The *PEACCH* Tool: Patient Engagement and Care Coordination in HIV Health

What is the *PEACCH* Tool?

The *Patient Engagement and Care Coordination in HIV Health (PEACCH)* tool describes the role of care coordination in serving people living with HIV (PLWH), and outlines steps and resources you may need to set up a care coordination program. It includes five modules:

Module 1: What is Care Coordination and Why is it Important for Serving PLWH?
Module 2: Laying the Groundwork for HIV Care Coordination
Module 3: Staffing HIV Care Coordination
Module 4: Determining the Target HIV Care Coordination Population
Module 5: Conducting Interdisciplinary HIV Care Planning
Module 6: Using Health Information Systems in HIV Care Coordination
Module 7: Supporting Continuous Quality Improvement in HIV Care Coordination

Who is this tool for?
This tool may be useful to you if:
➢ Your clinic serves PLWH, particularly PLWH with complex care needs
➢ Your team provides care and services to patients in addition to direct HIV care
➢ You need to improve communication and coordination within your HIV care team, or between your HIV care team and other clinical teams

Do I have what I need to get started?
You may find it easier to follow the recommendations in this tool if your clinic already has:
➢ A well-functioning electronic medical record with population management tools
➢ Agreement that care team communication and coordination need to improve
➢ The ability to hire and train care coordination personnel

Module 1: What is Care Coordination and Why is it Important for Serving PLWH?

What is covered in this module?
(1) What is care coordination why it is important for PLWH?
(2) Introducing the Workforce Development Initiative
(3) Care coordination use in the Workforce Development Initiative

Part 1: Care Coordination and HIV

What is care coordination?

Today, one is likely to find a care coordinator working in many health settings in the United States. But exactly who may fill that role, and what that person does may vary. In 2014, a group of stakeholders at the National Quality Forum (NQF) conducted a review of care coordination practices and determined that what may be called *care coordination* in practice is broad, but can be generally defined as:

"… the deliberate synchronization of activities and information to improve health outcomes by ensuring that care recipients' and families' needs and preferences for healthcare and community services are met over time." [1]

Why is there a need for care coordination within HIV care?

To understand why care coordination matters for PLWH, one has to consider progress along the stages of HIV identification, care, and treatment that PLWH ideally experience, known as the HIV Care Continuum. The Continuum reflects how many PLWH have been diagnosed, linked to care, retained in care, and achieve viral suppression. In the United States, many individuals are diagnosed but not retained in care or virally suppressed. This can be seen in **Figure 1** below.

Figure 1: Prevalence-Based HIV Care Continuum, 2014
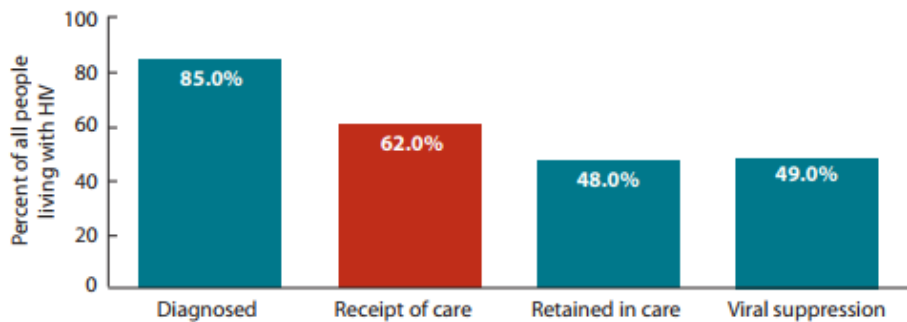
Source: Centers for Disease Control and Prevention. Understanding the HIV Care Continuum. (2017). Available at https://www.cdc.gov/hiv/pdf/library/factsheets/cdc-hiv-care-continuum.pdf. (Last accessed: November 29, 2017.)

In 2015, the United States' National HIV/AIDS Strategy acknowledged that many of the factors behind less-than-ideal retention and viral suppression could be improved through care coordination. Specifically, the Strategy:

- Acknowledges that as the HIV specialist workforce declines, more and different types of care team members (e.g. primary care, behavioral health, peers) will need to be integrated into the HIV care workforce. **The Strategy recommends care coordination to assist with communication and increased capacity across care teams.**

- Also, the Strategy highlights the role that competing demands—such as the need to obtain stable housing, food, or legal services—play in interfering with the ability of PLWH to engage in care, and **suggests that care coordination may be needed to help address these issues alongside medical needs**.[2]

Part 2: The Workforce Development Initiative

The *PEACCH Tool* was created by members of the *System-level Workforce Capacity Building for Integrating HIV Primary Care in Community Health Care Settings* (referred to in this tool as *The Workforce Development Initiative*, or *WDI*)[3] to share our experiences with care coordination from this initiative with other clinics serving people living with HIV (PLWH).

The Workforce Development Initiative

The WDI is funded by the United States Health Resources and Services Administration's (HRSA) Special Projects of National Significance (SPNS) Program, which funds safety-net HIV clinics as demonstration sites nationwide to pilot, evaluate, and disseminate innovative models of HIV care that support desirable health outcomes for PLWH. SPNS designed the WDI to explore how clinics can more efficiently and effectively care for PLWH in an era in which the HIV provider workforce is shrinking as demand for care increases.[4] WDI sites piloted a variety of methods to transform their practices, but most fall into one of three categories:

- ➢ **Expand the workforce**: Increase the number of providers able to care for PLWH
- ➢ **Share the care:** Distribute responsibilities among a wider set of primary care and mid-level providers, and make delivery of care more efficient
- ➢ **Improve patient engagement:** Implement services to promote more reliable engagement in routine HIV care, reducing the need for acute care

Care coordination supports practice transformation efforts in each of these categories.

Part 3: Care coordination in the WDI

Nationwide, what is called *care coordination* can vary depending on clinics' individual needs, and includes a variety of duties performed to support different groups of patients, by professionals with a range of credentials.[5][6][7] However, some common themes have emerged across academic and government literature, and in our initiative. Read on to see how some of the WDI sites used care coordination.[11]

Care coordination centralizes communication

Care coordination unifies **points of communication and organization** between patients and care teams and within care teams, including support service providers in and outside of the clinic. [5][6][7]

In the Workforce Development Initiative:
- ✓ **La Clínica del Pueblo (LCDP),** a Federally Qualified Health Center (FQHC) primarily serving immigrant Latino residents of the District of Columbia metropolitan area, utilized care coordination practices to streamline communication as they trained primary care providers to care for PLWH, empaneled HIV patients to care teams, and integrated community health workers and navigators into the care teams.
- ✓ **University of Miami/Jackson Memorial Medical Center (UM/JMMC)**, which serves approximately 3,250 patients in Florida's Miami-Dade County, hired a patient navigator and two medical assistants to serve as points of contact for communication with patients. This has allowed clinic flow to improve.

