Team Based Consistent Messaging

NYLinks Implementation Package

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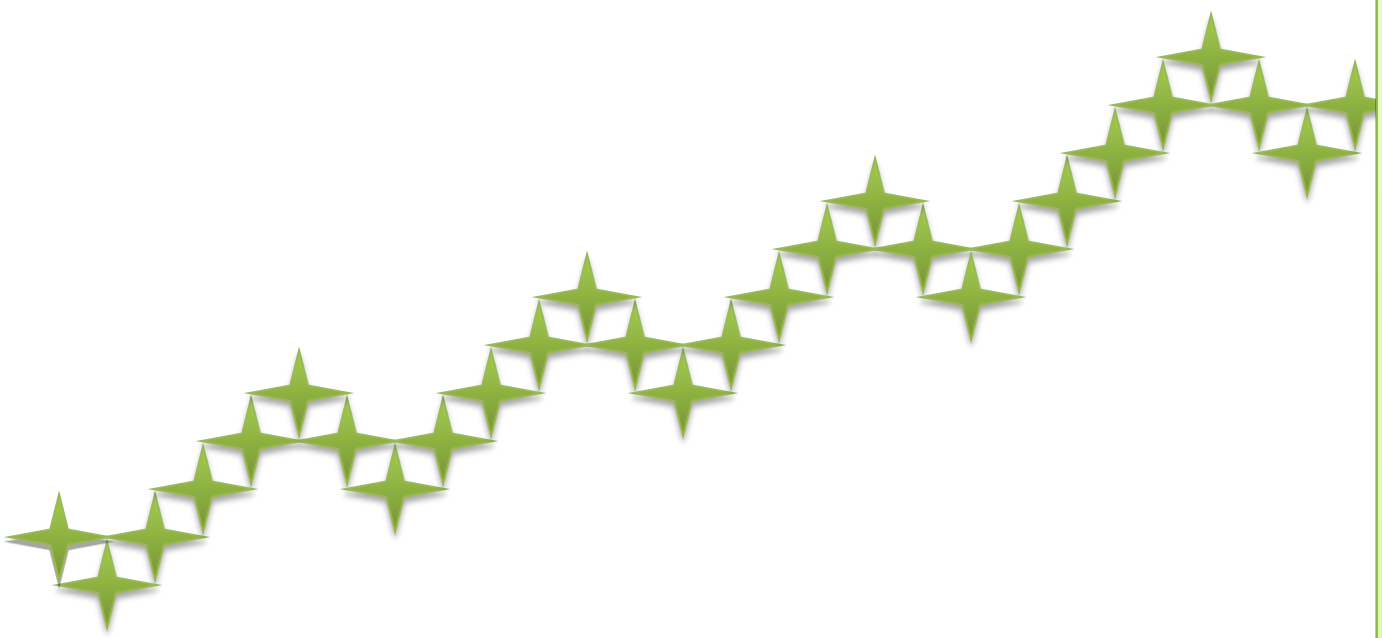

A. What is the NYLinks Team Based Consistent Messaging Intervention?

The NYLinks *Team Based Consistent Messaging* intervention provides guidance on closing gaps in communication through the application of the latest research and tools that have been shown to be effective in improving communication with patients. The aim of this intervention is to engage or re-engage the patient in care by employing the use of positive and action-oriented statements that are uniformly delivered by each team member to all patients, acknowledging the importance of retention in HIV primary care. These messages are positively phrased and action-oriented and are delivered by members of the HIV care team at engagement points identified by the organization.

Data suggest that consistent messaging is an effective tool that can help to improve health outcomes (Marks, Gardner, 2010). Consistent messaging has been utilized on the clinic level in New York State both through the distribution of health education literature in waiting rooms and through verbal interaction with patients by various members of the clinic team. Consistent communication to the patient from cross functional HIV care team members has proven to be an effective tool in supporting patient retention and viral load suppression. (See section N for references and citations). Teach-back has been used to ensure patient understanding of the message being conveyed.

