

Data to Care Link-Up Detroit Jackson County

Michigan Premiere Public Health Conference

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Presenters



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Agenda



Presentation (20 min)

- Data to Care (D2C) Overview
 - What is D2C?
 - D2C Methodology
- D2C in Michigan
 - Jackson County
 - Detroit Health Department (DHD)
- Starting a D2C Program
 - Planning
 - Implementation



Q & A (10 min)

- Questions
- Answers



Breakout Groups (30 min)

- Develop action plan for D2C
- Groups break down by community size
 - Small
 - Medium
 - Large

D2C - Overview

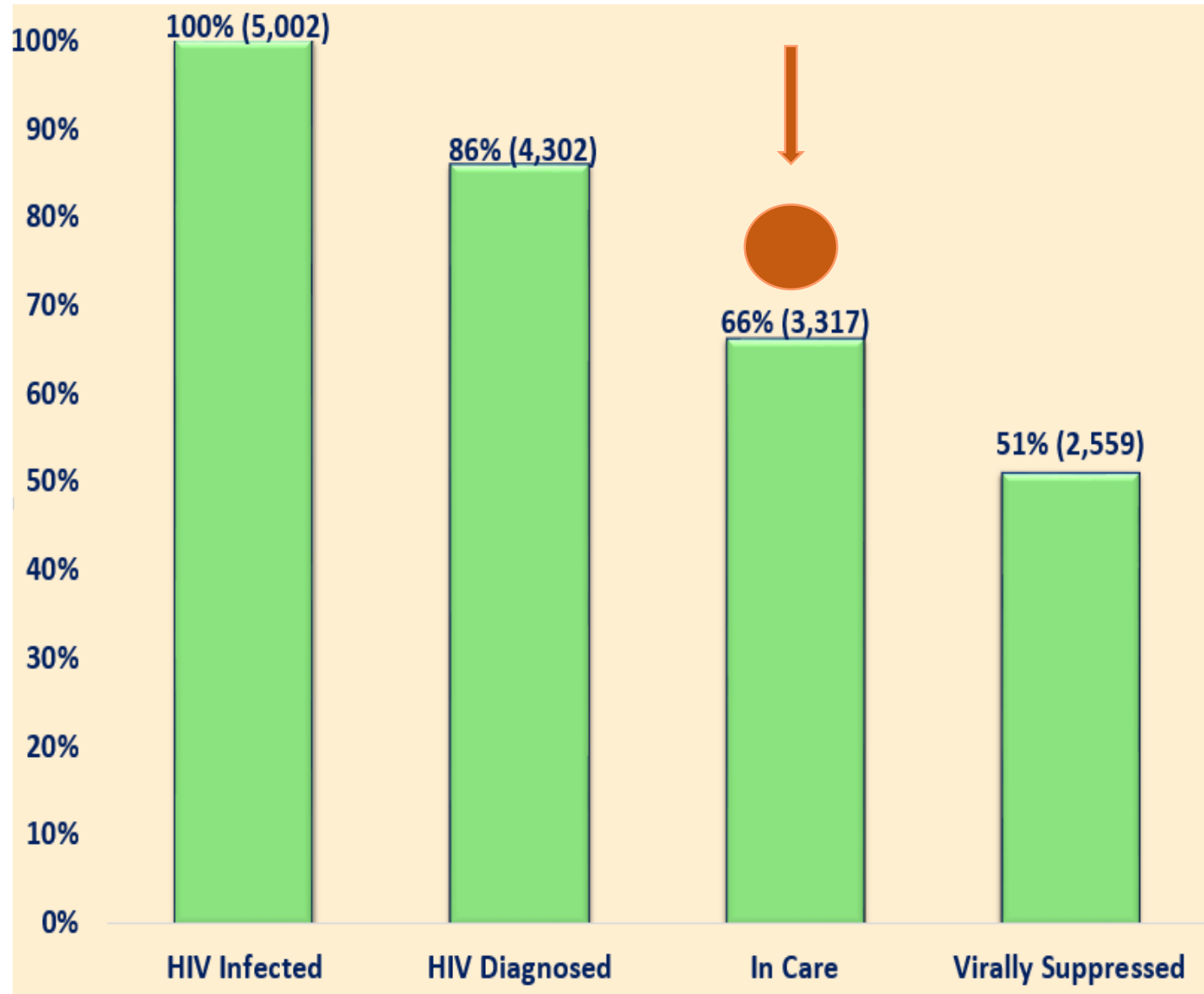
What is D2C?