Care coordination helps teams share information and stay on the same page

Care coordination **supports exchanging information and data** necessary to establish a **common plan for a patient's care** and promote meeting patients' goals for health and well-being.[5][6][7][8]

In the Workforce Development Initiative:
- ✓ **The Ruth M. Rothstein CORE Center,** a provider for more than 5,000 patients within the Cook County Health and Hospital System (CCHHS) of Illinois, developed data infrastructure to support care coordination by facilitating linkage and retention efforts, informing quality improvement activities, and coordinating outreach efforts for patients lost to care.
- ✓ **The Comprehensive Health Program at Columbia University-New York-Presbyterian Hospital**, an outpatient program serving over 2,000 patients in New York City, implemented panel-based care and population health management through the Stimulating Transformation through Technology and Team Structure to Reach PLWHA (STaR) Project. The STaR Project's nurse care coordinator used a new dashboard to identify care coordination priorities for the Clinical Care Team (CCT), facilitated meetings during which interdisciplinary patient care plans were developed and updated, and implemented care transition plans for patients being discharged from the hospital.

Care coordination helps providers and patients by managing psychosocial needs

Care coordination helps to **address patients' psychosocial needs** and in so doing, helps to **free up providers** and other medical staff to perform at the top of their licenses.[5][6][7][8]

- ✓ **Coastal Bend Wellness Foundation**, an HIV care and service provider and FQHC in the Corpus Christi, Texas region, introduced care coordination to align with patient-centered medical home (PCMH) standards, and to support the incorporation of additional members into their care teams (e.g., medical assistants, case managers) and co-location of supportive services (e.g., mental health and substance abuse treatment, food pantry). The coordinated support of the interdisciplinary care team and psychosocial services encouraged patient engagement.
- ✓ **NYC Health + Hospitals Correctional Health Services (CHS) and One Stop Career Center of Puerto Rico (OSCC-PR)** provided transitional care coordination to PLWH moving from jail to the community after incarceration by developing and following an individualized plan of action to address social determinants of health that present barriers to care engagement (e.g. housing, substance use treatment, food, employment, transportation) after release, alongside support for continuity of medical care.

Care coordination may especially help PLWH who need the most help

Care coordination is useful for a variety of patients, but may be **particularly useful for patients with complex care needs**.[5][7]

In the Workforce Development Initiative:
- ✓ **Access Community Health Network,** a 36-clinic FQHC in the Chicago, Illinois region providing HIV and primary care to 900 PLWH among its 180,000 patients, targeted care coordination services for maximum impact by utilizing a health risk screening tool that assesses complex needs to focus these services on patients the tool identifies as medium or high risk. Care coordinators facilitate and monitor connection for these patients to clinical and psychosocial services within and outside of the Access system.
- ✓ **The MetroHealth System**, the county hospital in Cuyahoga County, Ohio, serves over 1,600 PLWH in its HIV clinic and added two behavioral health coordinators to improve the identification and treatment of PLWH with depression. Care coordinators assessed patients for symptoms of depression, encouraged self-management strategies, connected patients with higher-acuity symptoms to behavioral health providers and services, and assisted with follow up.

Care coordination works when the model suits the patients

Care coordination may, in part, have a broad definition because it works best when it is **designed to fit the needs** of the patient population at a specific care site.[5][7]

In the Workforce Development Initiative:
- ✓ **Brightpoint Health**, a multi-service organization and FQHC serving approximately 1,500 PLWH in the greater New York City area, incorporated care coordination practices in partnership with implementation of a patient self-management

curriculum aimed at empowering and educating clients to manage their health, and mitigating barriers to treatment adherence. The Brightpoint team assessed the degree to which patients felt the self-management curriculum was relevant to them and adjusted the model to better fit their patients' needs and circumstances, encouraging ongoing participation in the self-management program.

Summary

➢ Care coordination is a clinical practice tool that can help progress along the HIV care cascade by streamlining communication and increasing capacity within care teams, and by organizing and formalizing methods for addressing psychosocial needs that may present barriers to HIV care engagement.

➢ The SPNS Workforce Development Initiative Demonstration sites employed care coordination practices in their clinics to centralize communication, share data, manage psychosocial needs, and support PLWH with complex needs.

Given both the range of care coordination definitions and practices, and the benefits for PLWH outlined in this introductory module, we feel it is important to add our experience this still-evolving field. Read on for our suggestions on how to go about implementing a care coordination program at your clinic.

References and Notes:

1. National Quality Forum: Care Coordination Committee. Priority Setting for Healthcare Performance Measurement: Addressing Performance Measure Gaps in Care Coordination. Washington, D.C.: National Quality Forum; August 15, 2015. Available at: http://www.qualityforum.org/Publications/2014/08/Priority_Setting_for_Healthcare_Performance_Measurement__Addressing_Performance_Measure_Gaps_in_Care_Coordination.aspx. (Last accessed July 24, 2017.)
2. Office of National AIDS Policy (ONAP). The National HIV/AIDS Strategy: Updated to 2020. Washington, D.C.: ONAP; July 2015. Available at: https://files.hiv.gov/s3fs-public/nhas-update.pdf. (Last accessed: November 29, 2017.)
3. For more on the *Workforce Development Initiative*, please visit http://workforce.ucsf.edu/about-us, or https://hab.hrsa.gov/about-ryan-white-hivaids-program/spns-workforce-building. Our project consists of 15 clinical demonstration sites in seven U.S. states, Puerto Rico, and Washington, D.C., and one evaluation center at the University of California, San Francisco.
4. Carmichael, JK, et al. Averting a Crisis in HIV Care: A Joint Statement of the American Academy of HIV Medicine (AAHIVM) and the HIV Medicine Association (HIVMA) On the HIV Medical Workforce. The AAHIVM and HIVMA Medical Workforce Working Group. (June 2009.) (Last accessed July 31, 2017.)
5. Watt N, Sigfrid L, Legido-Quigley H, Hogarth S, Maimaris W, Otero-García L, Perel P, Buse K, McKee M, Piot P, Balabanova D. Health systems facilitators and barriers to the integration of HIV and chronic disease services: a systematic review. Health Policy Plan. 2017 Jun 29.
6. Friedman A, Howard J, Shaw EK, et al. Facilitators and Barriers to Care Coordination in Patient-centered Medical Homes (PCMHs) from Coordinators' Perspectives. J Am Board Fam Med. 2016 Jan-Feb;29(1):90-101.
7. Weiss L, Netherland J, Egan JE, Flanigan TP, Fiellin DA, Finkelstein R, Altice FL; BHIVES Collaborative.. Integration of buprenorphine/naloxone treatment into HIV clinical care: lessons from the BHIVES collaborative. J Acquir Immune Defic Syndr. 2011 Mar 1;56 Suppl 1:S68-75.
8. Quigley DD, Predmore ZS, Chen AY, Hays RD. Implementation and Sequencing of Practice Transformation in Urban Practices with Underserved Patients. Qual Manag Health Care. 2017 Jan/Mar;26(1):7-14.
9. Stitzer M, Matheson T, Cunningham C, Sorensen JL, Feaster DJ, Gooden L, Hammond AS, Fitzsimons H, Metsch LR. Enhancing patient navigation to improve intervention session attendance and viral load suppression of persons with HIV and substance use: a secondary post hoc analysis of the Project HOPE study. Addict Sci Clin Pract. 2017 Jun 27;12(1):16.
10. Irvine MK, Chamberlin SA, Robbins RS, Myers JE, Braunstein SL, Mitts BJ, Harriman GA, Laraque F, Nash D. Improvements in HIV care engagement and viral load suppression following enrollment in a comprehensive HIV care coordination program. Clin Infect Dis. 2015 Jan 15;60(2):298-310.

