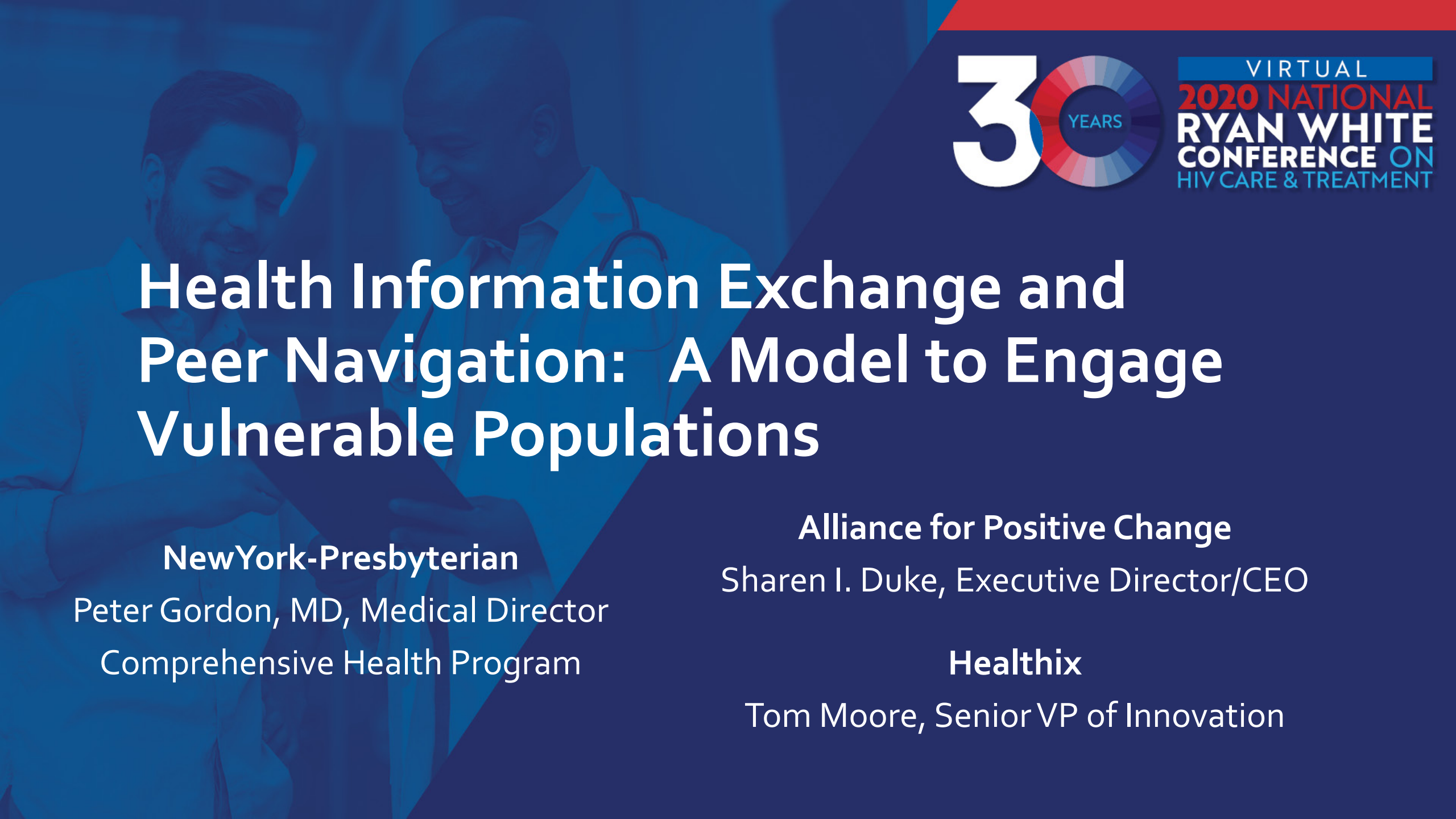


VIRTUAL
2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Health Information Exchange and Peer Navigation: A Model to Engage Vulnerable Populations

NewYork-Presbyterian

Peter Gordon, MD, Medical Director

Comprehensive Health Program

Alliance for Positive Change

Sharen I. Duke, Executive Director/CEO

Healthix

Tom Moore, Senior VP of Innovation

Pilot Collaborative Partners

NewYork-Presbyterian

NYC Human Resources Administration

Healthix

The Alliance for Positive Change

CUNY SPH GRADUATE SCHOOL OF PUBLIC HEALTH & HEALTH POLICY

Pilot Project GOALS

Use a multi-stakeholder approach—combining social service engagement and linkage to care with real-time clinical encounter data—to empower outreach and engagement efforts that address the care engagement needs of vulnerable populations.