B. Target population

All new and existing HIV-positive patients will receive the intervention by care team members during routine clinic encounters. In cases of limited resources organizations may choose to focus this intervention solely on new patients or patients who are returning to care after a greater than 6-month absence or on patients who are not virally suppressed.

C. Core elements of the intervention

This section describes the essential components of the intervention. The core elements are critical to the success of the intervention and must be implemented exactly as designed. If one or more of the core elements is altered or dropped, the intervention will be compromised resulting in reduced effectiveness of the intervention.

The core elements of the Consistent Messaging intervention in NYLinks ensure that patients linked to care remain in care and improve viral load suppression outcomes. They are:

A) HIV-infected adult patients with medical appointments receive retention in care messages to encourage them to maintain active engagement in HIV care

- During every medical appointment each patient is delivered one brief and consistent retention message by a care team member in an empathetic and supportive manner. The message builds confidence and encourages positive behavior change. There are three specific components to this step:
  - Develop a brief, clinic-specific retention message that can be routinely and consistently delivered in person to all patients who attend the clinic for each medical appointment
  - Each member of the care team can deliver this message to the patient, including the physician, nurse, case manager, front staff, peer, etc.
  - Document that the message was delivered to each patient

The following organizational requisites are needed for this intervention:

- The clinic needs to develop consistent messages for retention to be applied in the clinic
- All staff, including medical and non-medical providers need to be trained in the delivery of these messages
- The development of a flow-diagram is strongly suggested to ensure who and when these messages are being delivered; this process chart should also include a reminder system to ensure that these messages are being delivered consistently to all eligible patients (See appendix B for an example of a flow-diagram)
- Adequate data systems need to be in place to
  - track patient appointments over time
- Documentation systems need to be in place to track staff training of the messages
- Staff resources need to be available to track the intervention activities and its outcomes
- Every 3 months, staff should meet and review how to deliver consistent messages

D. Adaptable elements of the intervention

Unlike the core elements of an intervention which must be implemented exactly as designed, adaptable elements are activities and delivery methods that can be tailored to meet the specific needs of an agency without compromising the integrity of the intervention.

The adaptable elements of the Consistent Messaging intervention in NYLinks are as follows:

1. Patients. If resources are limited, the organization may decide to narrow the population that will receive the intervention based on limiting criteria such as patients with histories of no show, patients who have viral loads above a certain amount, patients who are new to the organization, etc.

2. Messages. Organizations can develop messages that are specific to their organization and to their populations and can rotate messages on a more frequent or less frequent basis.

3. Staff who deliver messages. The care team can be changed from message to message to add to the variety and increase the potential impact. For example, during the first month the message could be delivered by registration staff while the second month it could be delivered by nursing and medical staff.

E. Length of time the intervention is delivered to each consumer

The intervention should be delivered for at least 90 days so that it impacts the largest number of patients. Messages can be changed after the 90 day time period so that a new message is delivered. The time period can be longer or shorter based on clinic patient load and specific care guidelines.

F. Staffing requirements/roles and responsibilities

Team Leader:

- Responsible for encouraging staff use of the retention in care messages.
- Responsible for setting the agenda for discussing particular patients during case conference.
- Oversees the development of a case list (new patients, all patients, patients returning to care, patients case conference).

Data entry staff: (any staff can do data entry if a designated data entry staff person does not exist.)

- Track process measures

Care Team Members:

- The composition of the HIV care team will vary but ideally includes all individuals providing care and support for consumers (e.g. consumers' family/close supports, medical providers, nurses, social workers, case managers, front desk staff, peer educators, peer navigators, adherence counselors, etc.). The care team can be specifically identified by the organization.
- Help to develop, communicate, and document consistent retention in care messages.
- As necessary and appropriate participate in case conferences to develop individualized messages tailored to address barriers or anticipated needs specific to individual patients.

G. Staff training

Staff training would be beneficial in the following areas:

- How to use standardized assessments to identify patients at risk of loss to follow up.