11. In addition to the sites mentioned here, this initiative also included six other demonstration sites, which are featured in other products from the WDI: Family Health Centers of San Diego, the Florida Department of Health, FoundCare, Inc., Special Health Resources for Texas, San Ysidro Health Center, and the University of Pittsburgh Medical Center.

Module 2: Laying the Groundwork for HIV Care Coordination

What is covered in this module?
(1) Getting buy-in from the care team
(2) Exploring the role of external partners in care coordination

Some clinics may find they have many of the elements they need for care coordination already on hand within their clinic. Even so, reorganizing a care team around a care coordination model can be a significant change, so it is important to make sure that you:

➢ Know what resources you already have, and what is needed
➢ Ensure your leadership, providers and staff are on board
➢ Know exactly what you plan for care coordinators to do and help care teams understand how to incorporate this new role
➢ Hire and train based on competencies necessary to perform these tasks
➢ Identify which PLWH will receive care coordination and why

To begin, we will discuss the partnerships you will need within and outside of your organization in order to design and implement your program. We will discuss staffing, patient populations, care team meetings, electronic resources, and population management and quality improvement in the modules that follow.

Part 1: Gain buy-in

Implementing care coordination practices will ultimately change how members of your team do their jobs and care for PLWH. Some team members may no longer have tasks they once had, and others may have new tasks. Information may be shared differently. Many team members may end up working with someone new. With these changes, we recommend you engage early and frequently, generating buy-in at every level.

➢ Have clear conversations with leadership, staff, and providers about why you think care coordination will help your clinic better care for PLWH.
➢ Dedicate time to identify and make plans to address concerns raised by your colleagues.
➢ Clarify expectations about upcoming changes to roles, training requirements, and workflows, and share implementation timelines.
➢ Share desired care coordination outcomes and benefits for PLWH.
➢ Remember that buy-in is gained and maintained continuously; you could gain it at the outset and lose it over time if you do not continue to invest in it.

The WDI demonstration site at the **University of Miami/Jackson Memorial Medical Center (UM/JMMC) Adult HIV Outpatient Center** employs healthcare providers who are affiliated with the University of Miami Miller School of Medicine, but the clinic itself, and its associated support staff, are a part of Jackson Memorial Medical Center. Therefore, implementation of new care coordination practices required buy-in from both entities. In addition, any needed approval processes and administrative considerations were doubled. To help support buy-in, reduce confusion, and address the administrative challenge of working under a two-agency partnership, the project team routinely held joint meetings to encourage teams from both institutions to work together and remain on the same page. These meetings were facilitated with workflows aimed at helping teams from both agencies visualize how clinic processes worked before implementation of new care coordination practices, and how they would work after implementation (see **Figure 2)**. The project team felt that these guided, collaborative meetings greatly increased buy-in.

Once obtained with initial teams, buy-in proved to be an iterative process. Frequent turnover among providers and staff from both institutions meant that each new provider and staff member had to be educated on the role of care coordination practices in the clinic, and how the new provider or staff member could work within the care team to support that model. Again, well-designed, accurate workflows were instrumental in quickly and easily familiarizing new employees with care coordination processes and encouraging buy-in.

Figure 2. Part of a University of Miami/Jackson Memorial Medical Center (UM/JMMC) workflow.

Part 2: Formalize and Solidify External Partnerships
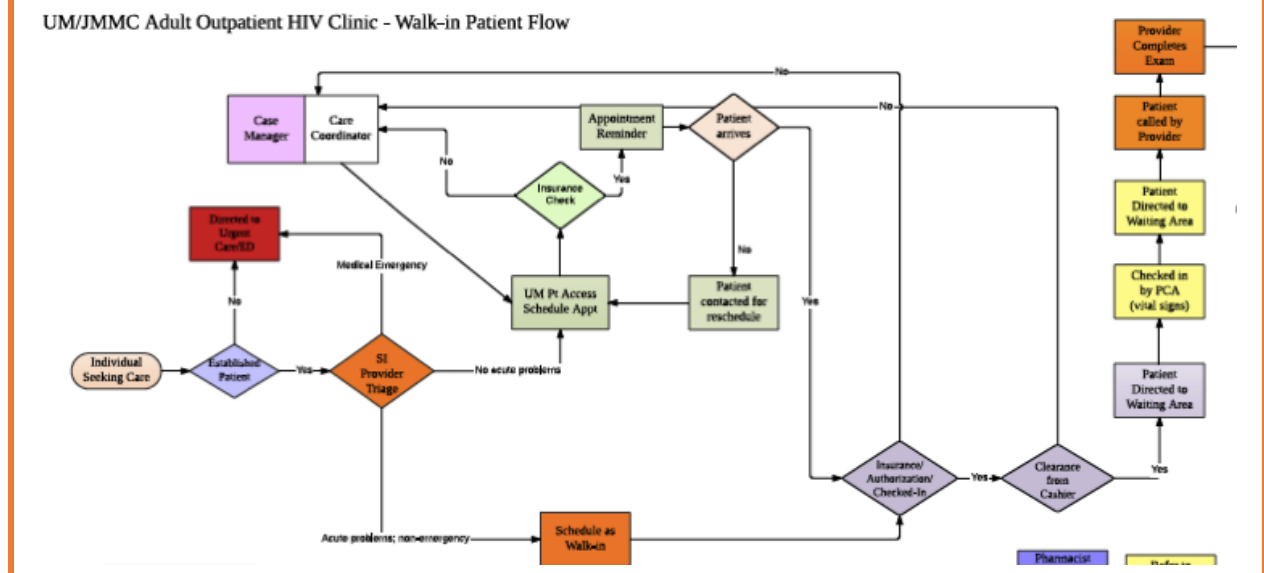
By definition, care coordination involves working with the many parties needed to provide care and services to PLWH. As noted earlier in this tool, many of the psychosocial needs that external service providers address can present barriers to care, and therefore should be considered within the scope of care planning and coordination. A care coordinator needs to have established relationships with all care providers and support services to encourage patient engagement and support better health outcomes for PLWH.

