Exploration of Potential Actions to Improve Follow-up Contact Rates for "Hard-to-Reach Patients"

Introduction

Goal and Background

The goal of this project is to identify and disseminate best practices for improving rates of follow-up contacts between care managers and patients. Previously, the Institute for Clinical Systems Improvement (ICSI) created a guide about best practices for the content and quality of follow-up contacts, and the Pittsburgh Regional Health Initiative (PRHI) developed a list of best practices for the systematic case review process by learning from the medical groups with the highest percentages of systematic case reviews among patients with at least one missing value or one value above goal.

Importance

PRHI pursued this project, because the percent of patients with at least one missing value or one value above goal who were contacted by the care managers at least once in the past month ranges from 4.7% to 77.2% at the medical group-level using cumulative data or 14.3% to 77% using data from January 2015. This variation suggests an opportunity to learn from each other and to identify best practices to consider when thinking of ways to improve contact rates for patients.

Approach

For this project, PRHI staff held 12 conversations with care managers or supervisors of care managers from 12 medical groups. During these conversations, PRHI staff used 10 open-ended questions to help inform and guide the conversation in order to elicit the current condition, root causes, and countermeasures.

Findings

Challenges and Countermeasures

When asked to describe the top three to five reasons for not being able to reach a patient when needed, the following reasons were provided in order of how frequently they were mentioned by the medical groups. These barriers are likely inter-related. The conversations also elicited countermeasures that the care managers have used in response to each barrier.

Barrier (frequency)	Countermeasures Mentioned by Care Managers
The patient chooses not to answer the phone call or is not engaged* (9)	• Relationship Building o Address the patient's concerns and priorities "right off the bat" o Build rapport with patients o Use motivational interviewing o Show empathy o Assess readiness to change o Use active listening skills o Keep a cheat sheet of motivational interviewing questions o Ask the patient: "How can we make this more helpful for you?"

Barrier (frequency)	Countermeasures Mentioned by Care Managers
	○ Make a dedicated effort to always have the first contact occur in-person ○ Start with weekly contacts to build relationships ○ Send personal birthday and holiday cards • Proactive Follow-up Contact Attempts ○ Notify and talk to the patient's PCP ○ Initiate the outreach process and use letters ○ Attempt to meet the patient at an upcoming appointment within the system to build rapport (e.g., at the patient's next PCP appointment) ○ Be persistent and supportive; "don't give up" • Scheduling ○ Try to call at different times of the day and change your routine • Other ○ Refer to and *meet with* community resources, human service agencies, and behavioral health providers
Limited Cell Phone Minutes (8)	• Offer in-person meetings • Offer to send out information • Send text messages • Send emails
No phone service or disconnected phone service (4)	• Offer in-person meetings • Check government discounts on phone services
Socioeconomic stressors (3)	• Refer to and *meet with* community resources and agencies • Conduct home visits with social workers
Telephone numbers that keep changing (2)	• Look for upcoming, scheduled PCP appointments • Conduct home visits
The patient is not home (2)	• Try to call at different times
Working full-time and unavailable during business hours (2)	• Be flexible and try to call during non-business hours • Extend clinic hours
The patient forgets (2)	• Remind them ahead of time • Send text message reminders • Offer the patient a calendar
Transportation Costs (1)	• Try to get parking vouchers • Offer telephone calls • Conduct home visits
Very depressed and off track or mood problems (2)	• Discuss with the patient's PCP and systematic case review (SCR) team
No answering machine (1)	
Changed PCP providers (1)	
Language Barriers (1)	• Use a language service
Transient, homeless population (1)	• Refer to and *meet with* community resources and agencies
Hospital admission (1)	• Follow-up on hospital admission notes
Work with other patient populations and need to balance priorities (1)	

*The conversations with care managers and supervisors did not reveal why the patient chooses not to answer or is not engaged, but as previously note, these barriers are likely inter-related.

Similarities and Differences between Groups

This section outlines the themes and elements of the conversations in two categories:

- the medical groups with a contact rate above 50% based on cumulative data (the "above 50% group") and
- the medical groups with a contact rate below 50% based on cumulative data (the "below 50% group").

Differences between groups included:

- All of the medical groups in the above 50% group talked about a process to *track no-shows and missed contact attempts with electronic reminders and flags* that prompt for systematic follow-up contacts.
    - In comparison, about half of the medical groups in the below 50% group talked about this process, and when they did, they mentioned challenges (e.g., turnover among care managers or figuring out whom to assign the role of tracking lost-to-follow-up patients to) or variation by care managers (e.g., one care manager may use a paper filing system whereas another may use the AIMS Care Management Tracking System).
- Medical groups in both categories talked about a *process with activities and timelines for trying to contact patients with missed contact attempts,* but medical groups in the below 50% group only had a *general process* that varied by care manager or patient, whereas groups in the above 50% group had *detailed processes without variation by care manager*.
    - These activities includes a series of calls, reminder "I miss you" letters/emails, communication with PCP and SCR team, and ultimately a discharge letter.
- All but one of the medical groups in the above 50% group used language that reflects *motivational interviewing principles*. For example: "I ask the patient about what frequency they would like, and I also use their disease target to inform this. Some are weekly contacts, but it is really involving the patient as a partner. I put the patient in charge."
    - In comparison, only one of the below 50% groups described their follow-up process in a way that reflects motivational interviewing. For example, the one medical group in this category said, "We always ask for the patient's permission."
- 40% of the medical groups in the above 50% group placed on emphasis on having the *first meeting between the care manager and patient occur in-person* to establish trust and rapport. This was not emphasized among medical groups in the below 50% group.

