# WEBINAR VIDEO TRANSCRIPT

Partnership for Care HIV TAC

## Strengthening Referral Policies and Procedures to Enhance Care Completion

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STEVE LUCKABAUGH: Good afternoon. My name is Steve Luckabaugh and I'd like to welcome you to the strengthening referral policies and procedures to enhance care completion webinar. This webinar is brought to you by the Partnerships for Care, HIV Training, Technical Assistance and Collaboration Center, HIV TAC.

The Partnerships for Care project is a three year multi-agency project funded by the Secretary's Minority AIDS Initiative Fund and the Affordable Care Act. The goals of the project are to one, expand provision of HIV testing, prevention, care, and treatment in health centers serving communities highly impacted by HIV. Two, to build sustainable partnerships between health centers and their state health department. And three, to improve health outcomes among people living with HIV, especially among racial and ethnic minorities.

The project is supported by the HIV Training Technical Assistance and Collaboration Center, HIV TAC. Our speaker today is Michael Shankle. Michael has over 21 years of experience in HIV prevention and care delivery, public health program management development, outcomes performance improvement, and capacity building. As Health HIV's Senior Director of Capacity Building, Michael is responsible for leading the organizations day-to-day capacity building, technical assistance, and curriculum development efforts.

He develops strategic capacity building plans to address the needs of community-based organizations, health departments, clinical providers, fiscal administrators, and medically underserved communities. He has also built coalitions and developed strategic public health practice partnerships at the local, state, and national levels.

Additionally, Michael serves as the Project Director for a multi-site national medication therapy management demonstration project, integrating community health centers and community pharmacists, as well as a National Technical Assistance Center charged with building the capacity of health department and community partners to respond to comprehensive HIV prevention, treatment, behavioral health, and social service needs of MSM of color, at risk for, and living with HIV.

Prior to joining a Health HIV, Michael began his career as a Research Specialist with the University of Pittsburgh Graduate School of Public Health in the Department of Infectious Diseases and Microbiology, where he combined his experience of behavioral health sciences, health research and technology to develop online HIV STI interventions. While there, he

implemented programming that facilitated parity, inclusion, and representation of high risk sexually active young adults in HIV community planning processes.

In 2006, Michael produced and published the first public health textbook dedicated exclusively to LGBT health entitled The Handbook of Lesbian, Gay, Bisexual, and Transgender Public Health, The Practitioner's Guide to Service. Michael joined the AIDS Action Committee of Massachusetts in 2006, first as director of the MALE Center, Boston's Gay and Bisexual Men's Community Health and Wellness Center, and then as Director of Gay, Lesbian, Bisexual, and Transgender Health Services.

Please join me in welcoming Michael Shankle.

MICHAEL SHANKLE: Good afternoon, everyone. And thank you so much for having me today. Talking about this very important topic, strengthening referral policies and procedures to enhance care completion. Many structural, physical, mental, and social barriers can really complicate linkage to care and retention in care.

And as we know, poor linkage to and retention in care for individuals living with HIV may result in delayed or failure or failed antiretroviral treatment, delayed time to viral suppression, increased sexual risk transmission behaviors, increased risk of clinical events, morbidity, and mortality, decreased treatment adherence, CD4 and viral response, and that's just to name a few.

As we begin thinking about how we can better enhance care completion, we know that clinical health providers are often not prepared or lack the time to address and improve patients' linkage to and retention and care, and patient adherence to medication. Many existing programs that are out there fail to be effective in retention and engagement in care because they are not integrated to address the holistic needs of the patient population or lack a comprehensive referral system that engages both clinical and non-clinical providers.

The goal of the webinar today, Strengthening Referral Policies and Procedures to Enhance Care Completion, is really going to provide an opportunity to discuss some strategies that programs can adopt to be successful and sustainable. And examine how these strategies can be incorporated throughout the care system to include the clinical provider, auxiliary staff, non-clinical CBOs, pharmacists, and the patient in order to enhance the HIV care continuum.