➢ Consider external partners. Who do you often refer to now? How well are those referrals working? Is there an external need (e.g., transportation or housing assistance) that you do not refer for currently, but keeps your patients from easily accessing care?
➢ Build up these relationships. Contact external partners, inform them of your interest in establishing a care coordination program, and seek their support and expertise on how to incorporate their services.
➢ Depending on the extent of your collaboration, you may wish to formalize relationships with a contract or memorandum of understanding that establishes a framework for how external partners will collaborate and communicate with your care team to support PLWH.

Focus: Formalizing partnerships in Puerto Rico

The **One Stop Career Center of Puerto Rico (OSCC-PR)** established memorandums of understanding (MOUs) with over 60 organizations across Puerto Rico to assist them in supporting comprehensive care for recently incarcerated PLWH. Organizations include federally qualified health centers and other clinics and community-based organizations that provide housing, substance use treatment, food, transportation, and other services. In addition, OSCC-PR started what is known as the Transitional Healthcare Coordination Consortium, in which ten key agencies meet regularly to better coordinate and collaborate on behalf of their shared clients. Finally, the WDI helped support an annual meeting of all community providers across Puerto Rico who work with justice-impacted people living with HIV.

In particular, OSCC-PR's coordination efforts included working to improve partnership with correctional settings. For example, OSCC-PR did not initially receive any referrals or notice from correctional facilities when PLWH were about to be released from prison or jail and would need post-release services. Instead, OSCC-PR obtained permission to share information on their services during a post-release orientation provided to individuals soon due to be released. They also worked to build relationships with social workers in correctional facilities who later could refer eligible clients to them.

Summary

➢ Before you launch your care coordination program, consider the stakeholders in your care team who may be impacted, and work to encourage their buy-in.

➢ Develop informal and formal partnerships with external partners who provide support services to your patients and encourage their participation in the care coordination process.

Module 3: Staffing HIV Care Coordination

What is covered in this module?
  (1) Defining the scope of HIV care coordination roles
  (2) Considering key skills and competencies for HIV care coordination
  (3) Establishing a training program to support HIV care coordination personnel

For care coordination to work, it has to respond to a real need for a clinic and its patients. Do your patients need additional follow up to make sure they complete referrals? Do your care teams need additional training to use your electronic medical record to communicate? How can your procedures, roles, and responsibilities change to help you address such gaps? Take a formal approach to identifying what your clinic and patients need, how your care coordination program will be designed to fill those needs, what each team member's responsibilities will be, and how you will ensure they are properly trained to meet those responsibilities.

Part 1: Define the scope of HIV care coordination roles

➢ Consider a needs assessment to take stock of existing resources and identify where you need to focus your attention before you move forward. In particular, look at what surveillance data say about HIV in your area to better understand which needs are unmet.
➢ Establish job descriptions, competencies, and training requirements for all existing and planned care coordination personnel, formalizing how your clinic will address unmet needs and clarifying what is expected of each member of the team.
➢ Create or update detailed workflows for each member of the care coordination team.
➢ Develop or obtain necessary training resources and establish a routine training schedule for new and existing care team members.

Focus: Updating roles, responsibilities, and workflows at the CORE Center

The **Cook County Health and Hospital System (CCHHS) Ruth M. Rothstein CORE Center** implemented the Patient Centered Medical Home (PCMH) model in 2012. In the WDI, the CORE Center's goal was to build upon PCMH implementation and improve the patient experience. To achieve these goals, the project team conducted an extensive workflow mapping exercise to clarify roles and responsibilities and identify areas in need of improvement. The team conducted focus groups across clinical disciplines to discuss current provider and staff roles and responsibilities, and then met regularly with participants

to obtain feedback as workflows were revised and finalized. This process helped the project team identify discrepancies between policies and actual practice, duplicated efforts, and inefficiencies, and led to the creation of sixteen new workflows. Also, this process informed other improvements, described below.

- Workflow mapping highlighted the need to improve management of patient telephone calls. The team established a patient call center and adjusted the roles and responsibilities of staff working the call center to both decrease duplicated effort and increase call capacity.
- Needs identified in the workflow mapping exercise also led to the creation of four new staff positions: the Manager of Patient-Centered Care, who is responsible for guiding the implementation of the PCMH model; the Inpatient and Outpatient Clinical Transition Liaisons, who facilitate linkage to HIV primary care for patients identified in the inpatient hospital or outpatient settings; and Clinic Team Leaders, who are responsible for improving care coordination across all primary care and specialty clinics.
- The project team identified that patients were moved frequently from one room to another to see providers and staff, on an average of eight times per visit. The team determined that it would be more efficient to give patients designated rooms and have providers and staff move through to provide services. Under this model, patient movement decreased to approximately twice per visit and evaluation showed that patients overwhelmingly preferred the new process (see **Figure 3**).