- The development and delivery of uniform and tailored retention in care messages and checklists.
- A role-play can be conducted so that those being trained in the use of the consistent messaging will learn how best to administer messages.
- Team leader training on how to facilitate case conferences for development of patient-tailored messages.
- Basic training in behavior modification therapeutic approaches such as motivational interviewing and active listening technique are recommended.
- Assessment for and facilitation of needed referrals to address treatment adherence barriers.
- Training on data entry and reporting.
- Every 3 months, staff should meet and review how to properly deliver consistent messages

H. Resources required for implementing the intervention

Resources required for the implementation of this intervention mostly involve staff time and effort:

1. Training time for all the intervention components mentioned above.
2. Staff time to generate required reports and enter data related to the delivery of the intervention.
3. Staff time for case conferences to develop individually tailored messages based on individual patient barriers and needs related to retention in HIV care and ARV adherence.
4. Team leader time to meet with staff and ensure that all aspects of the intervention are completed including the intervention, documentation, data collection, and submission to NYLinks.
5. Electronic or paper documents for use in implementing consistent messages.
6. Community resource listing (referral directory) (social work, housing, peer navigation/support, support groups, etc.)

I. Implementation

Implementation will require leadership and HIV care team buy in. An action plan with clearly detailed roles, responsibilities, timeline, and measurement plan, including responsible parties will be needed for planning. The action plan should be reviewed and agreed upon by HIV care teams. In addition, the action plan should be reviewed by clinic consumers so their feedback can be integrated into the plan. This may occur in a variety of ways including review by the consumer advisory board or through consumer focus groups, and exit interviews. Specific steps related to implementation should include:

1. Develop written policies and procedures related to the consistent messaging process and how messages will be integrated into the day to day operation of the organization.
2. Describe how members of the treatment team intervene with clients at different points in the continuum of service delivering the "same message." Be explicit about what types of interactions will involve messaging and what staff will be involved in the delivery of messages.
3. Develop retention in care messages and a system for delivery of messages.
4. Define steps to be taken in the delivery of messages; i.e., when are messages delivered by whom, how recorded, etc.
5. Define patient population to receive messages. Patients newly diagnosed, patients new to clinic, patients returning to care after absence of 6 months, etc.
6. Tailor messages to fit patient situation as defined above.
7. Establish how treatment team will work together to deliver messages.
8. Train all team members on the delivery of messages, including effective verbal and non-verbal communication skills.
9. Where case conferences are utilized, structure them to assure full team discussion of individual patient barriers/needs and the development of tailored retention in care messages that are integrated into the care plan and day-to-day interactions with the patient. Case Conference Guide (from NYC DOHMH Care Coordination manual) specific to developing tailored retention in care messages (w/ examples of tailored messaging) http://www.nyc.gov/html/doh/html/living/hiv-care-coord-forms.shtml

Here's an example of messaging as used by the providers implementing the CDC funded messaging intervention:

Pocket Guide for clinic staff:

- http://www.newyorklinks.org/files/82826/Pocket%20Guide-Clinic%20Staff_FINAL.pdf

Pocket Guide for Primary Care Clinicians

- http://www.newyorklinks.org/files/82827/Pocket%20Guide-primary%20Care%20Clinicians_FINAL.pdf

At the end of this document are sample messages. There are 4 messages in total that address retention in care. These messages can be used in place of designing your own. We suggest you start with a single message and start with a short message before moving to longer and more complex messages. Organizations can choose a message depending on the population they are focusing on. As the organization becomes more experienced with messaging they can begin to deliver multiple messages to multiple populations.

Messages should be tested with a few consumers and adjusted according to consumer and staff feedback.

Alternately, organizations can choose to break up who delivers the messages in the following manner: A brief positive retention in care message is offered by all HIV care team members. A slightly longer message will be offered by one or more members of the care team to reinforce the briefer messages. Both the brief and long messages encourage retention in care. A tool should be used to help to ensure that all health providers and healthcare staff where consumers receive their care offer the same message to patients regarding the importance of keeping clinic appointments and sustaining an ARV treatment regimen.

Motivational Interviewing - Optional

Staff may receive training on the basic tools of Motivational Interviewing, Teach-back and the use of retention in healthcare messages. When peer services are offered at the HIV program, peer delivery of messages are clearly described and integrated.