Pilot Approach

- Leverage **Alliance's** capabilities to provide Peer Navigator services to find and re/engage hard to reach HIV-positive individuals who have fallen out of care or are marginally engaged.
- Utilize **NYP's clinical information systems and analytics** to identify PLWH who are lost-to follow-up (LTFU) or disengaged from care for targeted outreach and re/engagement.
- Access a health information exchange (Healthix – a leading HIE) for **updated demographic and contact information** — including HASA client info — by NYP and Alliance to enhance case finding, including the generation of real-time LTFU alerts when LTFU patients access services across multiple providers, institutions, and/or geographic regions.

NewYork-Presbyterian

- 2 major academic medical centers (Columbia and Cornell)
- 5 hospital sites in NYC
- 13 community ambulatory care sites, 7 school based clinics
- 665,517 unique patients seen in 2016
- 2,162,052 ambulatory care visits in 2017
- 105,000 inpatient visits
- 24,586 staff
- 7,145 clinicians
- Operating budget: 5.6 billion
- **64,108 HIV tests (last 12 months)**
- **64,741 HCV tests (last 12 months)**

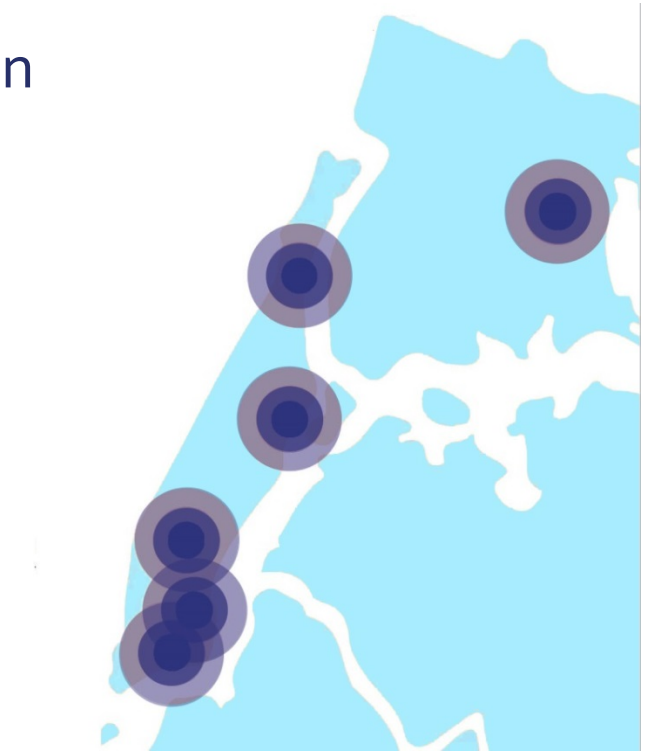
Healthix

Mobilizing secure health information to:

- Improve clinical outcomes
- Enhance care coordination
- Lower costs and facilitate efficiency
- Determine risk and provide actionable data
- Increase patient satisfaction
- Support research through de-identified data
- Protect the public health

The Alliance for Positive Change

- Alliance helps New Yorkers affected by HIV and other chron illnesses make lasting positive changes towards health, housing, recovery, and self-sufficiency.
- Each year, we help New Yorkers:
  - Get tested for HIV and HCV
  - Overcome addiction
  - Train individuals to become Certified Peers
  - Access medical care to get their health back on track
  - Escape homelessness
  - Rejoin the world of work
  - Replace isolation with community
  - And lead healthier and more self-sufficient lives.



Alliance's **individualized, full-service approach** gives each person the unique mix of support he or she needs to **feel better, live better, and do better**.