Figure 3: Patient flow at the CORE Center after workflows were reassessed
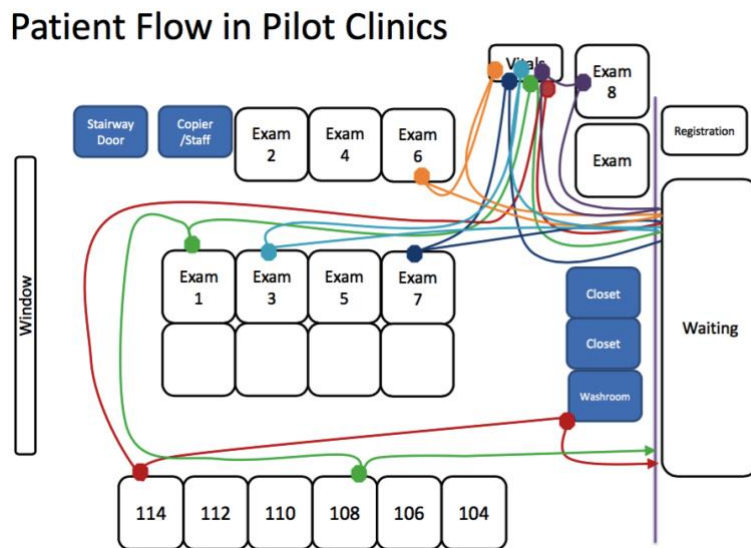
Part 2: Consider key skills and competencies for HIV care coordination

In addition to care coordination skills, care coordination personnel should be culturally competent to the needs of the patient population. Care coordination can be particularly useful

for serving PLWH with complex needs. Here are just some of the unique or complex care needs patients in the WDI faced:

➢ *Incarceration:* Incarcerated PLWH may experience heightened vulnerability due to HIV stigma. Care for incarcerated PLWH involves multiple parties across the health care and justice systems and can be fragmented. After release, formerly-incarcerated PLWH often face pressing survival concerns that present barriers to engagement in HIV care. During and after incarceration, care coordination is needed to address how health needs will be met.

➢ *Immigration status:* Undocumented PLWH may face stigma and fear associated with their immigration status, undermining trust in the health care system and willingness to go out in public to access health care. Immigrant PLWH may not have employment options that allow them to receive care during normal business hours. Undocumented PLWH may connect to clinics through community health workers on a care coordination team who foster trust and provide coordinated access to language, legal, mental health services, health insurance, housing, transportation, and childcare.

➢ *Stigma, trauma, and behavioral health issues.* PLWH with behavioral health issues may face homelessness, comorbid psychiatric and health conditions, and lack of access to psychosocial resources, all of which present barriers to engagement in HIV care. Also, both stigma and symptoms associated with these individuals' behavioral health conditions may impact their willingness to trust and engage with providers and staff.

Focus: Serving PLWH with depression at MetroHealth

MetroHealth implemented a collaborative care model to optimize the identification and treatment for depression among their PLWH. To do so, two behavioral health care coordinators were hired to coordinate care for patients who reported moderate or severe depressive symptoms on a standardized tool. Care coordinators assessed symptoms, taught self-management strategies, reviewed cases with a consulting psychiatrist for treatment recommendations, and facilitated connection to behavioral health providers when indicated. Care coordinators were assigned to treatment teams and were present in the clinic with their team, which helped to develop rapport and build trust with patients through frequent contact. At least every three months, care coordinators re-measured depressive symptoms to assess patient response and programmed the assessment results into the electronic medical record (EMR) based on decision support algorithms.

Part 3: Establishing a training program to support HIV care coordination personnel

Once you have defined roles, responsibilities, key skills, and competencies for members of your care team, you need to ensure everyone on your team is properly trained to carry out their responsibilities.

- For the purposes of HIV care coordination, it may be particularly important to train on such things as team communication skills, cultural competence for the local patient population, and use of the electronic medical record for communication and data extraction.
- Knowledge assessments are key to a training program. Conduct pre- and post-training surveys to determine what participants learned and what training needs they may still have.

Focus: Regional training resources

Many of the sites in the WDI partnered with their regional AIDS Education and Training Center (AETC) to design and implement a training program to support their practice transformation efforts. The AETCs offer technical assistance, online resources, training, and consultation to improve care and services for PLWH. Connect with your regional AETC by visiting https://aidsetc.org/aetc-program/regional-offices. In addition, you may find helpful resources by connecting with the primary care association in your region. These agencies also provide training and technical assistance specific to community health centers.

Summary

- Take stock of existing resources and unmet needs so you can focus your efforts.
- Formalize job descriptions and competencies for all HIV care coordination personnel, and update workflows to reflect each team member's roles and responsibilities.
- Create a training schedule and curriculum. Your regional AETC can help.
- Care coordinators should be culturally competent to the needs of the patient population.

Module 4: Determining the Target HIV Care Coordination Population

What is covered in this module?
(1) Identifying the target HIV care coordination patient population
(2) Supporting patient access and engagement

Rather than offering care coordination to all PLWH, it can be helpful to target care coordination toward patients with specific characteristics or issues based on your local epidemiology, the demographics of the clinic's patient population, and unmet needs. Having a target population with specific or more acute needs may increase the benefits of the program by directing resources towards patients who most need assistance. Once the target population is determined, develop infrastructure for routinely identifying and enrolling eligible patients, tracking desired program outcomes, and supporting patient engagement.

Part 1: Identifying the target population for HIV care coordination

While perhaps all PLWH at your clinic could benefit from some elements of care coordination, it is likely that some patients have needs that are more complex or acute, and are therefore most likely to benefit from an organized, whole-patient approach from your care team.

➢ Review local epidemiology and data from your electronic medical records as a part of your needs assessment to identify which subpopulations of PLWH may be most likely to benefit from care coordination.
➢ In addition to initial review, establish a method for routinely reviewing and identifying who is in the care coordination program currently, who may be transitioned out, and who needs to be enrolled. Your electronic medical record, population management software, or acuity screening tools can help. Be sure to designate who among care coordination personnel is responsible for regularly pulling and reviewing these data.

Focus: Acuity screening at Access Community Health Network

Access Community Health Network (ACCESS) has been incorporating care coordination throughout its 36 health centers for the past several years. In the WDI, two HIV care coordinators were hired to specifically support sites with infectious disease providers. These sites treat approximately 900 PLWH per year, so the care coordinators used two acuity tools to focus their efforts on the patients with the greatest needs. These tools record a patient's age, sex, recent hospitalizations or emergency department visits, HIV treatment adherence, viral load, opportunistic infections, and chronic conditions. The care coordinator then places the patient in low-, medium-, or high-risk categories (see **Figure 4**). The care coordinator uses the results of the acuity screening to guide the focus of individual patient education efforts, and to target further care coordination services to high-risk patients.

