

ACTHIV ChangeMakers: Early Intervention Specialist (EIS) Referral Process Utilizing a Standardized Referral Form For Newly Diagnosed or Lost to Follow-Up HIV Patients.

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Background

Tolan Park Clinic is the largest HIV clinic in the city of Detroit, caring for over 1,800 patients a year. However, referrals into the clinic from hospital-based providers (attendings, fellows, advanced practice providers) were inconsistent with multiple inappropriate referrals to EIS, i.e., HIV negative, in care patients, and STI treatment. A lack of consistent process limited tracking of referrals and follow-up of patients who did not attend their appointment. Additionally, there was a lack of knowledge around enhanced services available to patients and requirements for those services.



Methods

Included analyzing the technical and adaptive challenges around referrals and identifying steps to address those barriers. We used an adaptive leadership framework to improve the referral process. This included analyzing the technical and adaptive challenges around referrals and identifying steps to address those barriers. On a technical level, the referral form was updated with questions designed to filter out inappropriate referrals. The new form was presented to EIS and provider stakeholders. Then an education effort was made through presentations to providers and EIS to ensure form completion and adherence to the new workflow. The reported information was adjusted as more cycles were conducted based on the needs of the participants.

Figure 1. Technical problems vs. Adaptive Challenges



Figure 2. Technical problems vs. Adaptive Challenges



Goals

- Tolan Park staff, fellows, and colleagues know who to contact for loss to follow-up patients.
- Improvement in completeness of reports received from clinicians and use of referral forms.
- Increased appropriate referrals received.
- Increase uptake of linkage to care for patient's loss of care.
- Improved awareness among staff and providers of Tolan Park ID specialty programs.

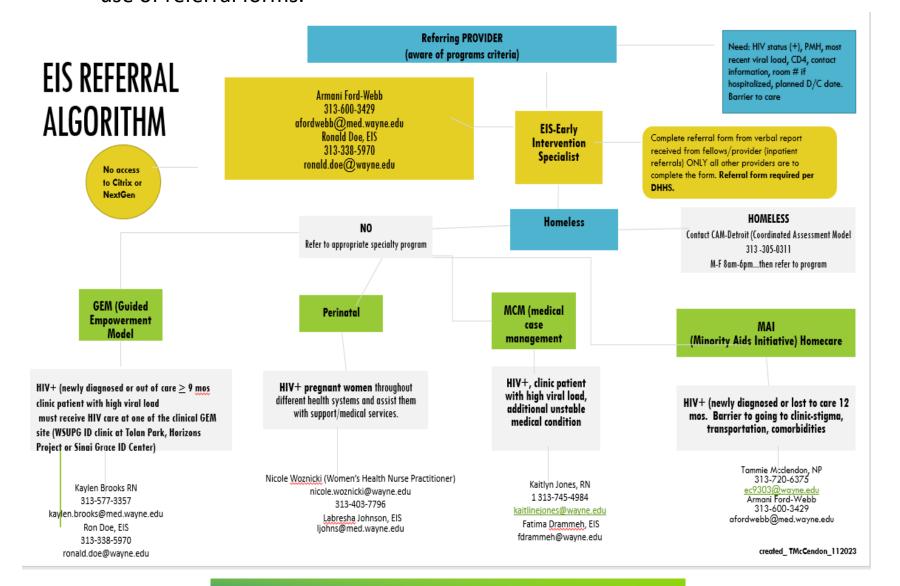


Figure 3. EIS Referral Algorithm



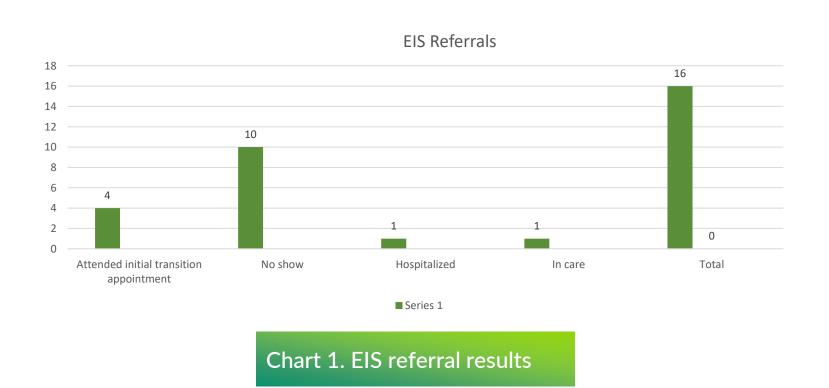
Please fax your request to 313-577-3551		
Call 313-600-3429 for further information.		
Referring Provider		
Date of referral	First Scheduled appt	
Referral Reason:		
Provider Name:		
Address:		
Email:	Fax:	
Patient Information		
Patient Name:	DOB:	
Address:	Phone:	
Alt. phone:		
Date last seen by ID provider:		
Date of Diagnosis:		
Date of last test Results: Viral Load	/CD4	
Mutations:		
Medication:		
❖ External Referring Provider ONLY		
Barrier to care: Transportation stigma childcare homebound		
Caregiver for ill or confined family member Frailty		
Decompensation secondary to co-morbid conditions i.e. CHF/COPD, CKD-hemodialysis		
a becompensation secondary to common to contain the compensation of the members of the containing to		
*Internal use ONLY		
Are residents in the home aware of their status? $\ \Box$	Yes 🗆 No	
Contact attempts: 1.)	_ 2.)	
3.)	_ 4.)	
EIS (Early Intervention Services)	Home Care	
GEM (Guided Empowerment Model)	MCM (Medical Case Management)	
Perinatal	Mental Health	

WAYNE

Figure 4. Enhanced Referral Form

Results

- A total of sixteen EIS referrals were received from 11/7/23-1/19/24.
- Four of those 16 patients attended their initial appointments.
- Ten patients did not attend and were not able to be rescheduled.
- One patient was hospitalized.
- One patient was in care with the Home Care program.



Conclusion

Improving the referral process from the hospital to the clinic resulted in better communication and more appropriate referrals. The form was easy to adopt and acceptable to the stakeholders. The use of scripts and ongoing education increased uptake of this system and the quality of communication. Getting clients into care, even for the first visit, remains an adaptive challenge and will be the focus of future efforts.

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Table: References

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