So as we move through, I crafted some learning objectives for today, really discussing the need for developing those formal agreement and procedures with external organizations to facilitate HIV care across the continuum, to identify some of the key components for drafting those agreements, and then concluding today's webinar with really outlining some best practices and referral agreements. And showing a case study that includes a performance-based contracting technique. And discussing how the evaluation metrics can be put into place to really assess the effectiveness of your referral agreements and partnerships.

I just want to start off by providing some broad brush strokes on the HIV epidemic today. We know that approximately 1.2 million people with HIV are living in the US today. And we've had about 50,000 new HIV infections occurring annually for about the last two decades. And of the

14% of those infected with HIV that do not know their status, because they have not been tested or not adequately engaged in care, 30% of those 50,000 new infections occurring annually are attributed to the 14% with unknown HIV status.

We also know that 32% of people with HIV are diagnosed late in their HIV diagnosis. And within one year, 24% of those people are also receiving an AIDS diagnosis at the same time. More importantly, 50% of individuals who are aware of their HIV status, and are not adequately engaged in care, account for about 61% of the new infections that are occurring annually.

Recently, CDC published some new data at the CROI conference that occurred in Boston, Massachusetts earlier this year, where they estimated the lifetime risk of an HIV infection for individuals. And one in two black MSM, one in four Latino MSM, and one in 11 white MSM are estimated to contract HIV in their lifetime, which really delineates the fact that many-- that a lot of our approaches really need to be enhanced to reduce this cycle of HIV transmission.

If we were to scale up all of our prevention and care efforts to really meet our national targets for testing and treatment, we could prevent 180,000 new infections by 2020. And millions of individuals still are not being tested for HIV routinely in their doctor's office. And less than half of black men and less than a third of Hispanic and white men will be offered an HIV test before they reach the age of 39.

When we begin thinking about our clinical organizations and our non-clinical organizations, we need to really begin focusing more on it having an outcome-based focus. How we integrate prevention and treatment to really achieve the HIV free generation that we hope to accomplish, which is attainable if we utilize our tools and our referrals and partnerships correctly.

As we look at the HIV care continuum and the HIV treatment cascade, or care cascade as it is sometimes referred to, we see this cascade really demonstrating how we are failing to achieve reaching viral suppression with many of our patients today. And as we look at new models for care and care coordination, we need to begin thinking about how our clinical and non-clinical partners have the shared role and responsibility at each of these bars across the continuum. And being able to think how we can engage those partners in sustainable, effective referrals and partnerships to really achieve a greater viral suppression.

So we have a poll question that we would like to answer today. We'd like to put up-- here goes our poll, thank you, Steve. What additional services do your clients need to remain engaged in HIV care? And we have-- you may select one or more of the following.

And the selections I have put on the screen are housing, transportation, employment, behavioral health, and other. And this is really an opportunity to get you all engaged in the presentation today. So feel free to select one or more of those items. And if you select other, if you could just drop in the chat box what your other comment was.

STEVE LUCKABAUGH: OK, we'll leave the poll up for couple of more seconds here.

MICHAEL SHANKLE: Terrific. Not surprisingly, in this poll, that housing and behavioral health were our top two pieces and needs to enhance our services across the continuum, following closely by transportation and employment. Just demonstrating the need that we need to begin thinking beyond the services that some of our health centers and organizations provide and how we can engage others in that process.

And I put the spot as a common misconception that occurs across the board with lots of organizations thinking that they have to be everything to everyone. And I just want to restate the process that really no one agency can do everything. And partnerships and effective referrals are really a powerful means of crafting solutions and adding value to our clients and to the care continuum as a whole.

This HIV care continuum or cascade was just recently released from CDC, which demonstrates how the care continuum will look if we apply the metrics in the national HIV/AIDS strategy and the national outcomes data for prevention and care to the cascade, what that would look like today.