CDC definition: “**Data to Care** is a new public health strategy that aims to use HIV surveillance **data** to identify HIV-diagnosed individuals not in **care**, link them to **care**, and support the HIV **Care** Continuum.”

Basic Concept:

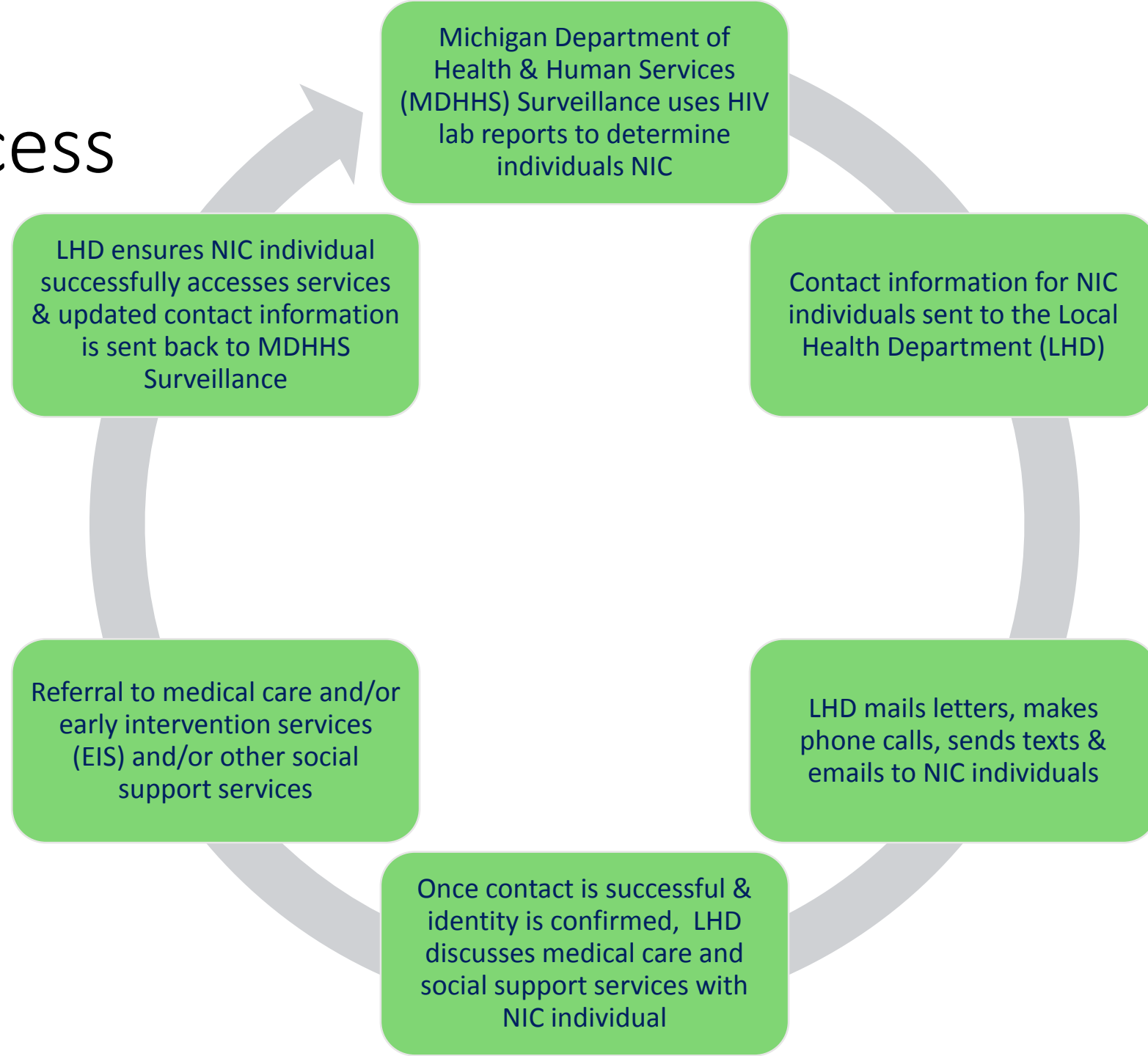
- In Michigan, HIV labs are reported to MDHHS
 - Lab reports are used as a proxy to determine if an HIV-positive individual has been to a medical appointment
- MDHHS sends contact information (name, phone # address, place/date of diagnosis) to the local health department
- The local health department reaches out to these individuals to offer re-engagement into HIV medical care

What group of people does D2C target?



