

Strengthening Clinical Linkages for Improved Patient Outcomes

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Objectives



Define Key Components
of Effective Clinical
Linkages



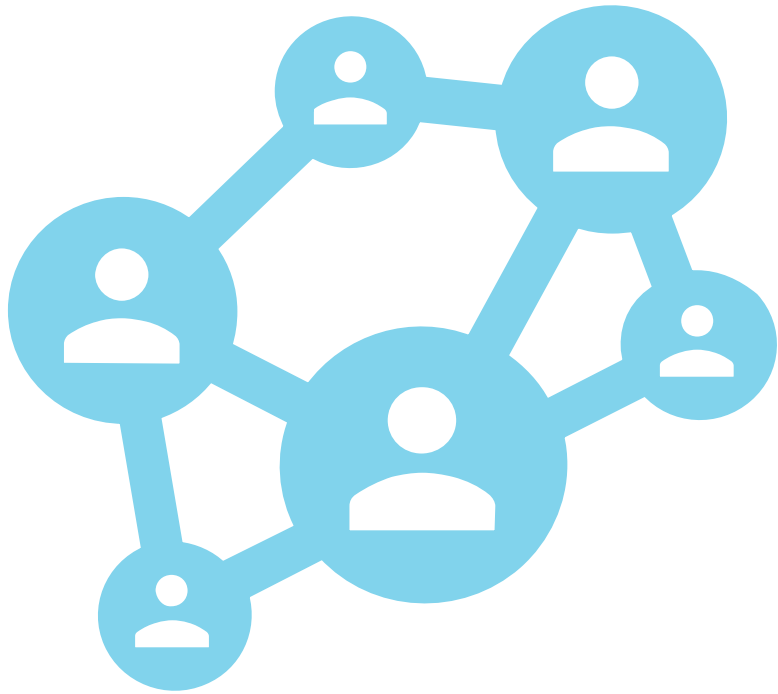
Explore Value of Clinical
Linkages



Discuss Challenges in
Developing Clinical
Linkages



Review Strategies for
Strengthening Clinical
Linkages



- The connection and collaboration between healthcare providers, organizations, and services to improve patient care
- Enhances care coordination, continuity, and patient outcomes

Importance of Clinical Linkages

Improved patient care...

- Ensures holistic, patient-centered care across multiple providers and settings
- Prevents fragmented care and care settings
- Enhances access to specialty care and resources
- Clinical services linked to community programs



Examples of Linkages

PRISMA

Team-based care models

Relationship building

- Peer to Peer
- Healthcare to Public Health
- Healthcare to Community Org
- Healthcare to Legislature

Tech integration

Community and social services integration

Collaboration Among Healthcare Providers: Its OK for it to vary!

Building multi-disciplinary teams

Adding new team members such as diabetes educators, registered dietitians, social workers, psychologists, or pharmacists

Expanding professional role of existing team members

Training nurses as health coaches or care coordinators, training medical office assistants to conduct pre-visit screenings

Support people obtaining CDCES, diabetes tech training, etc

Small teams or "teamlets"

Led by providers who are supported by one or more health care professionals, such as an advanced practice nurse, registered nurse, licensed practice nurse, medical office assistants, or care coordinators, to improve case management.

Coordinating shared care between primary care providers and specialists

Podiatrists, eye doctors, dentists, pharmacists, endocrinologists, therapist, psychiatrist, MFM