Similarities between the two groups:

- Medical groups in both categories discussed a *process for checking appointment schedules* for upcoming appointments with the "hard-to-reach patient" within the organization.
- Medical groups in both categories discussed a *process for scheduling a specific date and time for the next telephone call or in-person meeting* just like a regular appointment. Or if this was attempted at the beginning but didn't work for patients, then they developed *a routine for creating a call list for the day based on timeframes that work for their patients*.

- Relatively few medical groups in both groups (30% in the below 50% group and 40% in the above 50% group) used language that reflects *behavioral activation* when they described their processes.
    - For example: "I change the frequency based on what the patients tell me and whether they are doing the things they want to do...and taking responsibility for their own goals." And "The contact frequency is partially determined by whether the patient has demonstrated an ability to set and work towards behavioral activation goals."
- Few medical groups in both groups (20% among the above 50% group and 30% among the below 50% group) discussed a *process for reaching out to family members and emergency contacts* if the care manager cannot reach the patient.

In addition, it was interesting to hear that two of the groups with contact percentages above 50% said their patients love and expect the frequency of the contacts. For example, one care manager explained: "If they are interested in the COMPASS program, this is what they want and expect." This may speak to the *organizational culture and clearly communicated expectations* of standard contact frequencies for care managers and patients. Also, many of the groups explained how they *establish follow-up contact frequencies in partnership with the patient* during the initial contact.

Summary and Ideas to Consider to Inform Your Own Quality Improvement/PDSAs

The most frequently identified theme among the groups with a follow-up contact rate above 50% was an electronic process to track no-shows and missed attempts. This reflects the core concept of population-based care, where the entire case load is tracked instead of just those with an upcoming scheduled contact or who are actively engaged in the care process. Although this was the third most frequently mentioned theme among the groups with a follow-up contact rate below 50%, these groups talked about the challenges that they experienced with this process (e.g., turnover among care managers, changing the tracking role among different team members, and varying approaches by care manager).

- ***Consideration:*** *Build a common process across care managers that includes reviewing the entire case load, not just those who are already scheduled, and stratifying by the time since the last contact and high BPs, PHQ-9s, and A1cs in order to generate a daily call and meeting schedule.*

All of the medical groups were able to describe a process for attempting to contact "hard-to-reach patients" that includes specific activities and timelines (e.g., a series of calls, reminder "I miss you" letters/emails, and communication with the PCP and SCR team prior to a discharge letter). There was not a clear best practice in terms of the length of this process (e.g., 3 months vs. 6 months) or the number of contact attempts. However, when the conversations were compared between the group with follow-up contact rates above 50% and the group with follow-up contact rates below 50%, the group with the follow-up contact rates below 50% described variation in the number of calls and duration between care managers, whereas the group above 50% did not talk about variation.

- ***Consideration:*** *Write out the standard work and roles for each follow-up contact process, standardize these details across the care managers, and then monitor whether this increases the follow-up contact rates.*

Although the PRHI[1] staff who talked with the care managers did not ask whether they use motivational interviewing, *the way the care managers described their processes in the group that had a contact rate above 50% frequently resembled the core values of motivational interviewing (MI).* This suggests that there is a high penetration of the "MI spirit"—a way of being with people that is collaborative, evocative, and respectful of autonomy—in the group with follow-up contact rates above 50%. Also, a majority of the countermeasures for the top reason for not being able to contact patients on page one reflect the spirit of MI.

- ***Consideration:*** *Identify a care manager champion or a care manager supervisor who could be trained to provide motivational interviewing coaching and feedback to the care managers to evoke and strengthen their motivational interviewing skills.*

Lastly, there does not seem to be a silver bullet. For example, some of the practices with follow-up contact rates above 50% always end the follow-up contact with a scheduled date and time for a next follow-up contact, but others tried this and learned that for their patients, finding a general time of day and day of the week works best. Regardless, in both cases, they learned from their patients what works best and used this to develop a routine.

More Information about Best Practices

If you are interested in learning more about how to improve your follow-up contact rate, reach out to your colleagues who have monthly follow-up contacts rates above 70% for patients with at least one value above goal or at least one missing value:

- Mayo Clinic Health System: 77.2%
- Excela Health Medical Group: 75.4%
- Lakeview Clinic: 74.7%
- Neighborcare Health: 71.9%

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[1] The PRHI staff who had the conversations with the care managers and supervisors are motivational interviewing trainers and coaches; they were able to actively listen for motivational interviewing language.