Role of NYP's Center of Excellence

NYP produces a monthly *Lost to Follow-Up* (LTFU) list and transmits to Alliance and Healthix

LTFU list developed by identifying NYP COE patients who:

- Have not had a visit in 9 -18 months
- Were not virally suppressed on last visit
- Have no recent medications refills (>6 months)
- No evidence for care transfer, out migration, incarceration, or death

Role of HASA and Healthix

HASA

- Review Healthix consent with all clients
- Work to obtain consent or refusal from 100% roster
- Maintain up-to-date demographic information
- In the future provide real time registration event alerts

Healthix

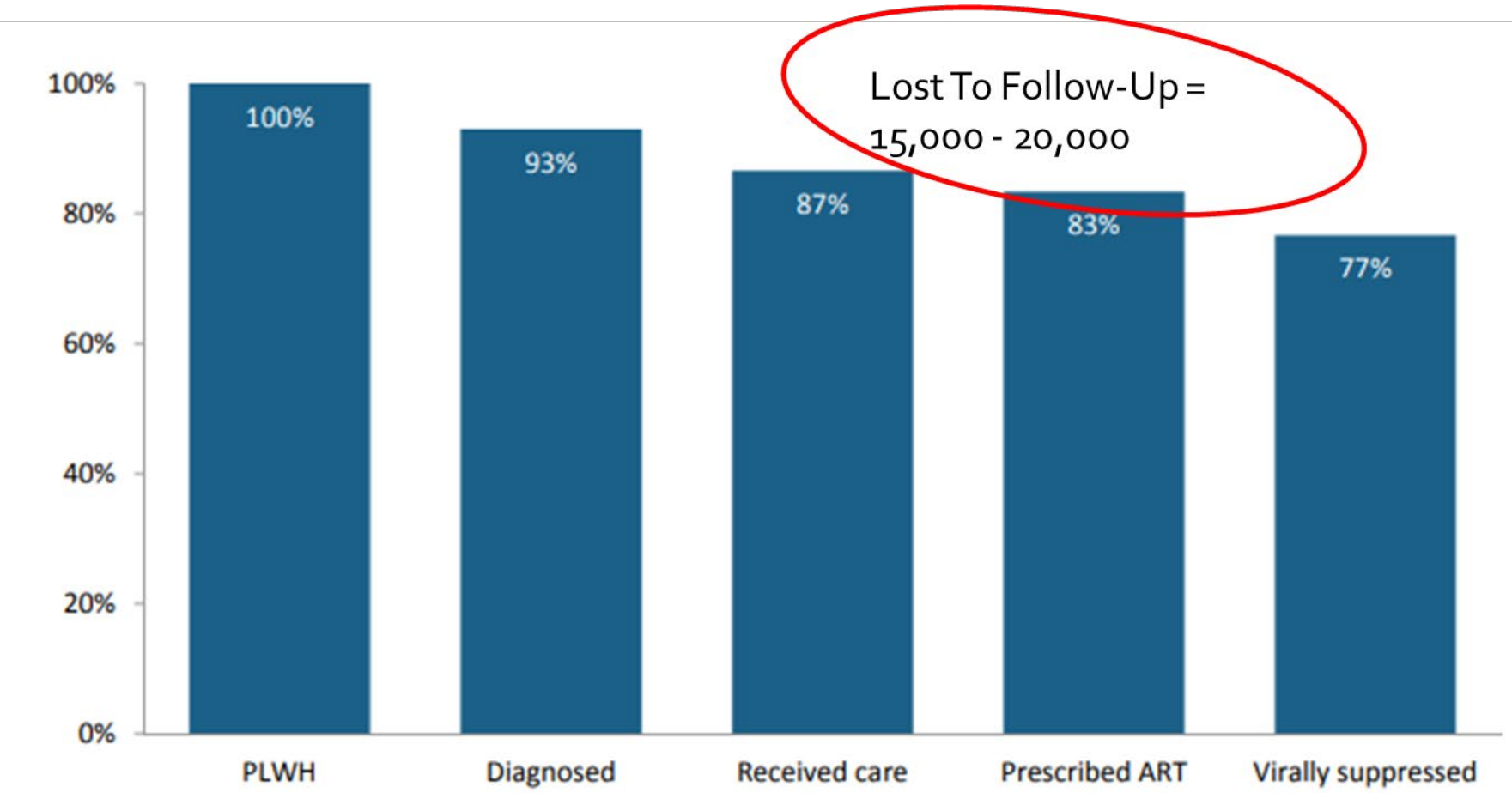
- Real time alerts related to ER visits and hospitalizations
- Provide current demographic information
- Allow access to medical information once consent is obtained