Figure 4: Risk stratification matrix for PLWH at Access

Risk Stratification Criteria for HIV Care Coordination

Risk Level (Points)	Qualification	Services
Low (0)	• Stable on ART, viral suppression, engaged in care	• Regular health center services
Medium (4)	• New to ACCESS • Referred by providers PRN**	• Care plan update Q90 days • Outreach Q90 or increased frequency based on need (telephone or in person) • Risk assessment annually (unless change in status) • Following labs • Following appointments • Transitions of care
High (8)	• Newly diagnosed HIV positive • Treatment adherence challenges • Elevated viral load (VL > 200) (if on antiretroviral therapy) • Newly on ART, restarting ART, or change in ART regimen* • New opportunistic infection • Referred by providers PRN**	• Care plan update Q30 days • Outreach Q30 or increased frequency based on need (telephone or in person) • Risk assessment annually (unless change in status) • Following labs • Following appointments • Transitions of care
TBD (Medium or High)	• Uncontrolled chronic condition (E.G. DM or HTN)*** • Poor utilization of services without other risk factor	

Part 2: Supporting patient access and engagement

While it is important to identify a target population and direct your care coordination resources toward those patients, other barriers may need to be addressed to facilitate patient access and communication and increase engagement in care among the target group.

➢ Review your communication systems for opportunities to improve ease of access and convenience for patients, while maintaining privacy. Your clinic may benefit from using a variety of communication modalities, including in-person outreach, patient portals, email, social media, texting, and telephone systems.
➢ Consider integrating outreach staff or community health workers into your care coordination teams. Hard-to-reach patients may be more likely to respond to outreach staff than to clinical staff, with whom their relationships tend to be more formal.
➢ Look at your clinic flow and visit history to get a sense of what clinic visit structure may work best for your patients and your care team. Some programs maintain walk-in availability, while other clinics benefit from working primarily off registries or provider schedules.
➢ As you launch your care coordination program, make sure any staffing changes are communicated to patients so that they know who to contact. Oftentimes, patients are wary of new team members or the health care system. Building trust is essential to success and takes time, consistency and a gentle approach. Consider using an introduction ("warm hand-off") from a trusted individual to facilitate rapport.
➢ Take a proactive approach to increasing patients' engagement with their health care. A self-management program may help support your patients.

Focus: Using self-management tools at Brightpoint Health

At **Brightpoint Health**, self-management workshops were incorporated into the care coordination model to empower HIV-positive patients to take a more active role in their health care. The organization piloted two models: Stanford's *Positive Self-Management Program*, and the SAMHSA-HRSA Center for Integrated Health Solutions' *Whole Health Action Management Program*. Subsequent feedback helped Brightpoint to develop an adaptation of these pilots into a version suitable for its patient population, many of whom manage co-occurring diseases and competing priorities. Below is a summary of that model.

Brightpoint Health's Living Healthy Workshop

Why? The self-management groups helped patients stay engaged in care and improve their health outcomes by developing health literacy skills, coping strategies, decision making skills, and medication adherence.

What? The self-management groups provided structured activities used to support patient learning in a group setting as they worked through problem-solving techniques, decision making, health education, and action planning. Action plans helped patients break down challenging activities into smaller, more achievable steps, such as:

1. What the patient wanted to do and what they thought was achievable
2. Making it specific: what, when and how much they would plan to do
3. Confidence level: how sure they were that they would do something

Figure 5: Action plan tool for patient self-management from Brightpoint Health

My Action Plan
In writing your action plan, be sure it includes all the following:
1. What you are going to do (a specific action)
2. How much are you going to do (time, distance, portions, repetitions, etc.)
3. When you are going to do it (time of day, day of week)
4. How often or how many days a week you are going to do it

Example: *This week, I will walk (what) around the block (how much) before lunch (when) three times (how many).*

This week I will _____ (what)
_____ (how much)
_____ (when)
_____ (how often)

How sure are you? (0 = Not at all sure: 10 = absolutely sure)
Comments:

Action planning within the self-management group helped to improve care engagement by encouraging patients to report back to others regarding progress toward their health care goals. This report back also helped the care coordination team assess patient needs and develop comprehensive care planning.

How? The self-management groups were adapted to the meet the needs of patients served within an outpatient clinic setting and were changed to address challenges with attrition. Participation improved when the model was:
- Conducted during regular clinic hours;
- Limited to a four-week, facilitated group module, with 90-minute meetings; and,
- Supported with transportation assistance and healthy snacks for participants.

Did self-management improve? Participants completed pre- and post- surveys. Evaluation of survey results showed that participants were engaged with action planning activities and felt that they had learned new self-management tools after completing the workshop.

Summary

➢ To increase the effectiveness of care coordination, target it toward patients most in need. Screening tools such as acuity scales can be helpful in identifying target populations.
➢ Support patient access across communication modalities and clinic visit structures.
➢ Remember that you need patient buy-in in addition to care team buy-in in order for your care coordination program to be successful.
➢ Make use of self-management tools to empower patients and promote engagement.

Module 5: Conducting Interdisciplinary HIV Care Planning

What is covered in this module?
(1) What care coordination within the care team looks like

You've taken all of the preliminary steps to set up a care coordination program with your staff, your patients, and your clinic infrastructure. But what does care coordination look like on a daily basis? How does care coordination actually happen within the care team?

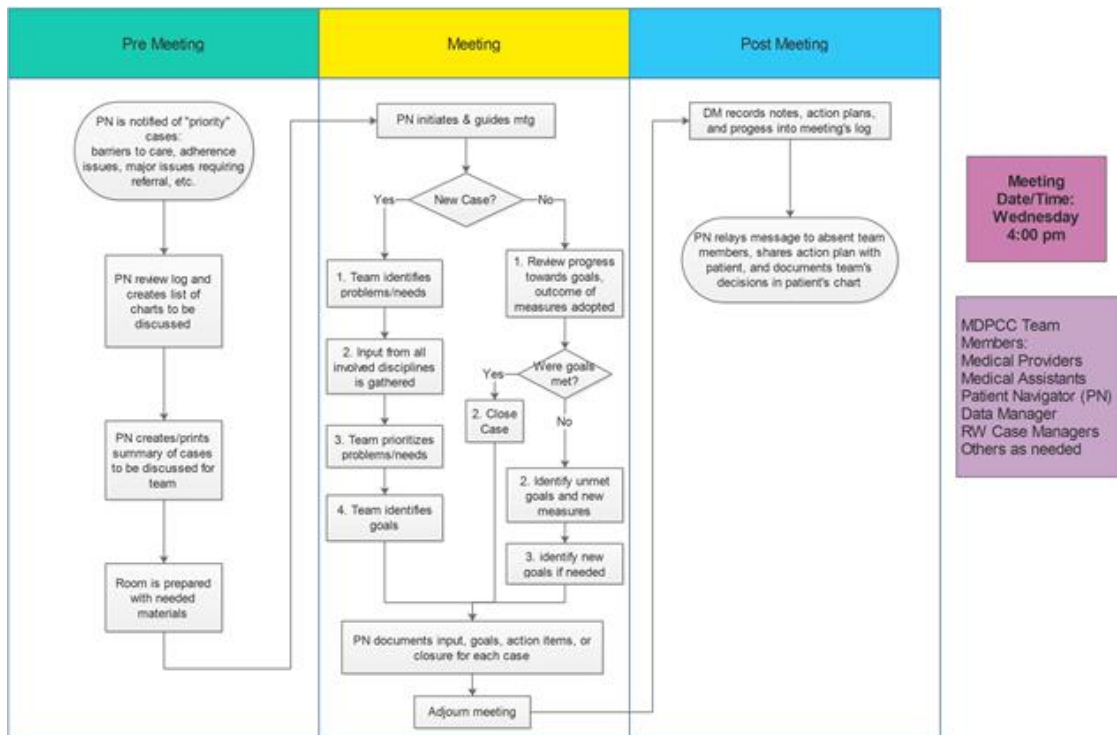### Part 1: Care coordination within the interdisciplinary care team

