Health Centers Detroit Medical Group (HCDMG)

Enhancing Linkages to Care: Our Best Practices

Anthony Clarke, MD - HCDMG Medical Director

Michelle McGarrity MA, LLP

Limited Licensed Psychologist

Integrated Primary Care Behavioral Health Clinician-HCDMG

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Our Best Practices Enhancing Linkages to Care (LTC)

Do:

- Set the stage for success.
- -Develop rapport with patients throughout primary care service relationship continuum. Inform the patient you are “riding alongside” of patient in this process offering care, concern, help and guidance.
- We have found primary care offices are often viewed by patients as trusted support centers, with providers and team members serving as type of ‘care family’. It is not unusual for some patients to build strong relationships with care team members. Building on these potential ties can be very helpful in enhancing engagement in the linkage to care process and follow though assessment and monitoring.
- Primary care and HIV/AIDS treatment and advocacy services provide best outcomes for the patient when the teams partner and work in concert throughout the care process.

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- -Create a non-judgmental, supportive, patient-focused and patient-empowering culture in your practice. A culture where patients feel safe to share and open up.
- -Utilize modeling and training approaches that may assist in teaching these principles and skills to the team.
- -Promote this tone and environment across leadership and providers throughout the practice and with each team member as they work with and exchange with patients.
- -Emphasize the practice team's patient centered approach, patient is the lead, advocacy component, stress importance of confidentiality, privacy and respect.

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- -Meet as a team regularly to reinforce skills and process team experiences, concerns, thoughts, questions.
- Options for building a positive, safe, non-judgmental culture:

Team Member Training:

- -Motivational Interviewing Approach
- -Brief Intervention Approaches for Primary Care Settings
- -HIV Counselling and Testing Certification
- -Mental Health and Substance Use Screening for comorbidities, depression, substance abuse (i.e. PHQ-9, DASH, CAGE, etc.) w/linkage to Behavioral Health Care.

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- Case Study Discussion: 19 Year Old patient history of trauma, sexual abuse, stigma around sexuality and HIV status.

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- **Tools and Modalities:**
- -PDSA Model: Plan – Do - Study - Act
- -Practice Team “Lunch and Learn” sessions (i.e. quarterly) to review new HIV/AIDS advocacy and service information, education and skills (consider inviting speakers).
- -Assess (i.e. PDSA) utilization, processes (i.e. developing LTC HR prompts and recording progress, questions and concerns.

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- **What We Know:**
- Engaging HIV-Infected Patients in Care: Assessing the Scope of the Problem
- Although knowledge of one's HIV serostatus is essential, it is only the initial step along the HIV care continuum (Figure), and connection to care must occur in a timely fashion in order to fully realize the benefits of HIV treatment. In studies examining linkage to care following an HIV diagnosis, only approximately two thirds to three quarters of diagnosed patients made a connection to care within the first year. Even more strikingly, a significant number of HIV-infected persons enter care only after they have already progressed to severe immunosuppression or experienced other HIV-related complications. In a study of 1038 hospitalized HIV-infected persons in Atlanta, Georgia, and Miami, Florida, 68% were aware of their HIV-positive status for more than 5 years, yet 20% had never seen an HIV primary care physician. **From Cheever, LW. Clin Infect Dis.**