Role of Alliance

Alliance for Positive Change

- Utilize Peer Navigators to find and re-engage NYP patients on the "Lost-to-Follow-Up" list with a goal of consent, enroll and link patients to:
  - Medical care within 2 months of program enrollment
  - Health Home Care Management
  - Treatment Adherence Services
- Utilize technology (i.e., Healthix demographic information and alerts) to supplement traditional "feet on the ground" outreach methods
- Document patient re-engagement with medical provider within 2 months of enrollment; enroll in Health Home care management

2018 NYC HIV Care Cascade



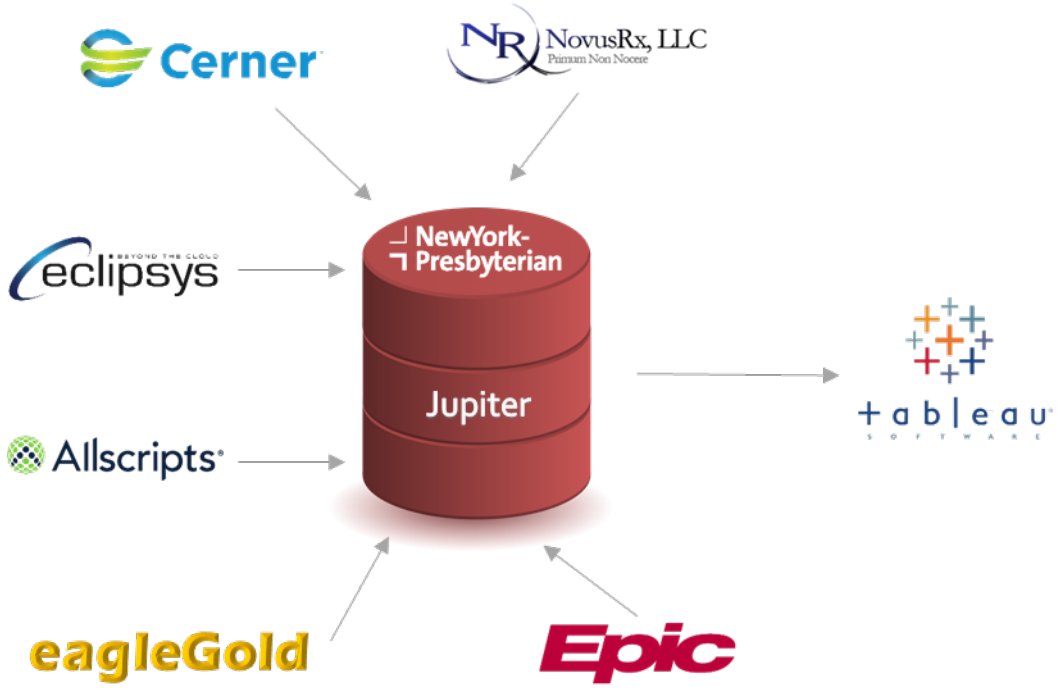
PLWH=People living with HIV; ART=antiretroviral therapy.
For definitions of the stages of the continuum of care, see Technical Notes on Page 16.