So we're still seeing a tremendous drop off, about 65% of those individuals diagnosed with HIV are not retained in care or are being lost to care. And once people are retained in care, about 96% of those individuals achieve viral suppression. Which leads us to the next important public health question is how do we ensure viral suppression of our populations that we're serving really to interrupt the transmission of HIV?

One of the other attributes that is very important for us to think about is not only looking at the care continuum, but looking at the prevention continuum. From individuals coming into our office and testing to providing them with risk reduction and harm reduction counseling, we have a myriad of prevention tools and services that are available for individuals to provide tailored prevention services for them.

How do we retain HIV negative people in our care? And ultimately, how do we support adherence with these populations outside of our routine clinical visits? And adherence could be remembering to have routine HIV testing and repeat testing throughout the course of their lifetimes for higher risk populations. Or it could also mean a related to adherence to PrEP or nPEP services.

If we take a closer look at the provision of tailored prevention services that are available for us today, we have this tremendous toolbox of HIV prevention services that are available to us--treatment as prevention, individuals who are on treatment and virally suppressed and 98% less likely to transmit HIV than individuals who are not virally suppressed.

We have PrEP on here and PEP, new biomedical interventions that are all coming to bear, that we need to think about how we implement these in combination to really maximize the outcomes across the care continuum.

We also have to understand and be aware of the social determinants of health and the conditions in which people are born, they grow up, they live, and the wider set of forces they have on

individual's daily lives. So how poverty impacts individuals, how biases and racial and structural discrimination can really impact individual's health, and put individuals at a disadvantage for care. So when we think about referral systems, we also think need to think about how we can refer or develop the capacity for our clients to address a variety of their social determinant health needs.

I won't spend much time on this slide, but I did list some structural barriers and some emotional barriers to HIV prevention and care. And we-- some of you have put in our last poll, transportation as an issue, housing as an issue, having the time to access appointments with clinic hours, health insurance, and some of the emotional aspects that individuals face. Huge concerns of stigma, the lack of social support, depression, and a distrust of our health care system in general are all mechanisms that prevent people from accessing care.

This slide, I put up here as a mechanism for really measuring the continuum outcomes. And I encourage all other partners and organizations on the webinar today, and the organizations we work with across the country, to take the time to develop a care continuum for your organization. And really set the metrics for your organization and use that as a gauge to how you are achieving your outcomes.

The UNAIDS and cities like New York City, San Francisco, DC, are all prescribing to the 90-90-90 initiative, 90% of people diagnosed, 90% on treatment, and 90% virally suppressed by 2020. And it's going to take a lot of work for us to think about how we achieve these goals and how we change the way we are thinking about the care system in general. And how we partner-- who we partner with, and how we partner, and how we make those referrals to partner organizations that can help us achieve our initiatives.

By mapping out a care continuum for your organization, this can really help you identify gaps where you are deficient in the services that you provide and how you could possibly partner with other organizations or refer to other organizations to enhance care across the continuum. If the 90-90-90 model was implemented effect-- implemented and those goals were achieved, mathematical modeling really demonstrates that we have the tools today, that we can really change the HIV epidemic, turn the tables on it, and allow for that flat line of 50,000 new infections to really begin to fall off.

So as we go to the next slide, which is a poll question that we have, I wanted to ask individuals, if you think about those individuals who are lost to care in your organization, how good or how would you rate your success of your health center at finding someone who is lost to care?

So this is a poll question that we'd like you to have one answer for, this particular poll question. So we'll give you a couple minutes. How good is your health center at finding someone lost to care. Are we good? Do we do an average job? Or do you think you do a poor job? And we promise we're not going to show who's answering what.

Terrific. So we have some people that are kind of doing a great job, about 17% of those people doing a great job. 70% say we kind of do an average job. And then we have 13% falling into a poor or needs improvement in the work that we do. And just thinking about as your organization

and as you begin doing assessments with your organization to identify gaps, really having a clear expectation and structure in place, and a metric that the clinics can quickly and aggressively identify clients who are lost to care or not adequately engaged in quick care.