Expanding access through non-traditional approaches

Telehealth, shared medical appointments, and group education

Adding community partners to the care team

School nurses, community health workers, trained peer leaders and others

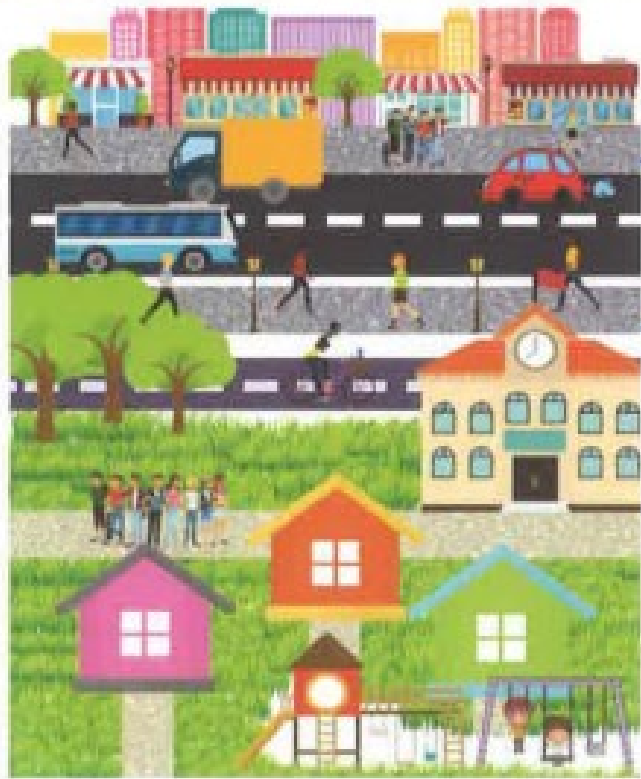
High Functioning Patient-Centered Teams:

Work more
efficiently
and
effectively to
improve
health
outcomes

Optimize
health
system
performance

Improve
provider
experience
by reducing
care burden

Connecting Communities to Clinical Services



Inform

Individuals and community partners about your program (e.g., what it covers, screening sites, referral process).

Educate

Individuals and community partners

Link

Individuals to health systems through community-based referrals.



Value to the Patient

PRISMA

- Streamlined care
- Feeling heard
- Not having to repeat your story
- Improved outcomes
 - A1c
 - BP
 - Lipids
 - Weight

