

## Central City Concern Old Town Clinic Process and Procedure Document

### #107.00 – Process and Procedure for Care Management Outreach at the Old Town Clinic

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#### ***Statement of Purpose:***

Outreach is the proactive contact of patients who are due for clinical and non-clinical services. The purpose of this procedure document is to provide guidance for staff on the process of outreach, documentation requirements as well as frequency of outreach. This document will be updated on an as-need basis to capture all consistent outreach either occurring within the team rooms or affecting clinical practice at the Old Town Clinic.

#### ***Scope:***

All procedures listed in the following document apply to all staff conducting outreach for each of the specific types of outreach as listed below.

#### ***Administration and Oversight***

Oversight of the processes defined within this document will be the responsibility of the Senior Director of Primary Care. The contents within this documented procedure will be reviewed and updated by the clinic's Quality Improvement Specialist in collaboration with the above staff as defined.

#### ***Care Team Outreach at the Old Town Clinic: Types of Outreach***

Outreach at the Old Town Clinic is divided into the following different types:

- 1) Appointment-based and utilization of services outreach**
- 2) Preventive care services outreach**
- 3) Chronic condition management outreach**

#### **1) Appointment-based and utilization of services outreach**

- i. Targeted outreach to patients who frequently use the Emergency Department
- ii. Patients not seen at the Old Town Clinic within the past 12 months
- iii. Patients whose eligibility for care at the Old Town Clinic is to expire within three months
- iv. Follow-up for no-shows related to reason and reschedule if applicable

#### **2) Preventive care services outreach**

- i. Eligible female patients in need of Cervical Cancer Screening
- ii. Patients age 65+ that have not had a flu shot within the last 6 months- letter
- iii. Eligible Patients in Need of Colorectal Cancer Screening

#### **3) Chronic condition management outreach**

- i. Diabetic patients needing an A1C
- ii. Patients with A1C>9%
- iii. Patients with Diabetes with a BP result > 140/90 at their last visit

**Outreach Table:**

<b>Outreach</b>	<b>Staff Assigned</b>	<b>Frequency of outreach</b>	<b>Source of Data</b>	<b>Frequency of reporting</b>
Patients who frequently use the Emergency Department	BH Program Assistant, Health Assistants	Weekly	PreManage	Monthly
Patients not seen at the Old Town Clinic within the past year, prioritizing patients whose eligibility for care at the Old Town Clinic is to expire within three months	Population Health Coordinator, Care Team Staff	Until completed	CCCER report- OTC Provider Panel report	Once monthly (1 <sup>st</sup> of month)
Follow-up for no-shows appointments	Front desk staff (after-hours)	Daily	Centricity schedules	
Eligible Female Patients in Need of Cervical Cancer Screening	Population Health Coordinator, Medical Assistants	Until completed	SSRS report	Monthly
Patients age 65+ that have not had a flu shot within the last six months	Care Team Manager	Runs query once a year in and sets up mail merge; coordinates with volunteer / available staff for mailing	Centricity – Inquiries	Once a year – September
Patients in need of Colorectal Cancer Screening	Population Health Coordinator, Medical Assistants	Until completed	SSRS Report	Monthly
Diabetic patients needing an A1c test in the last six months	Medical Assistants	Until completed	SSRS Report	Monthly
Patients with Diabetes with a BP result > 140/90 at their last visit	Medical Assistants, Pharmacists	Until completed	SSRS Report	Monthly
Patients with A1C>9%	Pharmacists	Until completed	SSRS Report	Monthly

## Appointment Based and Utilization of Services Outreach

***Procedure: Outreach for Patients who frequently use the Emergency Department (patients who have been seen in the ED 5 or more times in the last 6 months and who have BH diagnosis):***

- a) **Identifying patients for outreach:** Look at PreManage for patients who have been seen in the ED 5 or more times in the last 6 months and who have behavioral health needs/diagnoses.
- b) **Documentation:** All calls made and letters sent must be documented within the EMR.
- c) **Follow-up:** Attempt to call patient three times. If unable to reach patient, send a letter (ED Outreach).
- d) **Data and Tracking:** BH Program Assistant/ Health Assistant to track their outreach to patients within ED outreach spreadsheet.
- e) **Frequency of outreach:** ED Roster spreadsheets should be checked daily by care teams. An attempt should be made to contact the patient within 48 hours business days
- f) **Source of Outreach:** PreManage
- g) **Staff assigned:** BH Program Assistant/ Health Assistant

***Procedure: Patients not seen at the Old Town Clinic within the past year***

- a) **Documentation:** All calls made and letters sent must be documented within the EMR.
- b) **Follow-up:** Attempt to call patient three times. If unable to reach patient, send a letter (Panel Management – Outreach)
- c) **Data and Tracking:** Population Health Coordinator maintains tracker sheet.
- d) **Frequency of outreach:** Outreach to be performed monthly.
- e) **Source of Outreach:** CCCER report – Old Town Clinic Provider Panels
- f) **Staff assigned:** Outreach is primarily the responsibility of population health coordinator and health assistants.

***Procedure: Follow-up for no-shows appointments***

- a) **Documentation:** Outreach is to be documented within the text field of the original appointment note
- b) **Follow-up:** Follow-up for no-shows is to be performed by front desk staff after hours **for the following appointment types:**
  - General medical
  - Mental Health
- c) **Data and Tracking: Frequency of outreach:** Daily
- d) **Source of Outreach:** Centricity schedules
- e) **Staff assigned:** Front desk staff

## Preventative Care Services Outreach

- a) **Documentation:** All calls made and letters sent must be documented within the EMR.
- b) **Follow-up:** Attempt to call patient three times. If unable to reach patient, send a letter (letter within EMR)
- c) **Data and Tracking:** Outreach is tracked and performed by the clinic's Population Health Coordinator.
- d) **Frequency of outreach:** Outreach is performed daily and tracked within the Preventive Screening tracking spreadsheet
- e) **Source of Outreach:** SSRS report
- f) **Staff assigned:** Population Health Coordinator and Medical Assistants

## Chronic Condition Management Outreach

### *Procedure:*

- a) **Documentation:** All calls made and letters sent must be documented within the EMR.
- b) **Follow-up:** Attempt to call patient three times. If unable to reach patient, send a letter.
- c) **Data and Tracking:** Teams to turn in lists monthly to population health coordinator.
- d) **Frequency of outreach:** Outreach to be performed monthly.
- e) **Source of Outreach:** SSRS report
- f) **Staff assigned:** Outreach is primarily the responsibility of Medical Assistants, Population Health Coordinator and pharmacists.