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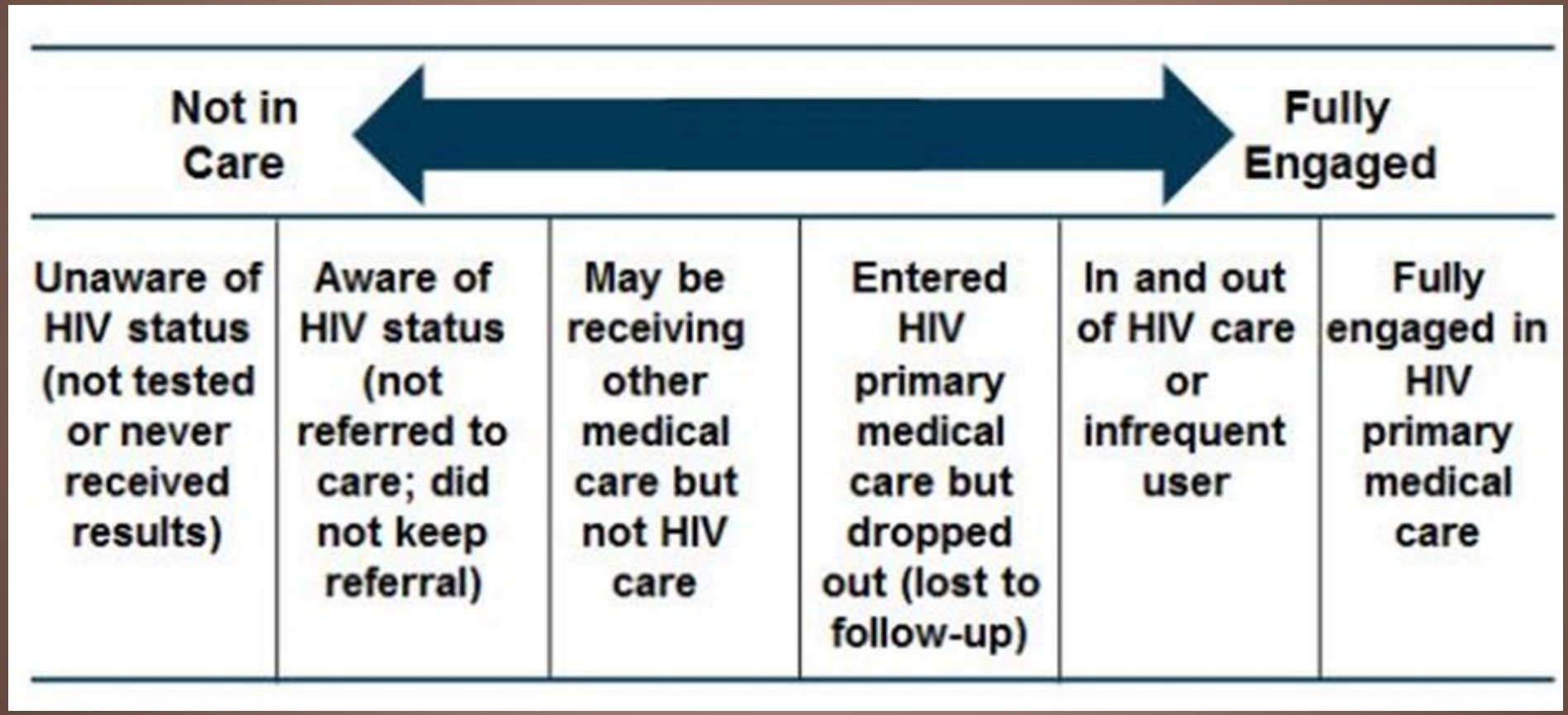

Identifying, tracking and monitoring progress and closing the Linkage to care gaps are essential.