Value to the System

PRISMA



Streamlined workflows
and more efficient use of
resources

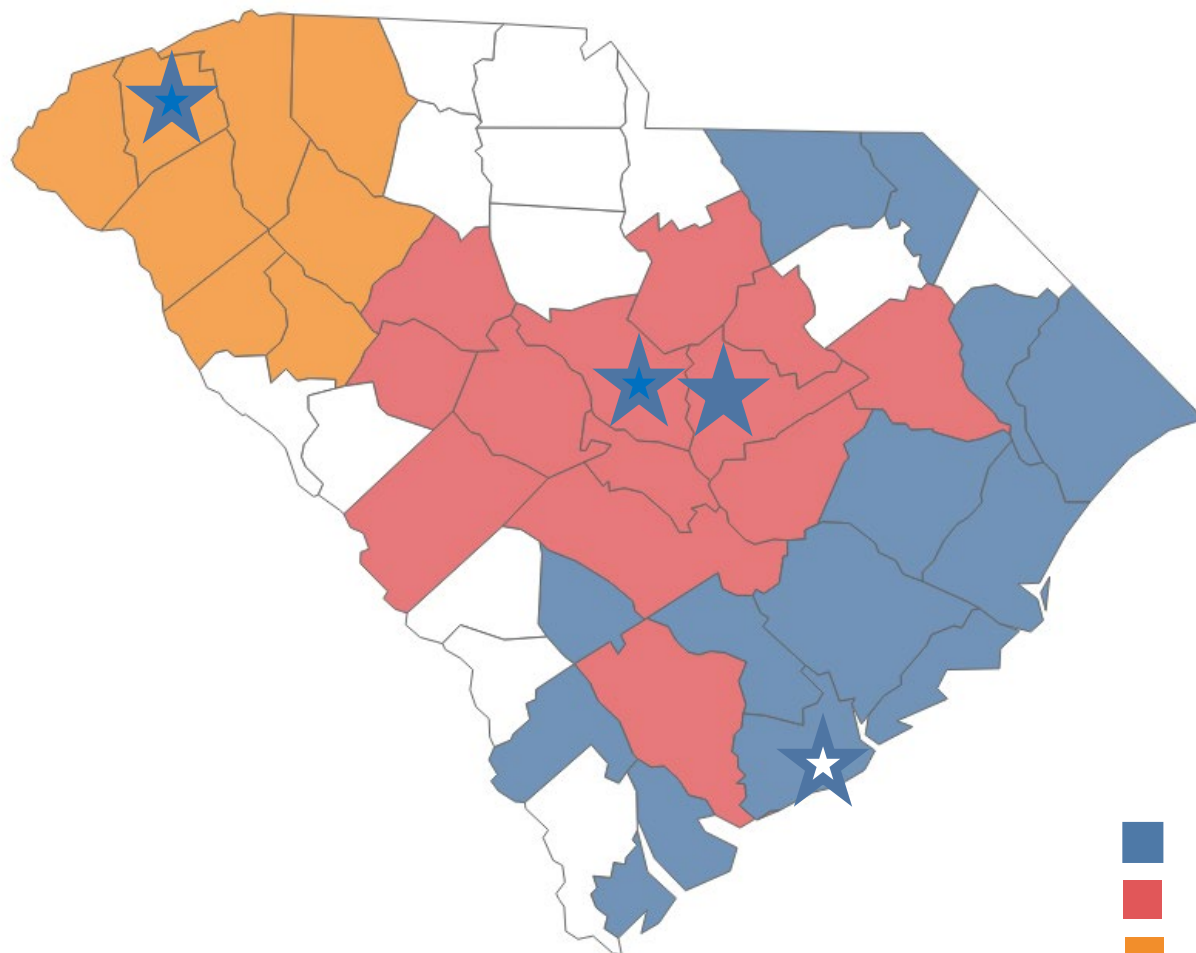


Reduction in hospital
admissions and ER visits



Better health outcomes
(→ savings \$\$) through
coordinated care

Management of Maternal Diabetes



PRISMA
HEALTHSM

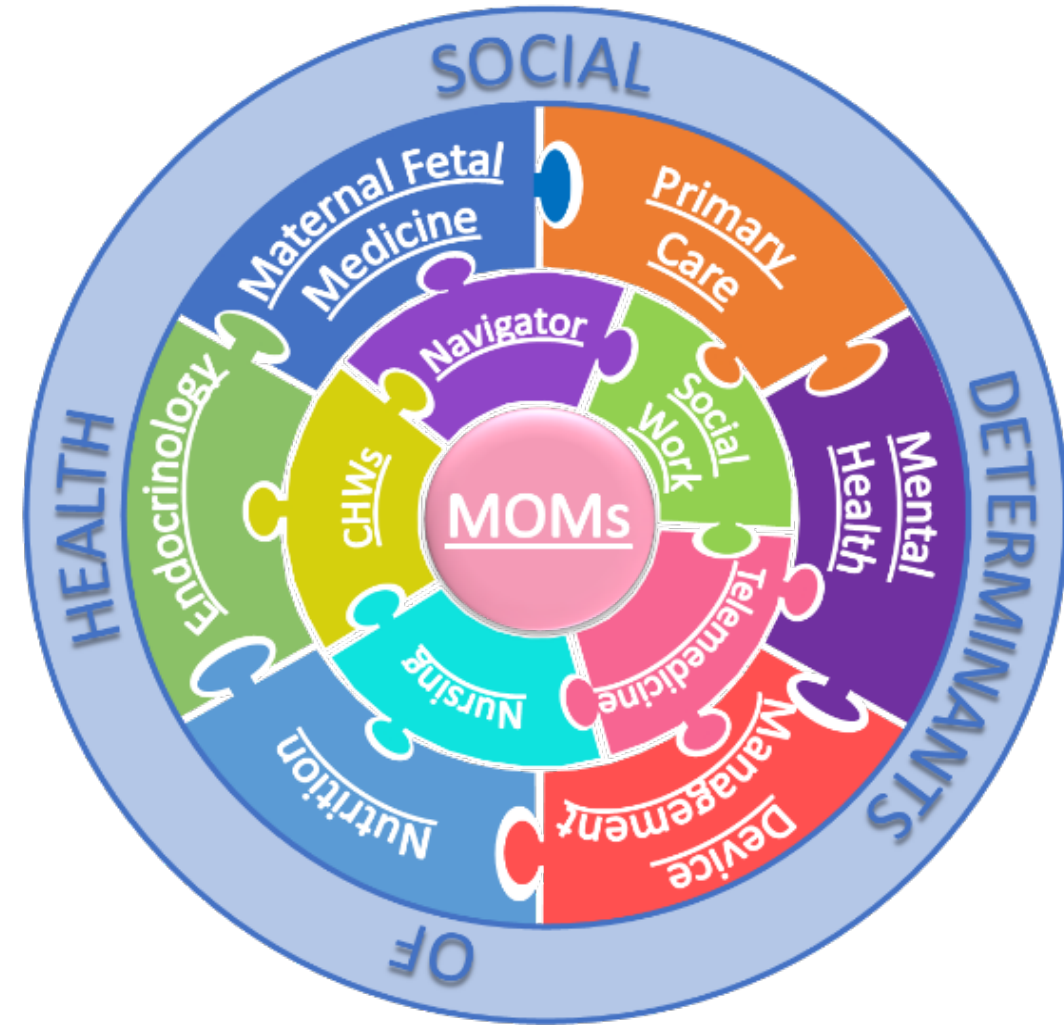
MUSC
Medical University
of South Carolina

