new contact #'s:
- 1 return visit kept; 1 appt. pending; 1 moved; 1 changed provider

Additional 2/61 ID as moved/incarc from pharm

Preliminary data 7/10: Sitapati, unpublished.

Workshop Goals:
Tool 7: Inside links/what didn't work

Persistence in calling was key

Getting to know the patient

A bit of help with mail & pharmacy

Limitations with myspace/facebook due to access restraints institutional

Working with Homeless programs for referrals

SUMMARY of patient experiences in Retention

"I really appreciated the call from the office in person, you calling and saying we have not seen you in a while, it means a lot to me"

"Is there anything else I can do for you", "No you just made my day"

A patient who had not been seen in 7 months and is currently on ARVs: "I'm not going to take a day out of my schedule, come in and wait in that office if I don't have to and don't need to."

Even if a provider has informed the patient of the need for a 3-4 months follow up a patient may feel the need to have a direct call from there provider to come in for a visit: "I don't go in unless something is wrong or he (Provider) tells me too"

“oh, my God, I think you just saved my life… “ - B

Dx HIV 1990 & clinic pt since1995

Last appt 3/27/2009

7 phone calls and 1 letter: multiple attempts. Calls taken by a housemate claimed B would get messg and call right back… but never did

On the 8th call, B answered. Explained lost insurance, MediCal; upon asking if knew about Ryan White funding, pt B“who is that”. Did not detail health. Return visit given 2 days.

B direct admitted from clinic to hospital and now well.

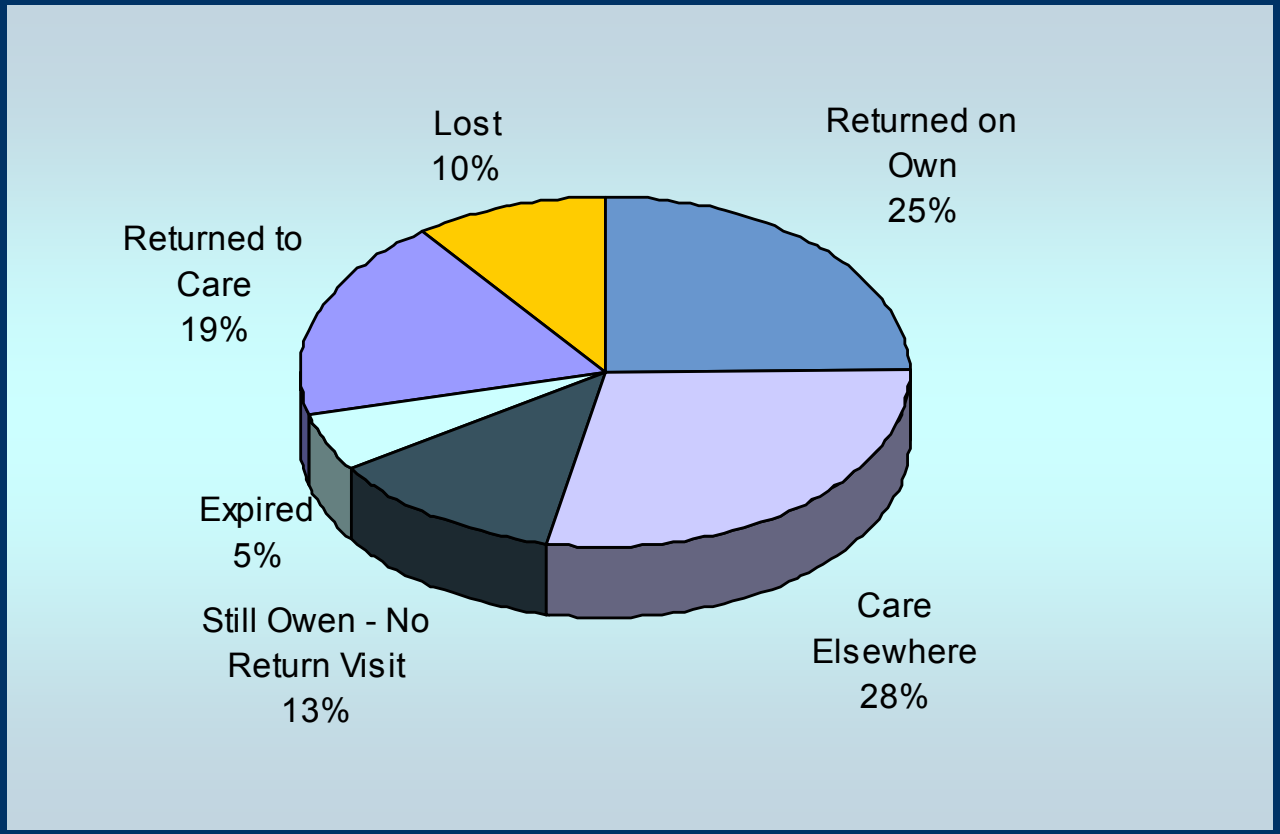
PUFF Impact Summary, Preliminary

Outcome	#	% of Total
Returned on Own	118	24.7%
No Longer Owen Patient - In Care Elsewhere	136	28.5%
Still Owen Patient but No Return Visit	60	12.6%
Patient Expired*	26	5.4%
Returned to Care at Clinic	89	18.6%
Lost	49	10.3%
Total	478	**100.0%**

*Of the 26 patients who expired, all but 2 died prior to the start of the project; of note, numerous unsuccessful attempts had been made to contact these 2 patients.