As a follow up poll question to this question, I wanted to ask individuals, how does your health center find someone who is lost to care. And you can select one or more of these particular categories. So how does your health center find someone who is lost to care? We telephone them or we call them. We send a letter, we send mail to them. We may go out in person and find them or all of the above.

And if you have another way that your health center helps to find someone who is lost to care, type it in your chat box. All of the above. That is really great to see that coming through. And many times, organizations and clinical providers will attempt to do a telephone call to individuals reminding them of a lost appointment or to do proactively calling their clients and reminding them of appointments. They may send out a letter or mail to them.

But often times, individuals have a really challenging time-- especially clinical organizations-- a really hard time going into the community and tracking someone down who is lost to care. So I'm encouraged by this particular graphic, where we see so many people that are really doing all three practices.

When we think about the care continuum again, we really need to think about what components of the care continuum do your organization-- which as your organization do well. Are we good at diagnosing clients? Are we good at getting them into care or retaining them in care? And ultimately, how we can use our partner referrals in order to help enhance our results across the continuum.

I see that on our one slide, where we ask about how you are engaging patients into care, we have contact other providers on a release form. We also have working with DOH and linkage specialists. Pharmacy's-- huge, huge benefit in working with pharmacies, which we'll talk about in a minute. Contacting their emergency contacts of people and other support agencies, all really really super ways to think about how to really engage people in care.

The referral system entails a process of coordinating service delivery, really to ensure that there is access to the needed services, and that access to those services is pretty expedited along the way. That there is confidentiality that is maintained, that referrals between organizations and a network can be tracked, and the outcomes of the engagement of those referrals can be documented.

There is some kind of referral loop, a loopback process or a feedback process to really inform the organization initiating the referral that the referral has been delivered, that they have met with a client, and that the client's needs are being met. And that they are-- and also really to identify gaps in services that can be identified and steps that can be taken by organizations to really bridge those gaps in care.

So with the referral partner identification, it's important for us to identify our resource limits. Whether that is staff, it's cultural competency, it's linguistic competency, it's time or a particular service area that we are not providing services for.

You may also have referrals to outside organizations to help provide some of these services. But thinking about how access to those services could be improved by co-locating services, bringing services within your health center, or bringing health care services to where the populations are most needed.

We also just have to think about in referral partner identification, where are our service gaps? What services do we not provide that are critical for our clients? And that may be home delivery of meals. Or there may be community-based engagement efforts. Or there may be special population needs that we're not able to address, such as the engagement and retention of women. We can add men who have sex with men of color, transgender men and women, all are important for us to consider the special needs of those populations.

This is one of your handouts that I provided today to you, which is HealthHIV's service matrix. This is a way for organizations to really sit down and go through 23 service categories that are provided. And it is available in the handout section on your toolbar today. And it really asks organizations to think about what services they are providing, how they are funded to provide those services, market them to the community and their clients, and how do they evaluate the effectiveness of those services.

And this map really walks through a process for organizations to objectively begin to look at their service delivery. And to determine what they do really well and where do they need improvement. And how are they automatically going to reach that area of improvement by how are they going to access subject matter or technical assistance expertise in the area. How are they going to partner with an organization? Where do they need to partner with organizations to provide additional services?

So I encourage organizations to take the time, the first step in your procedure on thinking about referrals is to really identify those gaps and those needs that your clients have, that you're currently not providing in-house.

By conducting a community inventory and doing some asset mapping is extremely important. After you identify those gaps in service delivery of what your clients need, really start developing a list of who and what you know. And ensuring that the individuals that and agencies that you're working with, are thoroughly vetted. That you understand and they understand the means of the population that you're serving, that they are culturally competent.