- ★ MUSC Multidisciplinary Program (est. November 2019; Supported in part by DFSC)
- ★ DFSC Supported Multidisciplinary Program (Prisma Upstate, Prisma Midlands)

■ MUSC
■ Prisma Midlands
■ Prisma Upstate

MOMs (Management of Maternal) Diabetes Program

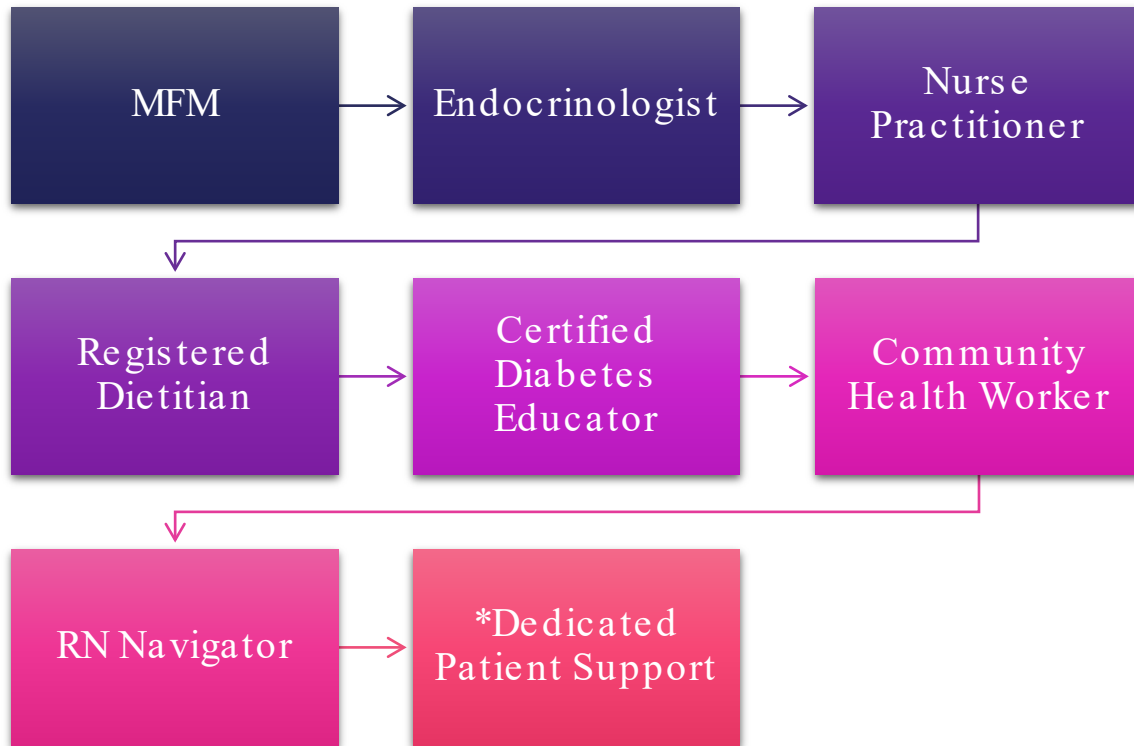
Integrating medical care, technology and
compassion for expectant moms with diabetes



diabetes *free* sc

Key Components of Care: Scalability

Access to multidisciplinary team



*Patient Support Specialists and Medical Assistants

Screenings & Services

- SDOH
- Mental Health
- Retinal exam
- Continuous Glucose Monitoring
 - Personal & Clinic-provided
- Telehealth/Virtual Monitoring
- Insulin Pump Training & Adjustment
- Foodshare SC produce boxes

