Patient Retention in Greenwich Village

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August 27, 2008

Public Health

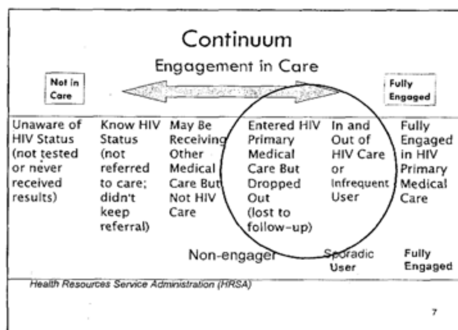
Retention is likely to help prevent and control chronic disease, reduce morbidity and premature mortality leading to improved population health

Why Is Retention Important

- Medical Care – the heart of the patient-provider relationship
- The Primary Care Model – Continuum of Care
- Revenues – Visits generate income
- Health Costs – retained patients are more likely to receive preventive care and use fewer emergency services keeping overall costs lower

Evidence Base for Patient Retention Efforts

- Patients who are retained in care have better likelihood of viral load suppression.
- Patients who miss appointments frequently are more likely to have virologic failure.
- Patients who miss visits have longer hospital stays and use emergency services more.



Why Don't Patients Come?

- Younger Age
- Education level
- Lack of Insurance
- Lower Income
- High CD4 Count
- No AIDS Diagnosis
- History of IDU or current user
- Lower Perceived social support
- Heterosexual patients
- Conflicts
- Shorter interval between baseline visit
- Less engagement with provider
- Minority communities, particularly AA
- Work Conflict
- No Transportation
- Family Illness
- Forgetting
- Feeling too ill
- Feeling Well

Return to Care Survey

- NYC Department of Health & Mental Hygiene/Care, Treatment & Housing Prgm
- Jacobi, St. Vincents (33), Cumberland & Bellevue Hospitals
- 54 Respondents/51 Completed
- Surveys offered in English only

Reasons to Remain Out of Care Prior to Receiving HIV Primary Care (N=51)

- I didn't want to think about or deal with HIV/AIDS (48.1%)
- I could not keep track of appointments (46.3%)
- I felt hopeless or overwhelmed (40.7%)
- I did not want to take my HIV medications (38.9%)
- I was using alcohol or other drugs (37%)
- I felt good – not sick enough to go to MD (32%)
- I had to put other concerns ahead of HIV (27.8%)

Reasons to Remain Out of Care (continued)

- I could not get transportation to and from appointments (22.2%)
- I did not expect medical care to do much good (20.4%)
- I had no insurance or had gaps in insurance coverage (18.5%)
- I could not get convenient appointments (16.7%)

Recommendations to Improve Access to and Retention in Care

- Provide other services, support at the same places that provide HIV medical care.
- Give every person with HIV access to the best possible insurance coverage for medical, mental health and preventive health services.
- Provide transportation to HIV medical care appointments.
- Offer peer counseling/support services to clients.
- Provide escorts to HIV medical care appointments.

Recommendations (continued)

- Train MD's and other providers to be more sensitive and helpful.
- Make alcohol or drug treatment services available to more people
- Make the HIV medical care clinic a welcoming and safe environment
- Change clinic schedules to have longer hours or flexible appointment times
- Provide translation services for multiple languages

Services Keeping Clients in HIV Primary Care

- HIV medical care
- Help with taking and staying on HIV meds
- Eligibility assistance
- Dental care and treatment
- Mental health services
- HIV prevention and/or risk reduction education
- Housing services
- Nutrition or getting healthy meals

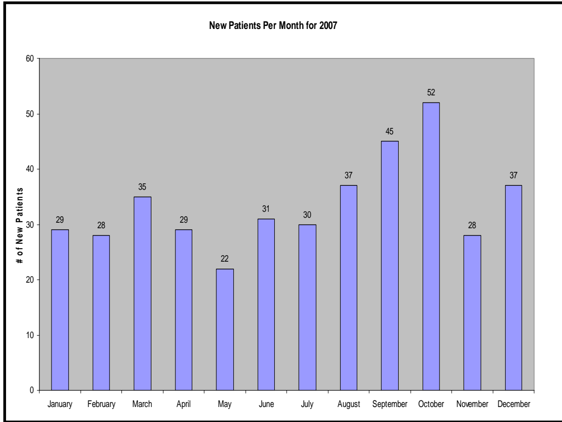
Keeping Clients…(continued)