While you should tailor your program to fit your clinic, be mindful of a few central components that build the foundation of your care coordination program:

➢ As discussed in Module 4, you need to routinely review who is in the care coordination program, who should be in enrolled, who can transition out, and how enrollees are faring on key health indicators. Usually, this means someone on your team—typically the care coordinator—will be responsible for running reports from the electronic medical record, including information on key health and health care engagement indicators.
➢ The information gathered from this system will serve as the basis for communication within the care team, guiding the conversation toward the patients most in need of attention.
➢ Establish regular meetings of the care team to discuss patients. In many clinics, this may include both daily interdisciplinary meetings (or "huddles") aimed at addressing immediate needs, and less frequent, longer meetings to review trends in health outcomes or have more in-depth case conferences around complex patients.
➢ To promote efficient use of time, care team members should identify in advance the patients they want to discuss, key concerns, and potential ways to address them. Team members participating in these meetings often include (but are not limited to): Clinic Director, HIV Specialist, Primary Care Provider, Patient Navigator, RW Case Manager, Receptionist, Medical Assistant, Care Coordinator, Scheduler, and other staff as needed.
➢ In addition to face-to-face meetings, support robust communication within your care team by developing and training personnel on the use of communication infrastructure, such as messaging systems available in many electronic medical records.

At ***Coastal Bend Wellness Foundation,*** the patient navigator generated a list of patients with the most critical needs by conducting a daily chart review, and through the recommendations of care team members. The navigator flagged priority charts and summarized issues to be discussed during team meetings. The navigator distinguished between urgent issues that needed to be shared during a daily huddle and those to be discussed by the interdisciplinary care team during longer meetings.

The navigator also encouraged care team meeting participation. Interdisciplinary team meetings were held weekly, and huddles were held for fifteen minutes prior to the first appointment of each day. Huddles allowed the team to review care plans and share feedback. All patients scheduled to be seen each day were discussed briefly, including any medical or service needs to be addressed during the visit. In weekly interdisciplinary care team meetings, the navigator presented priority cases to the team for discussion. The team created and documented action items in the patient's chart, including responsible personnel and desired outcomes. These cases remained marked as urgent until all action items were addressed (see **Figure 6**).

Figure 6. Coastal Bend Wellness Foundation interdisciplinary team meeting workflow.

Summary

- In practice, care coordination within the interdisciplinary care team is supported by routine review of clinical data to identify patient needs that should be discussed by the care team.
- Care coordination personnel often take the lead on pulling and reviewing clinical data, identifying priority patients, and encouraging participation in care team meetings.
- To keep members of the care team on the same page, utilize both brief, daily meetings focused on immediate priorities for the day, and less frequent, longer meetings focused on ongoing issues and health outcomes data.

Module 6: Using Health Information Systems in HIV Care Coordination

What is covered in this module?
(1) Leveraging health information systems to support HIV care coordination activities

While it is possible to coordinate care in clinics without electronic medical records, it is significantly easier and more efficient to create a data-driven care coordination program with the support of a well-functioning electronic medical record (EMR). EMRs can be used to generate reports on key health indicators for both individual patients and larger patient populations that may help you identify specific needs or gaps in care, and to assess progress toward desired health outcomes.

Part 1: Using your EMR to support HIV care coordination

As indicated in Modules 1-5, the EMR plays a critical role in each stage of the implementation of HIV care coordination.

- Your EMR may be used as an important source of data for your needs assessment, showing how the clinic is performing on key health indicators.
- As you develop infrastructure to support care coordination, the EMR may be useful in formalizing processes, tracking activities, and supporting communication. It may be helpful to form working relationships with your IT staff or outside vendors who can support your EMR use and help you customize it to both enter and extract the data you need.
- When selecting your target population, the EMR can help by providing—often with the use of additional, population management software—data on population-level health outcomes that may help you identify which sub-populations may need particular attention.
- As discussed in Module 5, care coordination involves some form of routine review of patient records in order to monitor and track the care coordination population and flag pressing issues for discussion. Work with your care team to establish which metrics will be regularly extracted and reviewed, and to determine how this data will inform workflows.
- As will be discussed in Module 7, the EMR is also an important source of data for quality improvement efforts.

At **New York Presbyterian,** the clinical care team (CCT) dashboard was developed, in collaboration with RDE Systems, to help the nurse care coordinator identify patients with complex care coordination needs by aggregating patient-level data from the hospital's database and organizing it into easy-to-use clinical and care engagement indicators.

Example: Reaching out to HIV Patients in the Emergency Department

Emergency department (ED) visits are an opportunity to re-engage out-of-care PLWH in HIV primary care. Yet, this opportunity can be missed if the ED does not promptly contact the patient's HIV provider. Even when this contact is made, it can be challenging to respond promptly if the alert goes to busy providers. Within the CCT dashboard, an "Inpatient/ED Contact" indicator was developed to identify ED patients who are out of HIV care or have high viral load and low CD4 cell count.

Two nurse care coordinators piloted the "Inpatient/ED Contact" dashboard indicator, using it twice daily to identify, reach out to, and re-engage clinic patients currently being seen in the ED, using nursing care management interventions. They also linked these patients to supportive services and provided them with information on same-day HIV outpatient services. 328 clinic patients received outreach during the pilot period, either in person during the ED visit or through telephone calls made on the same day, and in some cases, with a longer period of additional follow up. The "Inpatient/ED Contact" dashboard indicator was a valuable tool to prompt focused care coordination outreach to this population.