MOMs Collaboration

Funding



Midlands & Upstate Partners

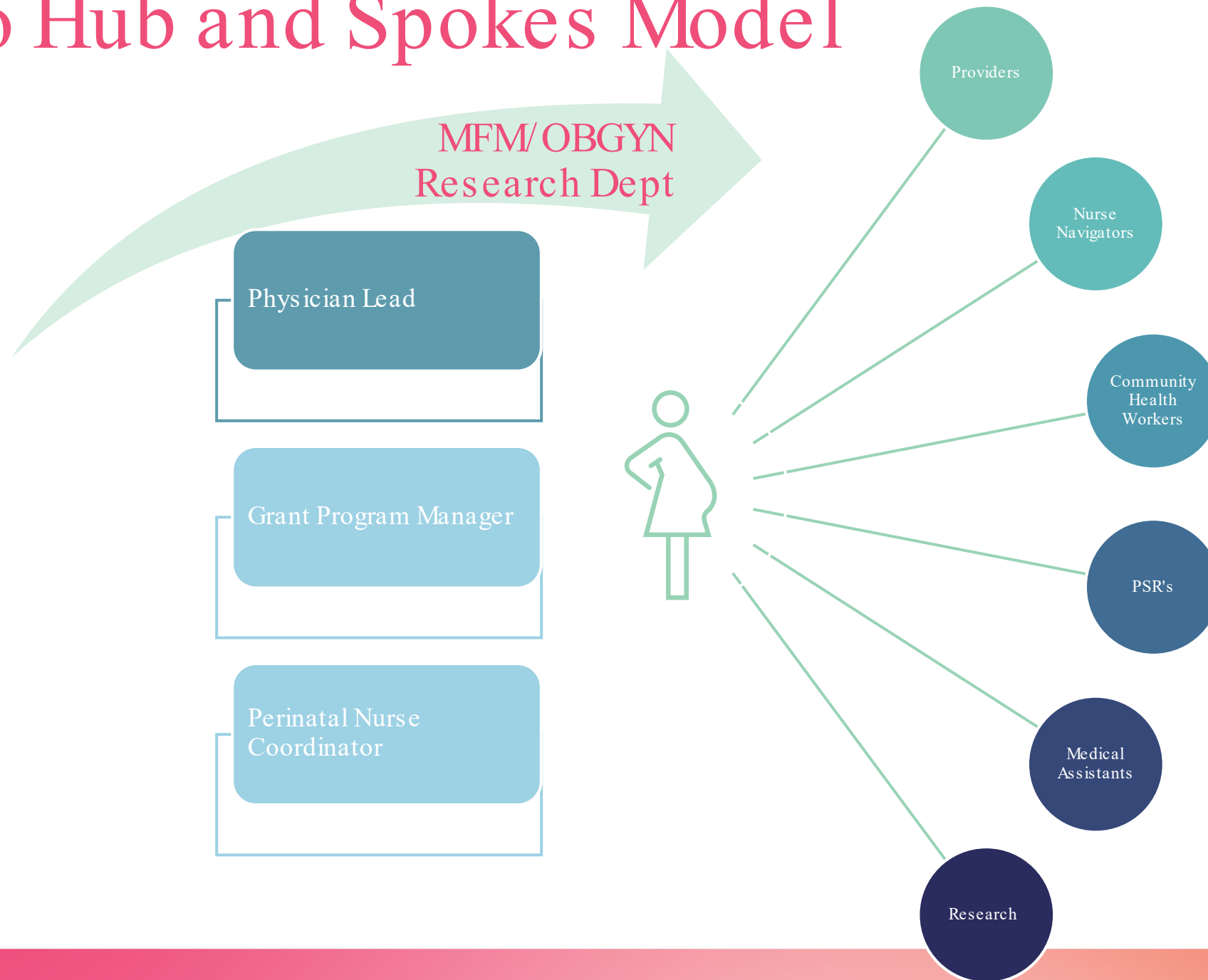


Lowcountry Partners



Shift to Hub and Spokes Model

PRISMA



Challenges

Barriers to Communication and Collaboration

- Major differences in organizations cultures and workflows
- Lack of standardized systems and protocols



Challenges

PRISMA

- Resource Constraints
 - Team-based care works
 - Takes time to recoup ongoing investment
 - Cost savings are seen in adverse outcomes that are prevented which is very difficult to put a number to
 - Turnover on highly skilled teams can be taxing both financially and mentally to the team