Data 2 Care: Some Institutional Barriers and Solutions

- Challenges
  - Large complex institution with a multitude of competing priorities
  - Just beginning its journey towards becoming an 'integrated care delivery system'
  - Complex staff governance
    - NYP, Columbia, Cornell
  - Three different EMRs
    - Eclipsys, EPIC, Allscripts

Utilizing Flexible IT Software for Data Aggregation and Visualization

- Most healthcare systems utilize multiple electronic information systems
  - NYP: Sorian, EAGLE, Epic, AllScripts, Eclipsys
- Underlying IT networks (often) use standard languages and coding
  - HL7, ADT, NDC, CCD
- Data warehouses/Data Marts offer advantages to EMR data extracts
- 'Off the shelf' tools, like Tableau, are ideally suited for developing dashboards that are agnostic to EMRs



NewYork-Presbyterian
The University Hospital of Columbia and Cornell

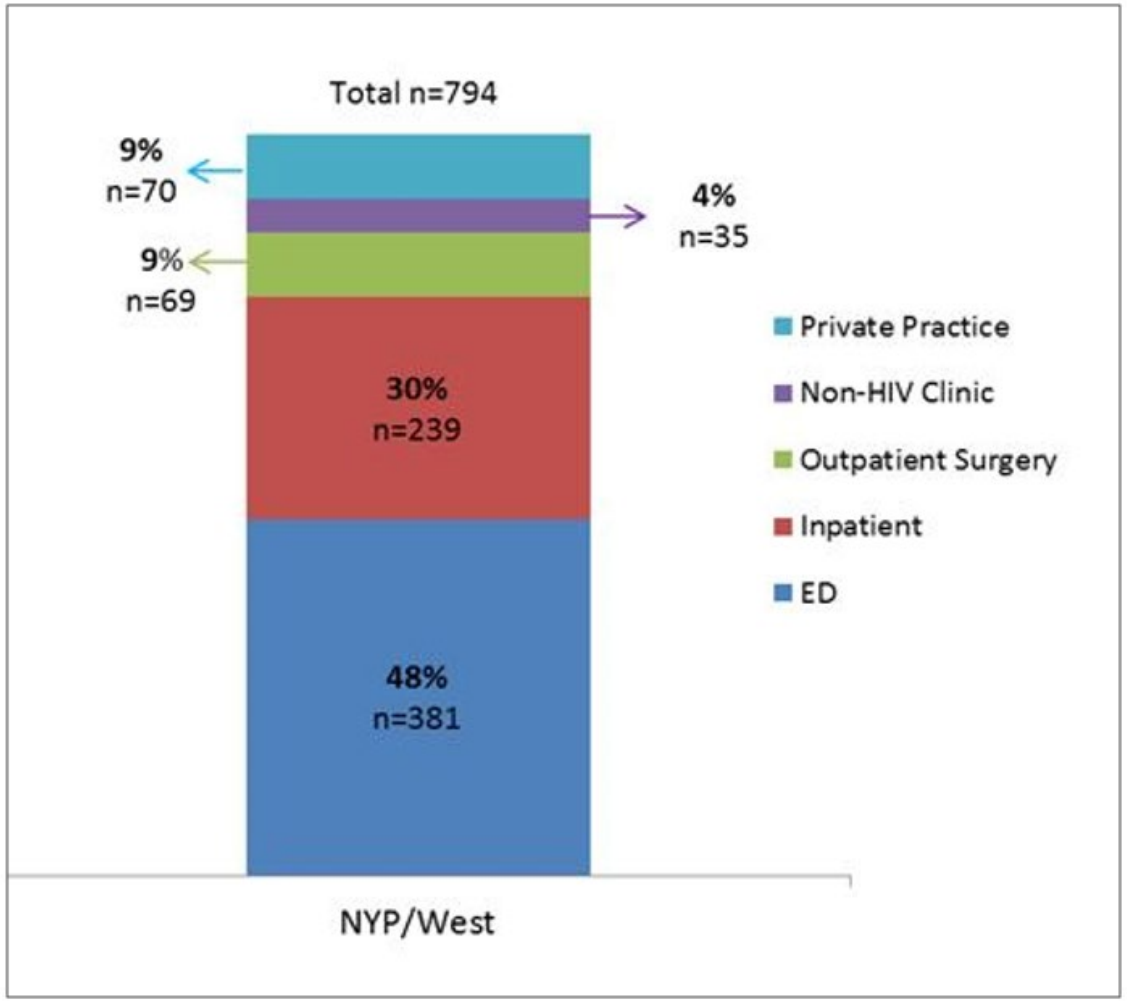
How do you drive organizational change around HCV / HIV Testing and LTC?