Figure 7: The Clinical Care Team Dashboard at New York Presbyterian.
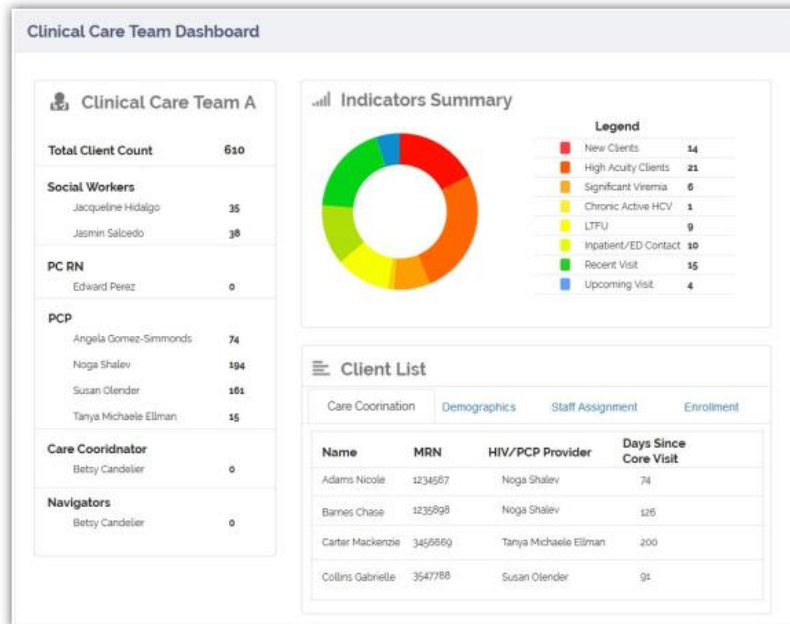
Summary

➢ Your health information system can be a critical tool for conducting needs assessments, formalizing clinic procedures, supporting care team communication, assessing individual and population-level health outcomes, and tracking and monitoring care engagement in the care coordination population.

Module 7: Supporting Continuous Quality Improvement in HIV Care Coordination

What is covered in this module?
(1) Evaluation and quality improvement in HIV care coordination

You've put a lot of effort into designing and implementing your HIV care coordination program. What are you doing to make sure that it is working?

➢ As you create infrastructure to support your care coordination program, look ahead to evaluation. You will need a system to regularly evaluate your care coordination activities.
➢ A key component of your evaluation should include a method for gathering and incorporating personnel and patient feedback. This feedback will help your care team understand the impacts of their efforts on patient care and how to improve care coordination. This can be done a number of ways, including surveys, patient or care team meetings, supervision, and targeted interviews and focus groups.
➢ Consider developing and implementing quality improvement processes supported by population-level data. Regular review of outcomes along key indicators (e.g., viral load, CD4, missed appointments, preventative care measures) can help you identify where in the care continuum to focus care coordination efforts, flag patients who are not meeting care and outcome standards, and identify steps to support more complex care needs.

Focus: Evaluation and population management at La Clínica del Pueblo (LCDP)

La Clínica del Pueblo (LCDP) uses Population Manager, a population-health data technology software. The software allows staff to identify subsets of their patients that are not meeting defined indicator targets and then drill down to patient-level data to strategize appropriate levels and approaches for care. On the last Friday of every other month, LCDP closes clinical operations and all care team members gather for two hours to discuss data on key HIV indicators, individual patient health, and ways to improve care. The Nurse Care Coordinator is responsible for selecting the indicators to be discussed and for facilitating the discussions within the care teams. The data help to identify those patients that are not meeting

indicator goals. Care team members then discuss the factors that contribute to specific patients' outcomes and strategies they can take individually and as a team to improve their patients' health and well-being. For example, for one session, the Nurse Care Coordinator selected and brought to the teams for discussion the indicators on HIV medical visit frequency and gap in medical visits. The teams reviewed the data and identified patients that had fallen out of care. They then discussed possible reasons for the patients missing appointments based on perspectives from their various roles within the care teams. Finally, the teams assigned tasks and came up with action plans to engage the patients back into care.

At LCDP, evaluation staff collect both quantitative and qualitative data at regular intervals, and report back to the care team during regularly-scheduled, bi-monthly care team meetings to help the team identify and discuss the areas in which there has been progress and areas in which the team will need to improve. Evaluation staff conduct patient surveys and patient interviews to capture patient perspectives on the quality of care and treatment. Evaluation staff also gain insight into changes within the practice resulting from WDI through the use of an exercise known as Most Significant Change (MSC). In the MSC exercise, each care team member is offered the opportunity to express what they believe are the most significant changes to have occurred within the practice in a specific time period. Through group discussion and analysis, care teams then collectively decide which changes are the most significant for the practice and discuss why they prioritized those changes (see **Figure 8**). Information generated from this activity helps LCDP understand successes and challenges and contextualizes progress toward outcome indicators.

Figure 8: LCDP care team members select and analyze most significant changes.
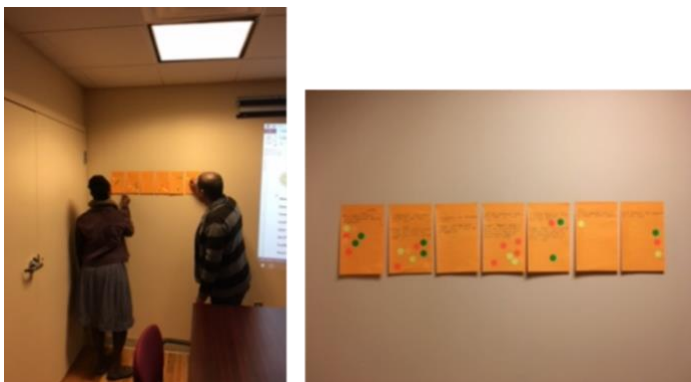
Summary

➢ Routine evaluation and quality improvement efforts are as critical to your care coordination program as the care coordination tasks themselves. Engage with evaluation and quality

improvement using a variety of measures at every stage of development, implementation, and program integration of HIV care coordination.

➢ Evaluation and quality improvement can support personnel and patient buy-in by providing mechanisms for hearing and responding to feedback and can support proper resource use by directing the attention of the care team to the individuals and populations with the greatest needs.

Conclusion

We hope this tool has given you some insight into our experiences with HIV care coordination, and how it may be helpful to you. As you move forward, remember that these changes are iterative, and will take time, patience, and an open mind.

We wish you all the best.