City of Detroit, HIV Care Continuum, 2015

D2C: Basic Process



Examples - D2C in Michigan

Small Community (Jackson Co.) Vs. Large Community (City of Detroit)

Jackson County



Jackson County

Client follow up to date (no recorded labs in >1 year):

- 22 clients identified for follow up
- attempt to update contact information and reach out to all 22 clients or clients physicians for follow up
- 3 clients identified as now residing and receiving care in another state
- 4 clients not ready to commit to care, 3 of whom agreed to receive future follow up calls from public health nurse (Reasons: 1. Not happy with care at ID doctor in Jackson 2. Feels fine and doesn't want to take medication 3 & 4. Client's using holistic therapies)
- 7 clients, not enough information/incorrect contact information, lost to follow up
- 8 clients re-engaged into care and were open to case management as well as public health follow up (identified barriers to care: transportation, parent resources, other medical conditions, not emotionally ready, too much "red tape", depression & overwhelmed, issues with physician and partner influence)

Jackson County

Advantages of Data to Care Program

- Community Health Awareness/ID resource needs
- Maintaining complete and accurate client data lists to identify clients in need of follow up
- Affording all clients the option of maintaining/receiving care by identifying and working to break down existing barriers
- Agency collaboration for client's coordination of care
- Up to date and accurate client listing to improve client relations and service delivery
- Reduce stigma of living with HIV by utilizing open, client centered communication

Challenges of Data to Care Follow Up

- Determining the accuracy of information source used to update contact information for client data list, i.e., EHR, MICR/MDSS/MDOC Offender Tracker/ Public Records/ Internet Search/White Pages/Facebook/People Search, etc.
- Contacting unfamiliar clients and relationship building
- Client's health equity
- Relationship building with local and out of county providers in relation to HIPAA
- Limitation of available resources for client
- Jackson county staffing available to maintain list and engage in follow up

Jackson County

- Jackson County continues to receive client data lists from MDHHS on a quarterly basis and continually works with community partners to coordinate care for clients living with HIV, i.e., Unified Case Management, local Infectious Disease Physician and providers, Lifeways, Henry Ford Allegiance Health.

Link-Up Detroit

Detroit's Data to Care Initiative



What makes Link-Up Detroit unique?

- Extensive planning
 - Community & provider planning
 - Community buy-in
 - Results in: Referrals
- Data management
 - Robust data systems
- Evaluation
 - Continuous evaluation and improvement of processes and data systems
 - Systematic data reports allow us to easily check progress and improve our program
 - Feedback from our consumers – Follow-up done with each client we interact with

Link-Up Detroit - Promotional Materials

Promotional materials are an important piece of initial AND long-term community engagement.

May include things like:

- Website
- Informational packets
- Handouts developed for community health fairs / events

Overall idea: Make sure PLWH and community members know there are resources available to assist PLWH get back into care.

Thought to consider: Having a different name than Data to Care. Detroit uses name *Link-Up Detroit*, because it is more consumer-friendly.

Website:
www.linkupdetroit.com

What is stopping you from accessing HIV Medical Care?

WE CAN HELP

LEARN MORE

SIGN UP

Are you ready to get back into care?

Name *

First Name

Last Name

Date of Birth

MM

DD

YYYY

Phone Number *

(###)

###

####

As of Sep 15, 2017, Link-Up Detroit has received 7 self-referrals from clients completing the website form.

Consumer Brochure

LINK-UP DETROIT

WHAT IS STOPPING
YOU FROM ACCESSING
HIV MEDICAL CARE?



WE CAN HELP

Client Brochure

WHAT DOES LINK-UP DETROIT DO?

We assist HIV-positive individuals, living in Metro Detroit, who are not currently accessing HIV/AIDS care. We provide each individual short-term, intensive support through referrals to existing community support programs and/or engagement with an HIV medical provider.

**Services are
FREE,
confidential, and
voluntary.**

Check out our website!
www.linkupdetroit.com

Provider Pamphlet

LINK-UP DETROIT

DETROIT'S DATA TO
CARE INITIATIVE



Link-Up Detroit/Data to Care (D2C) assists HIV-positive individuals, living in Detroit, who are not currently accessing HIV/AIDS care. Link-Up Detroit provides each individual short-term, intensive support through referrals to existing community support programs and/or engagement with an HIV medical provider.

Provider Pamphlet

HOW DOES IT WORK?

Link-Up Detroit is Detroit's new Data to Care (D2C) initiative. Link-Up utilizes HIV surveillance data to identify & contact HIV-positive individuals that are not currently receiving HIV medical care. Upon contact, Link-Up works with each individual to identify and address their medical and non-medical needs.