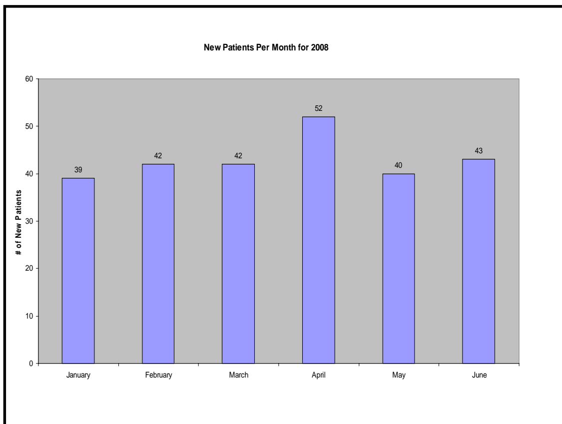
- Transportation assistance
- Hepatitis treatment and services
- Help with paying health insurance costs or premiums
- Alcohol or other drug treatment
- Prescription drug assistance
- Legal Services
- Home care/home visiting services
- Services for people who are getting out of jail or prison
- Tuberculosis treatment

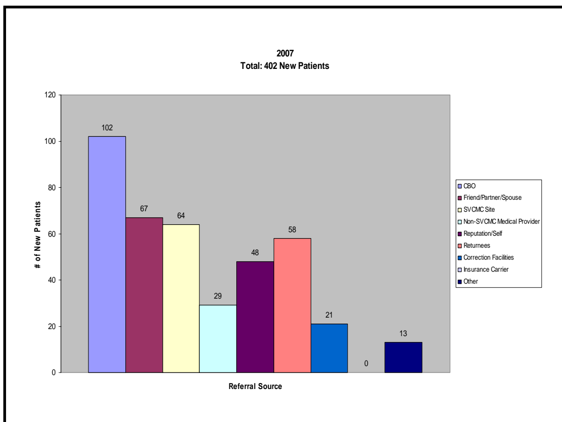
How do we begin?

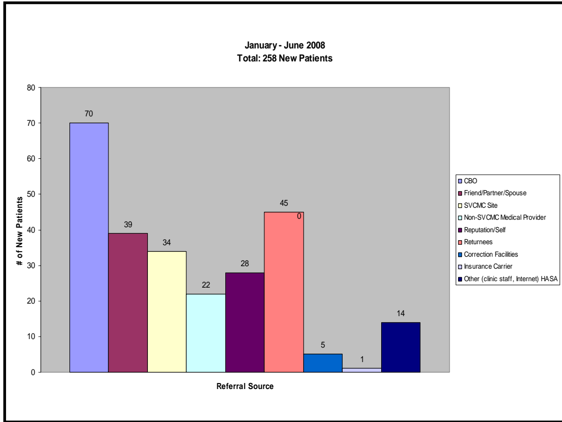
Step One:

Referral Sources


New Patients Per Month for 2007
# of New Patients
60
50
40
30
20
10
0
29
28
35
29
22
31
30
37
45
52
28
37
January
February
March
April
May
June
July
August
September
October
November
December


New Patients Per Month for 2008
# of New Patients
60
50
40
30
20
10
0
39
42
42
52
40
43
January
February
March
April
May
June


2007
Total: 402 New Patients
# of New Patients
120
100
80
60
40
20
0
102
67
64
29
48
58
21
0
13
Referral Source
CBO
Friend/Partner/Spouse
SVCMC Site
Non-SVCMC Medical Provider
Reputation/Self
Returnees
Correction Facilities
Insurance Carrier
Other



Where Are We Losing The Client?

Retention Study: N=30 January to December 2007

- 97% kept the first medical appointment after orientation
- 24% were no-shows for 2nd Medical appt
- 23% dropped out of care by December 2007
- 40% dropped out of care from the initial orientation in January to December 2007
- 60% were in care by December 2007

Interventions

New Patient Orientation Appointments 2006

Month	Scheduled	No Show	Kept	Show Rate
January	23			
February	52	19	33	63%
March	72	25	47	65%
April	49	21	28	57%
May	49	25	24	49%
June	68	68	42	62%
July	59	27	32	54%
August	54	23	31	57%
September	50	19	31	62%
October	60	26	34	57%
November	63	27	36	57%
December	52	28	24	46%
Total	651	308	362	56%

Planned Intervention

All patients who miss their initial New Patient Orientation Appointment will have an outreach attempt by the Maintenance in Care Program as a component of the Access to Care arm of the intervention.