While administering retention in care messages, the staff can employ *Motivational Interviewing* to gather additional information from the consumer. The four central tenants of Motivational Interviewing (MI) as described by Rollnick and Miller (1991) will be helpful when providing long and tailored messages developed in case conference. The Motivational Interviewing tenants are as follows:

1. Empathy is expressed by reflective listening (reflecting back to the patient what the patient says using the patient's words, which displays understanding.
2. Understand the discrepancy between the patient's values and their behaviors.
3. Avoid confrontation. Instead be empathetic. This will minimize resistance.
4. Facilitate patient self-efficacy by building confidence to change.

Motivational Interviewing training manual/resources and tools,
http://www.motivationalinterview.org/quick_links/manuals.html

Note that the messaging tools are chock-full of great messages! One anticipated challenge with implementation is the logistics that may be necessary to identify the type of visit a patient is at the clinic for and which message (short and long) is to be communicated and when. This will not be as challenging in terms of new/first visit to the clinic vs. existing but will be in terms of follow up messages. Also, while the need for redundancy is understandable, patients may get messaging "fatigue" with the longer messaging. In addition, the delivery of different elements of the longer message by different staff members could be very tricky in terms of "consistency" and flow. There is potential for some of this division of labor/messaging to seem out of context. These issues should be considered when developing a consistent messaging plan.

J. Data to be routinely collected and reported

Process measures

Process measurements are an assessment of intervention related activity. Process measurement involves the collection of data on intervention processes that are connected to a

desired outcome. This type of measure involves basic counts of intervention related procedures. For example, the number of patients who were referred to a program, the number of staff trained etc. Process measures are used to identify areas where improvements can be made during implementation of an intervention or as a tool in on-going monitoring of an intervention.

The NYLinks team has developed process measures that will be used in the statewide evaluation of this intervention. A data collection tool has been developed to aid providers to systematically track process measure information (Appendix A). The tracking tool should serve as a guide and is not required to be used as long as the provider has an alternative tracking method in place. The tracking tool is designed to be used electronically, but may be printed for manual record keeping. All providers implementing this intervention will be expected to collect and report process measure data to the NYLinks team on a monthly basis. Data should be reported on the 15th day of each month (or the next business day if the 15th falls on a weekend). Providers should develop a schedule to perform routine quality assurance on the data to ensure that information is being collected and recorded accurately and frequently.
The following naming convention may be used for the log in Appendix A to track process measures monthly.
Filename: Consistentmessaging tracking tool_MMYYYY.xls
where MMYYYY represents the 2-digit month and 4-digit year of the data contained in the file.

Aggregate data will primarily be used in the statewide and multi-state evaluation. In order for providers to report aggregate data to the NYLinks team, process measure data should be collected and recorded for each staff member who should be participating in the intervention and then aggregated as a total for all staff every month. For example, whether or not a staff member received training on consistent messaging would be aggregated into the total number of staff trained in consistent messaging that month.

Many of the individual-level data elements described below may already be routinely collected by providers such as the name or unique identifier of the staff member. Although individual-level data will not be reported to the NYLinks team, all data elements that would need to be tracked to accurately report aggregate process measure data is provided below. Optional data elements are also suggested for providers who are interested in gathering additional information for their intervention. **No patient or staff identifiers should be included in any aggregate data process measure report that is sent electronically to the NYLinks team**.

Due to the challenging nature of tracking whether all patients who come in for an appointment have consistently heard the messages delivered by all staff, the process measure data for this intervention will focus on staff training. The NYLinks team will be using NYC and NYS HIV surveillance data to monitor the outcome and impact of Consistent Messaging on retention and viral load suppression across the state.

The following data elements will need to be collected *each month* to create process measures for the Consistent Messaging intervention:

Process measures

Individual-level data elements (not required to be reported to NYLinks):

- Staff member unique identifier
- Was the staff member hired this month
- Was the staff member trained in consistent messaging
- Date staff member was trained in consistent messaging
- During role play, did the staff member adequately display understanding of how to deliver the messages

Optional:

- Position/title of staff member (e.g. nurse, physician, social worker, front desk assistant, etc.)