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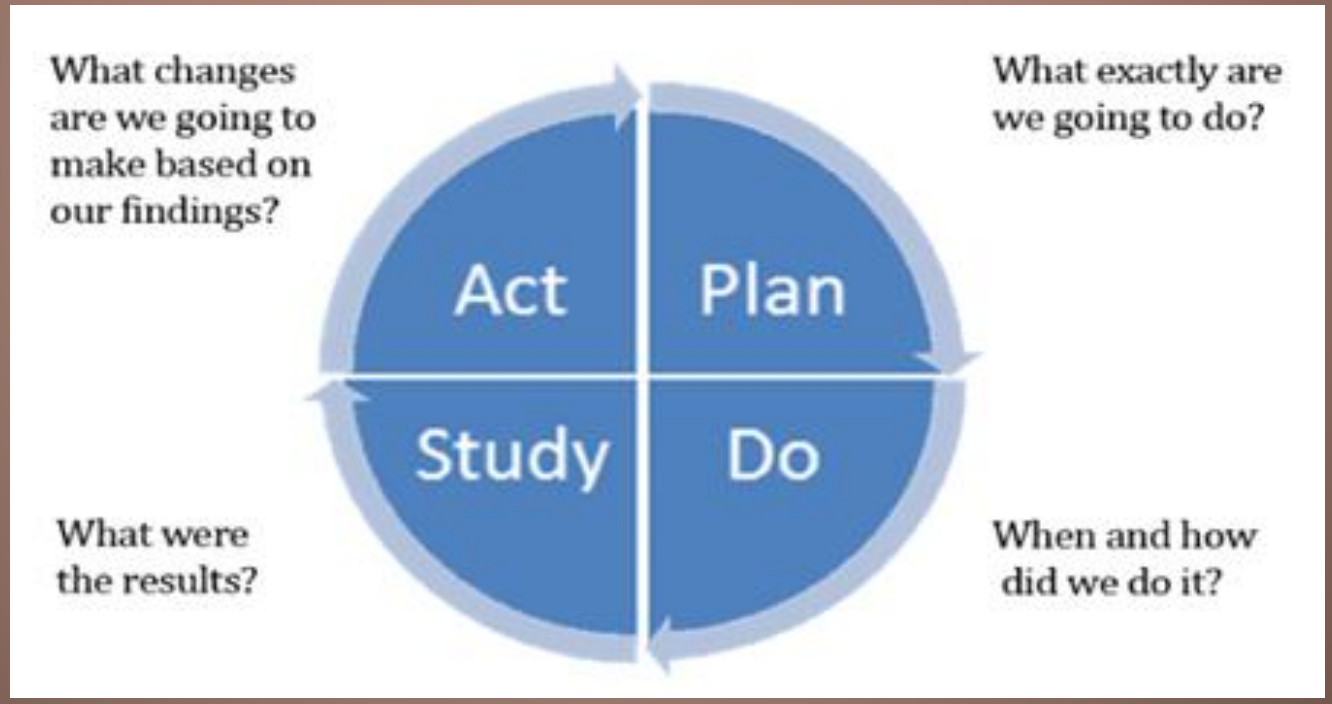
- Do: Assessment
- PDSA's A Closer Look at a Great Process Improvement Tool.



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Do:

- Create Linkage to Care Plan:
- Identify sources/contact information of HIV/AIDS Care, Services and Advocacy.
- Develop contact and partnership planning meeting schedule.
- Co-design process agenda.
- Implement or ‘do’ plan.
- Study implantation of plan.
- Act on new knowledge what worked what did not.
- Implement next cycle of PDSA.

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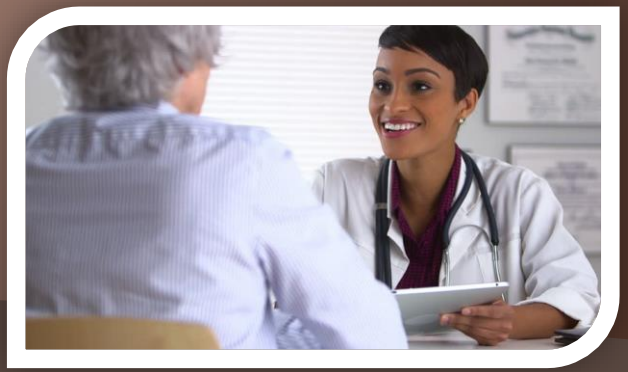
- With patient:
- Identify patient potential barriers to linkage to care follow through.
- -Give rationale and ask permission to review helpful resources with patient.
- - Identify patient's concerns, barriers, thoughts beliefs attitudes about linkages to care (i.e. privacy, stigma, lack of support, finances, and/or other, more pressing needs).
- -Seek out and develop community partnerships with HIV/AIDS service and advocacy based organizations that serve the patient population. Be an active agent for change in your organization, always seek new information and contacts.
- -Consider a Patient-Primary Care Team PDSA.



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- Options for developing partnerships:
- -Identify key practice team members to phone, visit with agencies. Invite agency providers to meet with team members at clinic, identify practice team members to attend HIV/AIDS community meetings.
- -Consider partnering with HIV/AIDS community service agencies.
- -HCDMG created LTC steps with key contacts with: Children's Hospital of Michigan/Horizon's, CHAG, Wayne State University Physician's Group Infectious Disease Clinic.