You may find other referral mechanisms from your local health department websites, your planning jurisdictions, or your HIV planning groups and health departments. And a lot of clinical and non-clinical organizations really need to begin thinking about how they leverage their expertise across the continuum to really support patients. A referral to an organization is just not enough. We need to vet these organizations and identify how we are going to work with them to ensure a seamless system of care.

The strategic benefits, not only for your organization, for your clients in increasing their comprehensive services for clients, but it also provides a bi-directional feedback mechanism in which new clients can come to you from your referring agencies or from new geographies or with new population focuses to your organization.

Working with other organizations and developing comprehensive referral agreements really can improve your agency's knowledge and capacity. It improves the efficiency of your existing referral networks. And you can help achieve shared outcomes, whether that is a community health outcome or community viral suppression or individual viral suppression.

I would be remiss not to talk about how we strengthen the referral process and thinking about the types of referrals that we are providing-- warm versus the cold handoff. And when we think about those warm referrals, we'll talk about in a minute-- those cold referrals are when we basically provide a telephone number, an email address, a sheet to a client and say go get these services here, without really providing the necessary added steps that are critical to ensure that a client is able to reach those services.

So referring department organizations plays a key role in the client being able to access those care services. We look internally, we need to look at even not only with external referrals within our organization, but we also need to look internally as well, as how information and resources and referrals are being made to other departments or other providers.

And when we're talking about other providers, I just have to stress that other providers may be and should include some of your non-clinical providers, which provide tremendous levels of support in the community to help individuals be retained in care such as food services, organizations that provide health navigation services, case management, housing services-- all need to be brought to bear to become part of a care team.

What we don't want to have happen is a client feeling like they're being dumped. They're being given a referral and say-- and basically given the impression that they will go somewhere and this person will be able to solve their problems or not being provided the necessary tolls they need to access services.

With warm referral components, we also have to think about these warm referrals can really provide mechanisms for us to address some of the barriers that prevent clients from seeking follow up care, such as those medical mistrusts and discomforts in the medical system. We've seen reports recently and studies recently, research studies coming out, that 70% of black MSM accessing care has a mistrust or discomfort with the medical system. We also know that individuals have challenges in health literacy issues with being able to understand how to access insurance and cultural competency.

With the warm referral process, really thinking about how we schedule the appointment for the client. And making sure that, again, I can't stress enough, that your referrals have been thoroughly vetted. And that there is some feedback mechanisms that are in place, that you receive feedback from your clients if they were successful, and what their experiences were with the referring agency.

Providing them transportation or ensuring the client really knows how to get to their appointment. These are all mechanisms that we really have to think about when we think about the warm referral process. And yes, it takes time, it takes energy. But we need to make sure that we are reaching our goals and our outcomes across the continuum.

And there has to be some simple standardized referral forms that really indicates how and when a clinician wants to be notified about a patient, when there needs to be feedback on the patient. And then what the patient needs to receive and what else relevant information about the patient-- the other organization needs to receive before his or her arrival.

Another poll question that we want to ask here. And this is a multi-answer question. So feel free to select more than one answer if you like. What are some best practices for successful referral completion? And we have introduced the client to the contact at the referral agency, go with the client to a referral agency, follow up with the client after the appointment and assess satisfaction, follow up with a referral agency after the appointment to assess outcomes, or all of the above.

All of you about excellent. Excellent. These are all great mechanisms to really add and enhance the warm referral process for clients. Excellent.

And one more poll question for you today, HIPAA prevents my health center from being able to share our medical records with outside agencies. Is that true, false, or I don't know? There's only one answer here. False. Excellent, that's great.

Many folks fall into the trap that HIPAA prevents them from being able to share data with other organizations. And we know that data makes health care better. And sharing data and using data in real time can really enhance care.

I want to encourage individuals to really think beyond the standard memorandum of understanding or memorandum of agreement with their organizations. And really thinking about how do we form a true contractual partnership and a business associate agreements with organizations outside of our clinic or practice.