Preliminary data 7/10: Sitapati, unpublished.

Chart of Reasons not returned



Preliminary data 7/10: Sitapati, unpublished.

Lost Patients: by Gender/age

Gender	Lost #	Lost %	Able to Contact #	Able to Contact %
Female	4	8.2%	51	11.9%
Male	44	89.8%	377	87.9%
Transgender	1	2.0%	1	0.2%
Total	49	**100.0%**	429	**100.0%**

Age Group	Lost #	Lost %	Able to Contact #	Able to Contact %
13-24			5	1.2%
25-44	27	55.1%	201	46.9%
45-64	22	44.9%	218	50.8%
>65			5	1.2%
Total	49	**100.0%**	429	**100.0%**

Preliminary data 7/10: Sitapati, unpublished.

Lost Patients: by Race/Ethnicity

	Lost		Able to Contact	
Race/Ethnicity	**#**	**%**	**#**	**%**
Asian	1	2.0%	7	1.6%
Black	5	10.2%	59	13.8%
White	27	55.1%	229	53.4%
Hispanic	13	26.5%	103	24.0%
Hawaiian/Pacific Islander			1	0.2%
Native American			2	0.5%
Multiracial			1	0.2%
Other	2	4.1%	16	3.7%
Unknown	1	2.0%	11	2.6%
Total	49	**100.0%**	429	**100.0%**

Preliminary data 7/10: Sitapati, unpublished.

Reason	#	% of Total
Jail/Prison	29	19.5%
Transportation Issues	2	1.3%
No Insurance	4	2.7%
Too Busy	14	9.4%
Don't know when to Schedule Appt	3	2.0%
Forgot	11	7.4%
Office Hours	2	1.3%
Don't want to think about	2	1.3%
Not sick	12	8.1%
I'll know when it's time	15	10.1%
Perceived maltreatment	1	0.7%
Insurance or Referral Issue	8	5.4%
Out of Town Split Work	13	8.7%
No Reason Given	10	6.7%
Psychological Issues	3	2.0%
Inter Research Study	1	0.7%
Tired/ Needed Break	2	1.3%
Residential Care	4	2.7%
Other	13	8.7%
Total	149	**100.0%**

Reasons current patients gave for missing care

Preliminary data 7/10: Sitapati, unpublished.

Reasons Patients Changed Clinics

Reason	#	% of Total
Didn't Like Clinic	2	1.3%
Moved out of the Area	75	50.3%
New Insurance/ Change in Insurance	30	20.1%
New Provider	16	10.7%
Dismissed from Clinic	1	0.7%
Insurance/ Referral Issue	5	3.4%
Other/No Reason Given	7	4.7%
Total	136	**100.0%**

Preliminary data 7/10: Sitapati, unpublished.

PUFF is afforbable

This is a project requires a ½ time employee at low cost Community Health Program Representative and is an affordable option.

PUFF Retention Resources:

- Work flow diagrams for Retention Specialist
- Retention Patient Letter
- Retention Community Flyer
- Patient engagement Hand out
- Access Database tool

Unanswered Questions: Improving FUTURE engagement

Med refills may tie patients to their providers. How utilize without risking interruptions in therapy?

How do we changing pt health beliefs and goals for care?

What better contact pro-active info gathering is needed?

Suggested Reading:

1. M Mugavero. Improving Engagement in HIV Care: What can we do? IAS-USA Topics in HIV Medicine Vol 16(5); December **2008**: 156-161.

2. KB Ulett, et al. The Therapeutic Implications of Timely Linkage and Early Retention in HIV Care AIDS Patient Care and STDs Vol 23(1); **2009**: 41-49.

3. MJ Mugavero, et al. Missed Visits and Mortality among Patients Establishing Initial Outpatient HIV Treatment Clin Infect Dis 48; Ja 15 **2009**: 248-256.

4. LW Cheever Engaging HIV-Infected Patients in Care: Their Lives Depend on It. Clin Infect Dis 44; June 1, **2007**: 1500-1502.

5. TP Giordano, et al. Retention in Care: A Challenge to Survival in HIV Infection Clin Infect Dis 44; June 1, **2007**: 1493-1499.

PUFF is Supported by:

- Health Resources and Services Administration Funding Opportunity: HRSA 5-H76-10-003
- San Diego HIV Funding Collaborative of San Diego Human Dignity Foundation: Grant No. 09-00009(CAT)

Additional Thanks to:

Jan Limneos for PUFF data support
Stephanie Moody-Geissler our PUFF Retention Specialist

20 Years of Leadership
A LEGACY OF CARE