WAYNE STATE University Physician Group

DMC DETROIT MEDICAL CENTER

ChildrensDMC.org

Steps:

- Review results with Physician, review patient history*, identify and contact HIV/AIDS services organization based on patient needs/preferences. Make plans for representative to be present for warm handoff (with permission) during/after results. Practice Warm Handoff with organization representative. Implement plan with patient, call associated organizations set appointments with patient while patient in office. Create follow up contact plan with patient and organization representative. Identify potential barriers, create plan to address. Discuss progress with providers

Develop

- -Develop staff education & sensitivity training around familiarity with cultures, social norms, attitudes, beliefs, terminologies within diverse populations. When co-designing LTC plan with patient consider patient's history, risk, trauma, stigma, privacy, confidentiality issues, how patient defines gender, sexuality, behaviors. Let this information inform and guide your dialogue. Promote nonjudgmental aspects of practice team members, care approach and culture.

Reinforce

- -Work to reinforce the established Linkage Plan building blocks (patient's strengths, priorities, values, social support and their links to HIV treatment and care engagement) relationships and resources, revisit progress periodically during PCP visits. Encourage the team to support plan (with permission and as indicated).
- -Reinforce these messages and plan – often throughout pre and post testing, results and LTC process.

Barriers & Drop Out: Avoid A Slip Through the Cracks

- Insurance barriers, absence of case management, absence of outpatient mental health services, mental health status score, illicit drug use, and certain health beliefs that included fatalism as well as mistrust of the healthcare system have been associated with delayed entry into care,[11] as have poverty, unstable housing, and incarceration as barriers and predictors of delayed linkage to HIV care.
- HIV/AIDS-specialty specific Case Management Peer Navigation may be of value in reaching patient populations. Individuals who experienced increased belief/fear barriers to care were less likely to engage in care. Belief barriers may include mistrust of the healthcare system, concerns about treatment, concerns/stigma around public knowledge of HIV+ status these barriers may be prevalent among certain populations.

Re-engagement

- -Make a plan for reengagement should drop out or lost to follow up occur. Update contact information each visit. Follow up calls, sending post cards/letters/texts as indicated.
- Identify HIV/AIDS service organizations willing to send a representative to practice during result delivery to complete warm handoff (with patient permission).
- Appoint team member to set linkage to care appointments – with patient taking the lead- while patient in primary care office.
- Identify names direct contact, back up. Revisit often update contacts. Document all information in EMR with identified timeline and associated prompts for follow up with patient.
- Help to shape expectations, overview of experience.
- Overview of organizations processes pros and cons, what to expect, how to prepare.
- Continue to ride alongside patient throughout linkages to care:

Navigate Linkages Alongside Patient

- Continue to ride alongside patient throughout linkages to care:
- Assess progress on a regular basis (potentially each PCP visit)
- -Reinforce support encourage-Consider Follow up calls did the appointment happen? Pros/cons? Helpful people? What worked what didn't? Plan made with agency? Record in EMR.
- -Engage "special team members" to connect with patient around existing rapport and reinforce messages encouraging follow through with linked care providers.
- -Create a "Patent Centered HIV services and Advocacy Neighborhood Resource Book" and offer new and updated information about services, providers, resources. (Identify key point persons on team to sign up with list serves, email lists, resource lists etc. Create plan to contact and reinforce/revise partnership linkage plans periodically (i.e. monthly/quarterly).
- -Consider having staff members receive HIV testing and counselling training.

Navigate Alongside Patient

- Using information, experiences gleaned, lessons learned from rapport building with patients, building partnerships, relationships, strategies and (monthly to quarterly) Linkage Process Revisions and Trainings to create a linkage to care protocol for the entire team with step by step instructions, contact information, timelines, identified persons to carry out tasks.

DISCUSSION:

- Take-Aways?
- Next Steps?
- Our Best Practices Resources:

Resources