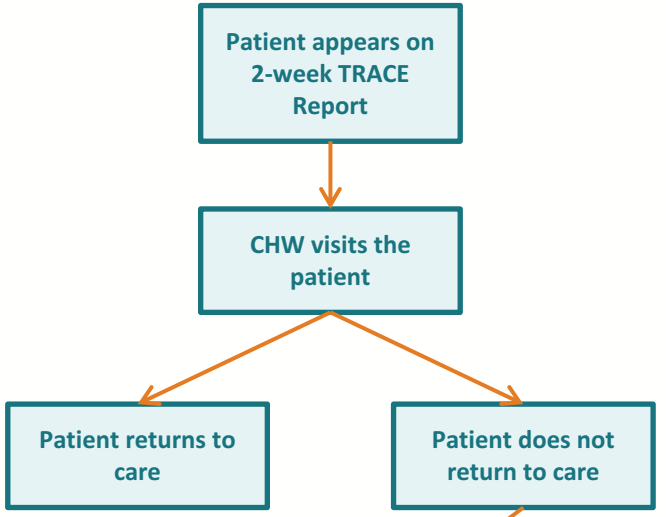
Part 5: Community-based Follow-up: TRACE

Tracking Retention and Client Enrollment

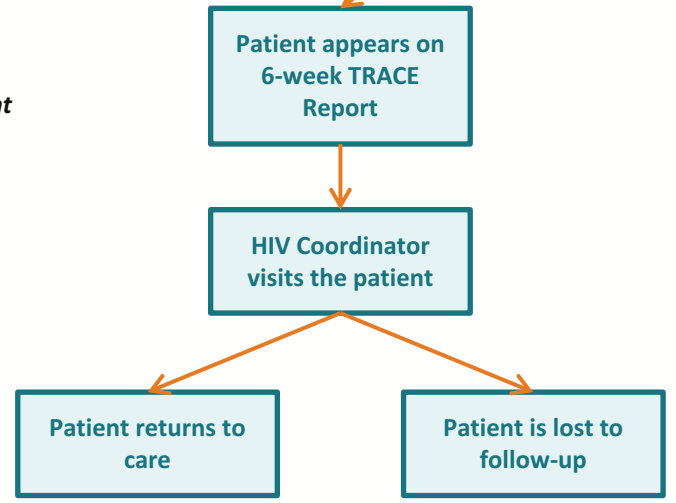
1. MISSED APPOINTMENTS

TRACE is PIH's system for following up with patients who miss an IC[3] appointment, and it is currently also used for patients who need to visit the health facility for lab work or results, as well as TB and nutrition patients with a missed appointment. It is a two-tiered system in which first CHWs and later the HIV Coordinator visit patients and bring them back to care. The TRACE cycle operates twice per month, beginning with printing and distributing the TRACE Report, which contains the list of patients who need to be followed, and ends when the reports, filled in with patient outcomes, are returned two weeks later so that patient records can be updated before the next cycle begins.

Tier 1:
2-5 weeks since missed appointment



Tier 2:
6-11 weeks since missed appointment



2. DOCUMENTATION SUMMARY

TRACE Report

The TRACE Report, which is generated by the EMR, contains a list of all patients who need to be visited due to a missed appointment. Patients are also included if they are due for lab work (i.e. viral load test), or have a new, urgent lab result (i.e. positive EID test).