Sample Outreach Protocol

Who Qualifies for Outreach

- At the **initiation of your agency's STEPS program**, medical providers must provide a list of clients who were lost to follow-up. This could be defined as a client who had a medical visit within the facility within the last two years but none within the last 9 months.
- Lost to care should be defined in collaboration with the medical providers as you are preparing for implementation to prioritize identifying patients at greatest need of STEPS to Care program services.
- Care Coordinators must maintain records of clients who have been enrolled into the STEPS to Care program but have since fallen out of care after continued failed attempts at communication following missed appointments. (See the Missed Appointment Protocol.)
- Both lists should be updated regularly on a quarterly basis.

Conducting Outreach

- Staff should verify the client's contact information, create a case finding record, and assign this record to a staff member (typically a Care Coordinator). **All outreach activities should be logged within this case finding record.**
- After this has been done, proceed to reach out to the client according to the agency's Missed Appointment Protocol (typically the Care Coordinator makes these calls but the Patient Navigator can also have a role)
- Internet/online searching for the client is allowed at any time during outreach.

Actions taken during case finding are detailed below:

If the client is found, and engaged in care elsewhere	Transfer the client's medical record to his or her new provider to ensure there is continuity of records. Make sure to receive written consent from the client to transfer the medical information.
If the client is found, not engaged in care elsewhere, and willing to return/enroll into the STEPS program	Schedule a medical appointment immediately and offer accompaniment.

If the client is found, and temporarily unable to return/enroll into the STEPS program	*For example, if the client has moved temporarily and plans to return or is incarcerated:* Transfer the client's medical records to his or her new medical provider. Make sure to receive written consent from the client to transfer the medical information. Communicate to your medical provider partner about the interruption in care and why. Note when the client will be able to return to your agency's care.
If the client is found, and permanently unable to return/enroll into the STEPS program	*For example, if the client is serving a long-term incarceration, permanently moving, or has passed:* Transfer the client's medical records to his or her new medical provider. Make sure to receive written consent from the client to transfer the medical information. Communicate to your medical provider partner about the interruption in care and why.
If a client is found, not enrolled in care, and unwilling to return/enroll into the STEPS program	Explore the reason why the client is unwilling to return to care. If the client has previously had a Patient Navigator assigned to him or her within the STEPS program, have the Patient Navigator reach out to the client. If the client has not built a good relationship with the Patient Navigator, the Care Coordinator could step in and ask if the client wants to be assigned a new Patient Navigator or work directly with the Care Coordinator. If the client continues to decline, work with him or her to find a care program more suitable to his or her needs.