Maintenance in Care

- NYCDOHMH funded intervention
- Staffed by full time RN and full time Outreach Worker
- Focusing on Maintenance in Care/Access to Care
- Comprehensive Medical Case Management & Outreach to connect patients to care

Procedures

- Patients who miss two consecutive appointments or have a history of sporadic attendance in clinic are referred to the RN.
- Referrals are made by multi-disciplinary personnel
- Electronic scheduling system automatically allows practitioners to make referrals to program.
- Outreach worker in conjunction with RN go into the community to find the client
- RN meets the client upon return to clinic and enrolls them in intensive clinical case management

Findings

- Clients are extremely transient and therefore many times the contact information on file is outdated.
- Patients like the outreach effort but are not necessarily accepting of an escort back to clinic.
- Once the outreach effort is made, if the client is truly out of care he or she does return.
- Using Equifax, etc allows us to obtain the latest information on client location and is usually more updated than our registration system.
- Success of project has permitted additional enhancements in funding from the NYCDOHMH.
- Use of Consumer Advisory Board members to update demographic information on patients

MIC PDSA -- Starting August 1

PART 1

P: To determine if pre-appointment reminder phone call will improve the show rate to the initial medical appt.

D: When orientation is complete the SW will hand the "orientation completion sheet," which has the pt's phone number on it, to Receptionist. She will call the pt just before the Initial medical appt.

S: After all August new pts have completed or missed their initial medical appt, we will determine the percentage show rate of those called and compare it to those NOT called in the previous groups.

A: If the reminder phone call is found to improve the show rate we will put it into consistent use. Caveat: this PDSA is totally dependent upon SW who must get the orientation sheet to Receptionist at the time of the SW appointment.

MIC PDSA -- Starting August 1 Cont.

Part 2

P: To improve long-term retention rate. Previous group had 60% retention without intervention. With involvement of MIC that rate improved to 66%.

D: All pts who miss the initial medical appt will be referred to MIC or CJI ASAP, preferably within 1 week of missed appt. For the month of August physician assistant will be made aware of all initial appts scheduled. PA will check to see if the pt showed up. If not, will refer immediately to MIC or CJI.

S: Will follow up on all August patients to determine if timely referrals to MIC and CJI improve long-term patient retention.

A: If timely MIC/CJI intervention proves to improve patient retention we will present findings to providers and request that they make the referrals themselves.

Increase Access to Care for Hospital Discharges Not Linked to Care

Assumption

- The optimum time to link persons with HIV/AIDS to medical care in the community would be during the course of a hospital stay and/or at time of discharge

Methodology

- Daily patient rosters listing individuals with HIV/AIDS Dx are generated
- The lists are reviewed by a social worker in HIV Center.
- Social worker visits hospitalized patients with special emphasis on those who were not in any medical care
- Social worker creates a "bridge" from inpatient to outpatient, and meets the client at the initial appt in the HIV Center

Findings

- The majority of patients seen have private doctors or named another facility at which they were being followed.
- For those already in care at St. Vincents, the visit solidified their connection to our hospital.
- Patients with no linkage to medical care have followed up with orientation appointments at the HIV Center.
- Patients with no linkage to care and fail to keep the initial appointment for outpatient treatment are referred to MIC for follow up.

NYCDOHMH
Field Services Unit (FSU)

Purpose

- NYS Law requires that providers insure that post test counseling of HIV+ individuals include discussion of contact notification and available medical and social services
- Program assists providers by assigning staff to clinical settings to interview persons newly diagnosed with HIV infection
- Studies show that persons who know their HIV status are more likely to protect their partners than those who do not.

Procedures

- The FSU interviews person reported with HIV infection and assist patients with partner notification and linkage to care.
- Identifying and testing partners and people from social networks provides an opportunity for identifying previously undiagnosed cases of HIV and linking them to care.

Findings

Under Development

Involving the Medical Providers in Retention

Procedures

- Medical providers get a roster of patients every 3 months with last viral load listed.
- They are asked to contact patients whose viral load is unstable and have not followed up in the appropriate time period or any patient who has not been seen in 4 months.

Findings for unstable viral load

- Substance Abuse
- Non-adherent
- Psychiatric issues
- Side effects
- Away
- Refuse Medications
- Resistance

Outcome of Interventions

Our clinic-wide rates for vial load control (<400) without respect to their CD4, or whether or not they are on medication went from 53% in 2001 to 73% in 2007

Conclusions

- Global outcomes cannot be attributed to any one intervention.
- Multiple interventions in multiple locations have the best opportunity for success

Acknowledgments:

- NYSDOH/AIDS Institute
- NYCDOHMH
- Barbara Johnston, MD
- Antonio Urbina, MD
- Daisy Soto, RN
- Theresa Rosenfeld, LCSW
- Edwin Ortiz