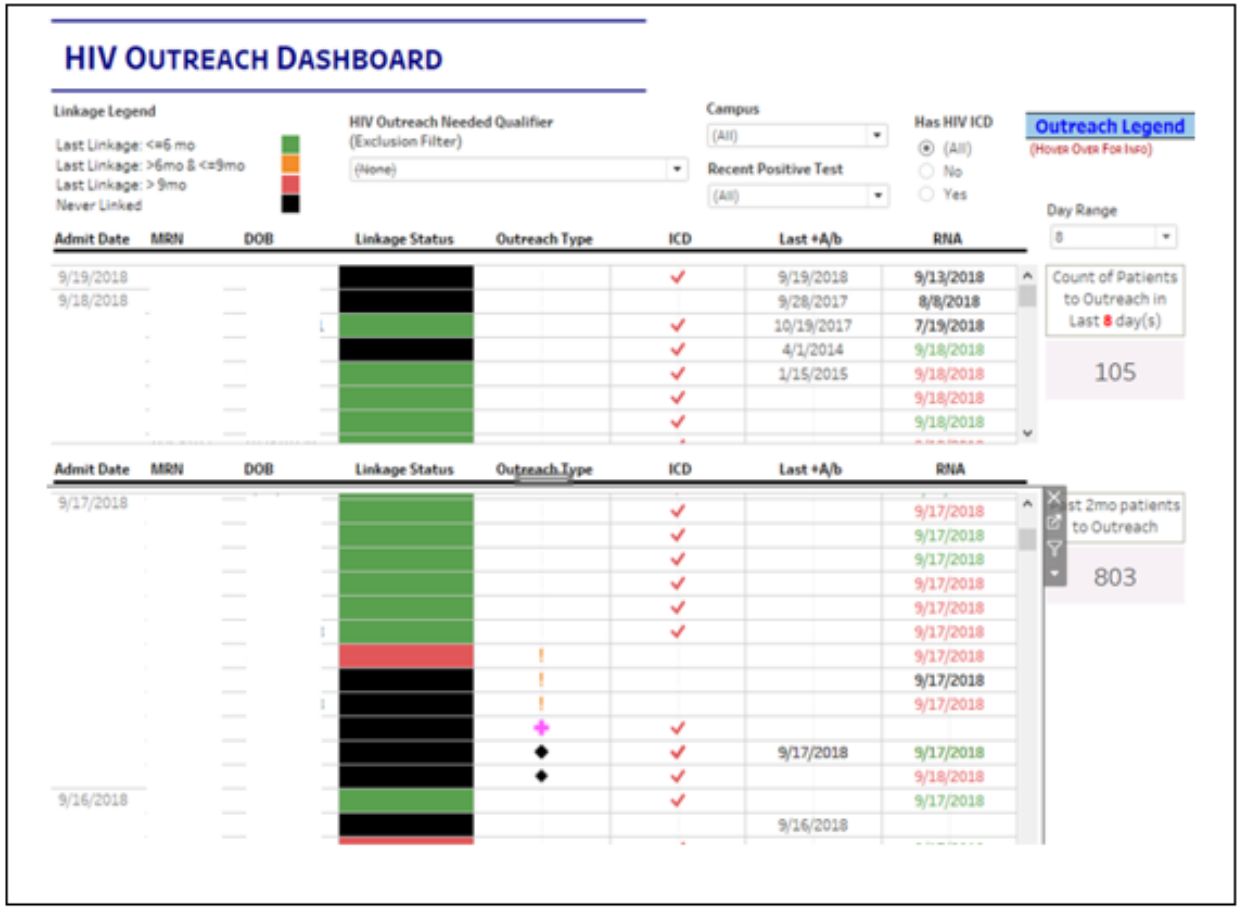
- Meet with stakeholders, subject matter experts, and leadership to explore barriers, potential facilitating factors, and possible solutions
  - Sexual Health Survey
  - ED Champion (Focus Y2 addition)
  - NYS HIV and HCV ETE Initiatives
- Fully leverage IT tools
  - EMR 'smart' order sets
  - Dashboard development (benchmarking and measurement tools, workflow management, corralling complexity)
  - Individual Provider Reports
  - Harness Health Information Exchange (HIE) advancements