So HIPAA has provided a number of goals and policies, and provides us a framework in which we can share personal health information with other organizations. And it also ensures that a covered entity, such as a health center or an organization that is collecting personal health information, can share that information with what is called a business associate as long as they-- there are some requirements that have to happen along the way. And I'm going to talk about those as well.

That the business associate-- there are some satisfactory assurances, that the personal health information is safeguarded. There are satisfactory assurances, which means a business associate agrees to on how they're going to use the data, how it's going to be released or when it's not going to-- how it's going to be released and share it with one another. And there's a direct liability in creating these business agreements. But it's very, very important to do.

So a typical business agreement really covers what the parties look like and who they are-- who's the covered entity and who's the business associate. And usually these agreements are drawn up by lawyers. And we do have one in our handout today that Whitman-Walker Health provided to us to share with organizations and how they have crafted their business associate agreements with community partners.

They have to describe the mutual promises and agreements that the parties are going to use regarding personal health information and how privacy rules are going to be followed. And it describes opportunities in how materials can be shared and requested from organization. And it really sets the terms of what happens when the agreement terminates along the way.

With compliance, and we saw that we had a question that was also a statement that was put in the box, not having a business associate agreement, you can do patient permissions on release forms to get permission to release personal health information to other providers.

And well-crafted patient authorizations and informed consents so that it really outlines all the members of the patient's treatment team can share information related to the care and treatment of a patient, explains what happens when a care team changes, or additional people are brought in to the care system, and ultimately, how prudent sharing and secure systems are along the way.

I want to end by just talking about a community-wide referral network. And show this as an example of a network that was established in DC by Whitman-Walker Health. And a number of collaborative organization.

And Whitman-Walker Health partnered with a number of community-based organizations really looking at their care continuum and identifying where they had deficiencies and where they needed to improve or enhance care and care delivery. They partnered with HIPS, typically a harm reduction organization in DC working with the trans community.

They recognized that they were having challenges getting individuals-- keeping them retained in care at their health center. They also recognized a deficiency related to nutrition and food access to their populations. And they partnered with Food and Friends, another nonprofit community-based organization in DC.

And then ultimately working with the Women's Collective. Understanding and working with how they can improve women, minority women in particularly, in care where they noticed their deficiencies were occurring.

So when they were looking at this, they really looked-- were looking for community partners that complimented or strengthened their patients being able to move through the care continuum. They established some formal and contractual partnerships, which included money to these organizations to really develop a mutual operational standards that they really became part of the larger Whiman-Walker organization and care network. They developed new skills and cost competency together to better address the patients across the continuum.

When you are creating these referral partnerships, it's important that you really take the time to assess them. And it may seem like some of these referral partners seem like they make really good sense on paper, but they don't work out sometimes. And they may not work out because of cultural differences between the organizations or difficulties in overcoming challenges. And sometimes it's purely because of a lack of response from organizations.

So you want to develop an organization and a referral partnership in which you have responsive organizations working with you, expediting the process in which your clients access care. There may be other challenges that are faced. Sometimes in our communities, there may be challenges between the organizational leaders or past political histories between the organization that needs to be changed and addressed before organizations can form meaningful partnerships.

And ultimately needing to think about, for years, you have been competing for money, but now how do you begin looking at working together to get money to shift the way that you're thinking about doing things.

Ultimately HIPAA was a huge challenge in this development of this referral system, really looking at-- in order to value the CBO network. They needed to be able to share information and data freely and in real time with partners. And that involved being able to share their EHR with community partners so that it would be all working off the same EHR platform-- really being able to communicate with one another, talk about patient issues and challenges, and really become part of an integrated care team.

That required Whitman-Walker to spend many hours with lawyers and developing the business associate agreement, which I have provided as handouts today for you. Thank you, Whitman-Walker.

It required them to also develop really a comprehensive curriculum and training for all their providers-- clinical and non-clinical, because the three community partners that started their collaborative were non-clinical partners. And conducting routine audits to ensure that circumstances were in place and conditions were in place to protect data.