Medical Needs: Link-Up makes active referrals to HIV medical providers in the Metro Detroit area.

Non-Medical Needs: Link-Up makes active referrals to existing social support services to address barriers, such as:

- Mental Health
- Housing
- Transportation
- Medical Case Management
- Early Intervention Services (EIS)
- Psycho/Social Support
- Financial Distress
- Co-Pay Assistance
- Insurance Enrollment
- Job Training
- Food Assistance
- Nutrition Therapy and Counseling
- Legal Aid
- Adherence Counseling

Link-Up is FREE, confidential, and voluntary

Progress – Link-Up Detroit

In 2016, there were 1,126 known HIV-positive individuals out of care in Detroit. Link-Up Detroit started on February 6, 2017.

As of September 15, 2017

- Information has been received from MDHHS for 500 individuals
- Initiated 390 of the 500
 - 1,163 letters sent, to 313 individuals
 - 1,314 calls attempted, to 252 individuals
- 91 clients or family members have successfully reached by staff calling them
- 45 clients or family members have initiated calls (because of a letter, text received, or voicemail left)
- 161 texts sent, to 85 individuals
- 218 voicemails left, to 94 individuals
- 101 Case Report Forms with updated contact sent back to MDHHS Surveillance

Closed Out

As of September 15, 2017, records for 367 of the 390 (94%) individuals initiated have been closed

- 142 (39%) Unable to locate
- 83 (23%) Likely DN exist
- **38 (10%) Accepted linkage to care**
- 26 (7%) In care
- 18 (5%) Not Positive (some are confirmed not positive, some are not confirmed)
- 17 (5%) Deceased
- 16 (4%) Moved out of state
- 16 (4%) Other
- 7 (2%) Declined assistance
- 4 (1%) Institutionalized (3 likely out of state, 1 in state – working on care coordination..)

External Referrals – 79 Received

Referral Outcomes:

61 of the 79 (77%) have been closed out

- 27 (44%) Emergency financial assistance
- **14 (23%) Linked to care**
 - 7 (11%) In care
 - 4 (7%) Unable to locate
 - 4 (7%) Other
- 3 (5%) Provided emergency transport to med appt
- 1 (2%) Linked to insurance assistance
- 1 (2%) Moved out state

Referral Sources:

- 23 Community agency
- 20 from medical providers
- 11 self-referral (other)
- 7 self-referral from the website

Total of 38 (D2C) + 14 (external/self referrals) = **52 people linked into care**

Starting a D2C Program

Planning & Implementation

Planning

D2C Checklist

Put together by DHD and MDHHS to assist counties develop D2C programs. *Note: Checklist is still a working draft. Please share feedback.*

Includes information / considerations for:

- Data Security
- Resource Mapping
- Community Engagement
 - Develop promotional materials
- Support

Planning - Protocol

- Protocol exists for Link-Up Detroit
 - Can be shared with interested LHDs
 - Request from Jacob or Lindsey
- Protocol includes:
 - Program design & methods
 - Data security considerations
 - Referral processes
 - Phone script
 - Outreach letter
 - Client follow-up surveys
 - Evaluation plan
 - Etc.

Planning – Community & Provider Engagement

VERY IMPORTANT!

Start with providers & community agencies that serve HIV-positive clients

- Building these relationships is imperative for D2C referrals for medical and non-medical (supportive) services for the not in care (NIC) HIV-positive individuals you will be contacting for D2C
- Providers and community agencies can be the gatekeepers to consumers
- Presenting the concept of D2C and your proposed outreach process to providers and agencies will help you:
 - Perfect your D2C outreach process (each county will be unique based on your demographics and the services available in your county)
 - Prepare for engagement with consumers
- Example: Link-Up Detroit came from community feedback. Consumers did not like the word “data” in a linkage program.

Implementation

- Making calls
 - Script available for LHDs, caller should be comfortable talking to clients & knowledgeable about HIV and available services
 - Practice!!
- Referrals to support services
- Referrals to medical providers
- Follow-up to ensure client has accessed services
 - Detroit does follow-up call after 1st medical appointment & 30 days after initial contact
- Returning updated contact info to MDHHS

These are developed during planning process

Quality Assurance

- Ensure accurate data is captured
 - Contact info updated
 - Referrals documented
 - Updated info reported to MDHHS
- Client satisfaction surveys
 - Six question phone F/U survey done ~30 days after client is referred
 - Feedback used to improve D2C program & outreach efforts
- Consistent & frequent reporting of results back to the community & consumers

Contact Info

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Questions