Challenges

PRISMA

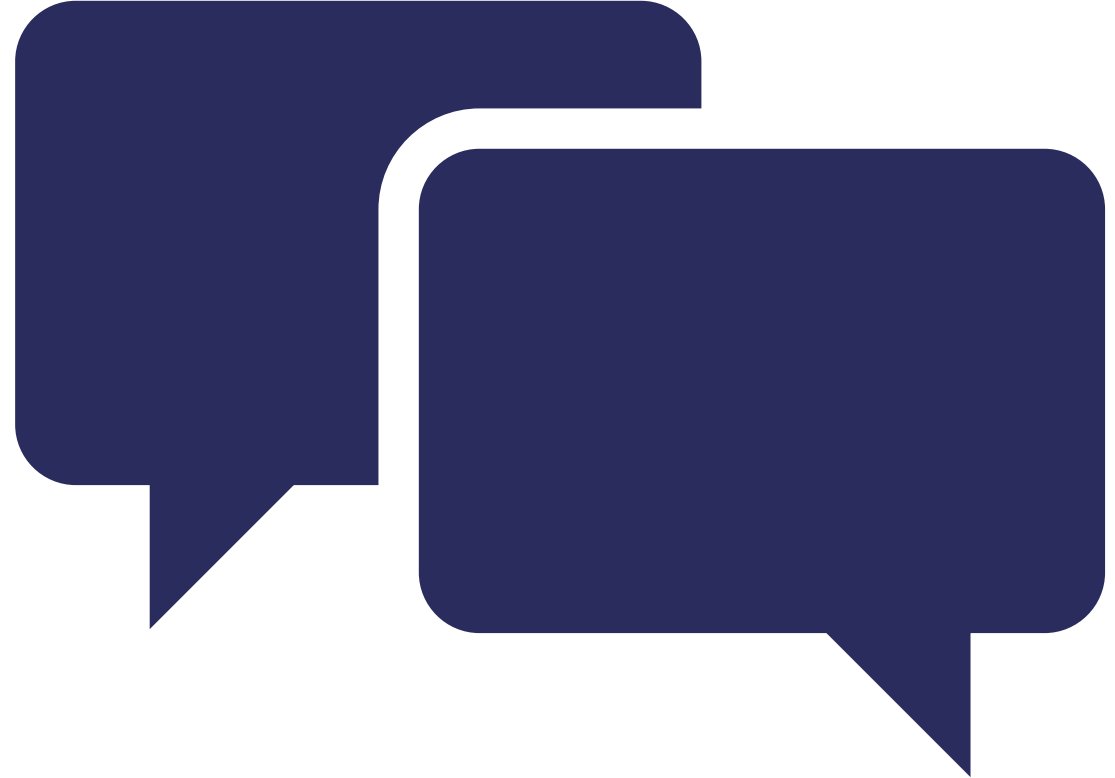
- Resistance to Change
 - It feels too good to stay the same
 - The unknown is scary
 - Losing money is scary
 - Burnout
 - Reality: our current strategy is NOT working



Strengthening

Standardizing Communication and Case Protocols

- Standardized referral processes, care plans, treatment guidelines
 - Shared patient care checklists
 - Shared smart or dot phrases
 - Shared messaging
 - Shared culture and vision
- Regular Case Discussions
- Interdisciplinary care team meetings



- Leveraging Technology
 - Encouraging data sharing
 - Peer to peer
 - Patient to practice
 - Telehealth, remote patient monitoring

- Training and Education
 - Accredited centers for training
 - Echo model
 - Supporting peers in getting hours for certification
 - CDCES
 - RDN
 - APPs
 - Lactation
 - CHW
 - Doulas

Strengthening

Engagement with your community coalitions and action councils

Figure 2. Continuum of a Community-Clinical Linkage



Adapted from Himmelman AT. *Collaboration for a Change: Definitions, Decision-Making Models, Roles, and Collaboration Process Guide*.

Strengthening: Building Strong Partnerships

PRISMA

Learn about community and clinical sectors

Identify and engage key stakeholders

Negotiate and agree on shared goals

Know which operational structure to implement

Aim to coordinate and manage the link

Grow the linkage with sustainability in mind

Evaluate the linkage



PRISMA