Aggregate data elements:

- Total number of non-new staff members who should be delivering messages (numerator 2a)
- Total number of new staff members hired this month (denominator 1a)
- Total number of new staff members trained in consistent messaging this month (numerator 1)
- Total number of staff (new and old) who displayed adequate understanding of how to deliver the messages during role play training

Optional:

- Number of types of staff members (nurses/physicians/social workers/front desk assistants etc.) who delivered messages this month

Follow-up measures

Individual-level data elements

- Was the staff member consistently delivering the messages this month
- How was consistent delivery of messages for this staff member primarily determined
    - Observation
    - Chart documentation
    - Meeting minutes
    - Patient survey
    - Patient interview
    - Other (specify)
- Date of last training
- Did staff member have a 3 month refresher training

Aggregate data elements:

- Total number of staff members thought to be consistently delivering the messages this month(numerator 3)

- Percentage of staff members thought to be consistently delivering the messages this month(numerator 3 ÷ [numerator 2a + denominator 1a])
- Total number of staff members who were up for a refresher training this month (denominator 4)
- Total number of staff who are due for a refresher training who attended a training session (numerator 4)
- Percentage of staff who are due for a refresher training who attended a training session (numerator 4 ÷ denominator 4)

Using the Process Measure Data Tool:

The tracking tool is intended to be a dynamic roster of staff trained (or who require training) in Consistent Messaging. Data should be collected on both new and old staff members each month. It may be easier to copy and paste certain parts of the individual-level staff information from monthly tracking tool to the next in order to save time (i.e. staff member unique identifier, date of first Consistent Messaging training etc.) while completing the tool each month.

K. Assessing fidelity to the intervention

In program evaluation, fidelity examines the extent to which an intervention is conducted as it was originally designed. Monitoring fidelity ensures that specific elements of an intervention are implemented according to protocol. This maximizes the effectiveness of the intervention and the likelihood of seeing the desired outcome.

To monitor the fidelity of the Consistent Messaging intervention, the NYLinks Technical Assistance Group will conduct 2-3 site visits. The first visit will occur shortly after the start date of implementation to help identify if the core components are being implemented or delivered as planned. This will allow for early corrections and improvements to be made if it is found that a provider has deviated from any of the essential elements of the intervention. An additional session or two will be conducted to assess if fidelity is maintained over time. This is primarily a time where technical assistance can be provided to any implementation site that needs it.

Fidelity can be assessed through the following methods:

First, an assessment should be made as to whether the agency has developed a protocol and guide for staff regarding the types of brief messages and information that should be relayed to all patients during their visit to the agency. An assessment should also be made to ensure that all staff participating in the intervention has been properly trained on how to deliver the messages to the patients, and meets to review that process. These assessments can be accomplished through documentation and process measure tracking tool checks, in addition to interviews with a random sample of staff members where they are asked about their knowledge of the messages. During these interviews, role play techniques can be used to

determine if staff know how to deliver the message in an appropriate manner or need to be re-trained.

In order to assess whether patients are being exposed to the messages, surveys or voluntary interviews can be administered to a random sample of patients asking them to recall whether or not they heard messages regarding the importance of staying in care and/or adherence to treatment during their visit with the agency. Questions on the survey or during the interview can also query about key take home messages that a patient should have heard. Failure to recall key messages can indicate either that the message was not delivered in a way that the client understood or that the message was delivered, but the client cannot recall. This can also give the patient the opportunity to offer some feedback or input into how to improve the consistent message activity.

L. Acronyms and key definitions

IAPAC: International Association of Providers of AIDS Care
Initial clinic visit: refers to the first clinic visit after the start of the consistent messaging intervention implementation at one's clinic/site

Motivational Interviewing (MI) is a patient centered counseling technique described as a therapeutic approach which has historically been used to work with patients with alcohol issues. The broad goal of Motivational Interviewing (MI) is to facilitate positive behavior change through helping patients understand ambivalent feelings about changing, and to come to terms with these feelings.[1]

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N. References

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O. Appendices

Appendix A. Consistent Messaging Process and Outcome Measures Collection Tool

P. Resources to be used in Implementation

Retention in Care Messaging Guidance and tools

Retention in Care Messaging Tools

These tools are given as examples. Messages should be developed by individual organizations to reflect the care and services that are delivered. It is important, however, to ensure that the intent of the message is maintained. Thus, in the first example, there needs to be an affirming line and a line pointing to action. For the longer messages you may note that some lines are paired, essentially giving the same information in multiple ways. This is to give an example of how the same message can be delivered using slightly different emphasis.