Some things to think about in a referral contract is really thinking about what is the joint mission statement of you entering into a referral agreement or a business risk associate agreement between two organizations. Really delineating what are the specific services that each organization is going to provide to the collaborative into reaching the mission of the organization and the mission of the collaboration and the partnership, the referral network. And what kinds of language needs to follow to ensure that appropriate regulatory laws are followed. And how to respond if there is a breach.

We should also know what the expectation is from the primary care provider on what services should the CBO expect their clients to be able to access and access expediently. And thinking about compensation, if there are opportunities for you to compensate non-clinical providers to be able to enhance care delivery, to enhance outcomes as we are beginning to move into a system in which its quality care versus quantity of care provided.

We need to think about how payment mechanisms are changing and how non-clinical organizations can really work with us to help increase health outcomes. Really looking and outlining the obligations of both parties in your referral network, ensuring compliance with programs that are in place, and ensuring that a standard of care of is delivered-- a prevailing standard of care is delivered. And assurance to your patients that they have a choice to make between their clinical providers and their non-clinical providers. And they're free to make those choices.

And that organizations are not being compensated based on being referred to a health center or referred to a community network, but they're being referred to these agencies to improve their health outcome across the continuum. And nothing in the agreements or the contracts that were constructed between these referral agreements would prevent organizations from contracting with other entities to really working with multiple entities along the way to enhance care.

We talked a little bit about the language and professional assurances, making people that-- making sure that individuals are certified and have appropriate certifications and licensure's when appropriate, that each party has insurance and liability and indemnification services, and there's also some terms and terminations policies that are in place on how the partnership could be dissolved over time. Or the referral network can be dissolved if so, if that is a desire.

And what does the relationship look like between the organizations. And thinking about privacy and confidentiality issues. And how organizations are going to communicate regarding the agreement. And what does modifications, and how do modifications work with agreement, with the referral agreement as well.

I just wanted to indicate, when we looked at the-- when Whitman-Walker looked at the services that they were providing, they needed-- they understand they needed to be able to enhance some of the services that they were providing medical case management or early intervention services, how they can get people tested and linked to care outside of their organization, or how they can get individuals linked to care more quickly, patient navigation services, and home-based services.

And some operational challenges on our next slide really demonstrated that their electronic medical record, they gave access to their medical records to community-based partners in order to input data and communicate, to talk about misemployments, to talk about issues that were occurring along the way with clients. And I encourage you to think outside of the box when you're thinking about sharing data and sharing referrals, on how that process of sharing can really increase patient outcomes along the way.

Really needing to define and clarify job duties with each organization in order to minimize duplicative work. And who is responsible for what, and where does and how does the handoff occur. Their CBOs were involved in case conferencing. And they provided a variety of ways that that was given, that it happened. They were all in the same city, but you know geography, staffing, volume, and adversity of provider's really created some challenges with case conferencing and how that occurred. But they were involved in provided access to that on clients that had difficulties. And I can't stress enough the real-time access to components of the EHR.

When you're thinking about your referral networks, Whitman-Walker put into place several positions or recrafted several positions. They created a Director of Community Health, which is really the person responsible for cultivating the community partnerships initiatives.

They created a Community-based Organization Network Coordinator, which really maintained the day-to-day operations and relationships with our community partners and the training between the partner. And that person acted as the hand-off, the linkage coordinator for referrals coming in to Whitman-Walker. So there was one person that they connected clients to along the way.

They also increased their medical adherence case managers through the process as well. And one of the things to think about when you're working with your clients and you're working with referral mechanisms is really assessing the acuity of care that a client needs and not every patient or client needs such a high intensity level of referral.

But oftentimes, we are working with HIV positive clients or newly diagnosed clients, they require much more engagement. Or clients would have complex histories require much more attention and much more engagement in order to stay engaged in care.