Initial Visit Retention in Care Messages (Checklists 1a and 1b)

1a. Brief Retention in Care Message to be offered by <u>all</u> HIV Care Team Members to all consumers at <u>first visit</u>:

1. I'm very glad that you have entered into care.
2. There is a lot of evidence showing that people who stay in care are more likely to stay healthy and well.

☐ ☐ ☐ ☐ ☐ ☐ ☐

(Each staff person that delivers entire message above must check one box above)

1b. Longer Retention in Care Message (<u>first visit):</u>

The entire message below is to be offered by one or more members of the care team for the first intervention visit. So long as all points of the checklist are touched upon at the first visit, specific points on the checklist may be offered by different team members. Example: Points 1 through 3 may be offered by the medical provider, points 3 and 4 offered by the nurse, point 5 through 8 by the case manager/social worker, points 9-11 the front desk clerk.

☐ 1. I'm very glad that you have entered into care.

☐ 2. There is a lot of evidence showing that people who enter into care are more likely to stay healthy and well.

☐ 3. It's the people who stay in care that are most likely to be well and to stay healthy.

☐ 4. Patients who keep their appointments or reschedule them within a few days are likely to stay healthy and well.

☐ 5. If you keep your appointments your medical providers can monitor your health and make any necessary changes.

☐ 6. This way if there are any issues in many cases they can be resolved before they become real problems.

☐ 7. Sometimes everybody has things that happen though that can get in the way of people keeping their appointments.

☐ 8. Some barriers that patients have told us about include having to work during clinic hours, not having someone to take care of their children, problems with family or friends, trouble with bills and housing,

☐ 9. If you run into any barriers that keep you from making your medical visits, a case manager can help you to get the services you need so you can keep your clinic visits without interruption. If you like I can refer you to a case manager now.

☐ 10. Do you have any questions? Please take this pamphlet (if a pamphlet on care or services is available. If not then skip this line) that has some information, tips on how to make sure your care is not interrupted, and phone numbers you can contact if you need help with anything.

☐ 11. You've made a great decision on entering into care! I look forward to seeing you next time! Be well!

Widespread Consistent Messaging Tools

Retention in Care Follow-Up Messages (Checklists 2a and 2b)

2a. Brief Retention in Care Message to be offered by <u>all</u> HIV Care Team Members to all consumers at <u>every subsequent visit:</u>

1. It's good to see you again.
2. I'm very happy to see that you are maintaining your healthcare so regularly.
3. People who stay in care, like you, are more likely to stay healthy and well.

☐ ☐ ☐ ☐ ☐ ☐ ☐

(Each staff person that delivers entire message above must check one box above)

2b. Retention Message: Subsequent Visits

The entire message below is to be offered by one or more members of the care team at every subsequent intervention visit. If all points of the checklist are touched upon at the first visit, specific points on the checklist may be offered by different team members. Example: Points 1 through 3 may be offered by the medical provider, points 3 and 4 offered by the nurse, point 5 through 8 by the case manager/social worker, points 9-11 the front desk clerk.

☐ 1. I'm very glad that you have entered into care.

☐ 2. its good to see you again.

☐ 3. I'm very happy to see that you are maintaining your healthcare so regularly.

- 4. People who stay in care, like you, are more likely to stay healthy and well.
- 5. If you do run into any problems keeping your visits, I'd be happy to help or to refer you to someone who can help.
- 6. Also, since you are doing such a good job staying in care, if you have any tips on helping other patients to stay in care, please let me know!
- 7. Do you have any questions today? Just in case you need it, here is the pamphlet with information, some tips from other patients on how to stay in care and some phone numbers to help you stay in care.

Appendix B Sample Flow Diagram