And a real need to really focus on how we identify and target which patients would work best with which community-based organization to provide that health navigation that day-to-day case management, social case management, access to food and housing-- how that all can come to bear out with your referral networks.

And just to conclude, really I want to leave you with, as you think about the steps as a strengthening your referral policies and procedures is one, really starting to assess your organizational strengths and weaknesses for care. Where are you losing people along the continuum? What services do your clients need in order to stay engaged in care? Or what causes them to drop out care?

Identify and develop that community referral network with strong partners that have been vetted. Remembering that no one agency can do it alone. And we have to think about those nontraditional partners in the work that we do. And I want people to think beyond those standard MOUs and MOAs that we have to get whenever we apply for a grant.

And we go out and we say we want to work with you and provide patients to you and share patients and we sign those things and they go on a shelf. We want to move beyond that and really develop some contractual agreements that have evaluation and outcomes measures associated with them such as a business associate agreement.

And ultimately not falling into the trap that HIPAA prevents us from being able to share data with folks outside of our organization. But how we can work with our partners to create a network of data sharing that can enhance care in real time. And encouraging organizations to not think of a referral as a pass off to another organization. But how can that referral agency really truly become part of an integrated care team for that patient. Again, sharing data and communication in real time to keep a client engaged in care.

And I would be happy to take any questions that individuals have.

STEVE LUCKABAUGH: All right, we have some time here. If you want to ask a question, please type your question into the questions pane on the GoTo Webinar toolbar. And we will take your question now.

We did have one that came in. Can you talk a little bit about monitoring and evaluation? What are the best practices in terms of tracking linkage to care outcomes? What data points should be collected? How and where should they be recorded? Who is responsible for recording this information?

MICHAEL SHANKLE: A great, great question. OK, there we go. We have it up here. OK, I'm going to try to get to all this. So ultimately, monitoring and evaluation, an important component that the patient is actually increasing or achieving some kind of health outcome as a result of your referral.

I think that sometimes we fall into the trap that we count widgets on clients and not really looking at what the outcome of that referral has done or could do for our client. There are data points. What data points should be collected?

I think we talked about looking at health data points, whether they are lab metrics as viral suppression, adherence rates, if we're just looking up at the care continuum, engagement and care, if clients attend appointments outside, so if they're actually completing appointments and referrals to other organizations within the care network are all important. This information should be maintained within the health record for the client.

And there's a variety of ways that has been happening that-- I know that depending on the health record that individuals have, there is a mechanism. And an individual that is assigned for tracking referrals to outside organizations and how those referrals, if it's client is attending those referrals and getting the case notes on the referral mechanisms back. And I'm not necessarily talking about referring to another clinical specialist, but even a non-clinical organization. And that information being included and becoming part of the health record.

We have done that in several different ways with organizations with some health centers. There is a clinical nurse coordinator, which helps with the referral process and manages these external partners and referral mechanisms with clients. And that individual is responsible for inputting that information.

We've had other organizations that have utilized their-- if they have a community health worker or case manager that really manages that process for them. But this information should-- as from a Health Organization perspective, should really become part of the comprehensive health record. I hope that helps you. And I can provide some additional metrics and data points that people should be thinking about collecting along the way, I'm happy to share some.

STEVE LUCKABAUGH: OK, thank you. I'm not seeing any more questions right now. Do you have any final thoughts here, before we wrap it up?

MICHAEL SHANKLE: I think that strengthening those referral mechanisms, I think is totally important. I know that there are challenges that individuals have across the board and the partners for care team, the folks at MayaTech and HealthHIV are happy to help organizations think about how they address some of the unique challenges with their organizations.

But really vetting and bringing partner organizations into your fold to advance health outcomes for your clients is so, so important. More important than ever as we try to achieve our AIDS free generation.

STEVE LUCKABAUGH: Thank you again for participating in today's webinar. And thank you, Michael, for that excellent presentation. Take care, everybody. And we'll see you next time.