Using Tableau Dashboards to Facilitate Institutional and Multi-Institutional HIV Linkage to Care

- New Diagnoses
- Identifying individuals LTFU across care sites

Multi-Institutional HIV Outreach Dashboard





NewYork-Presbyterian
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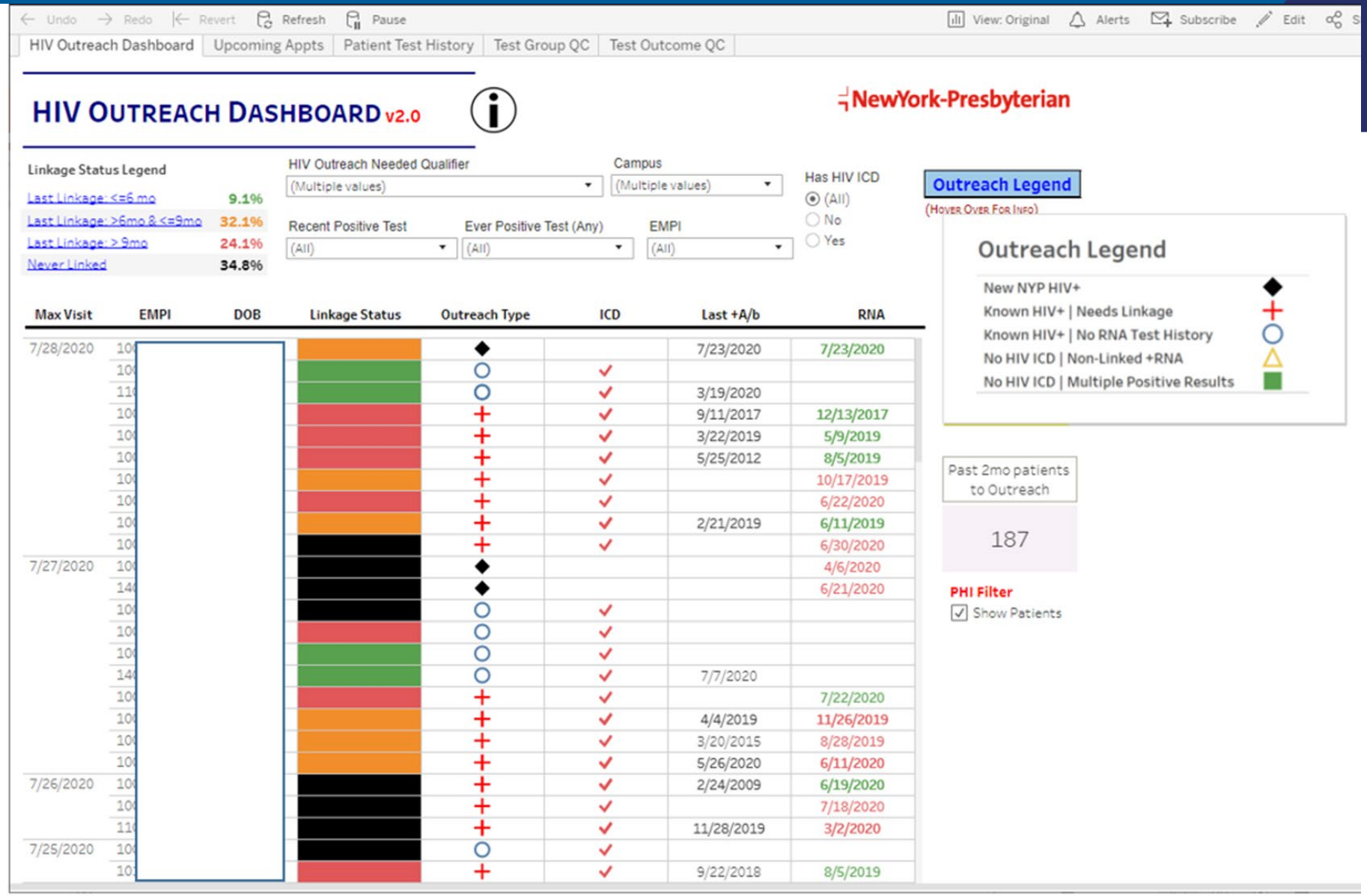
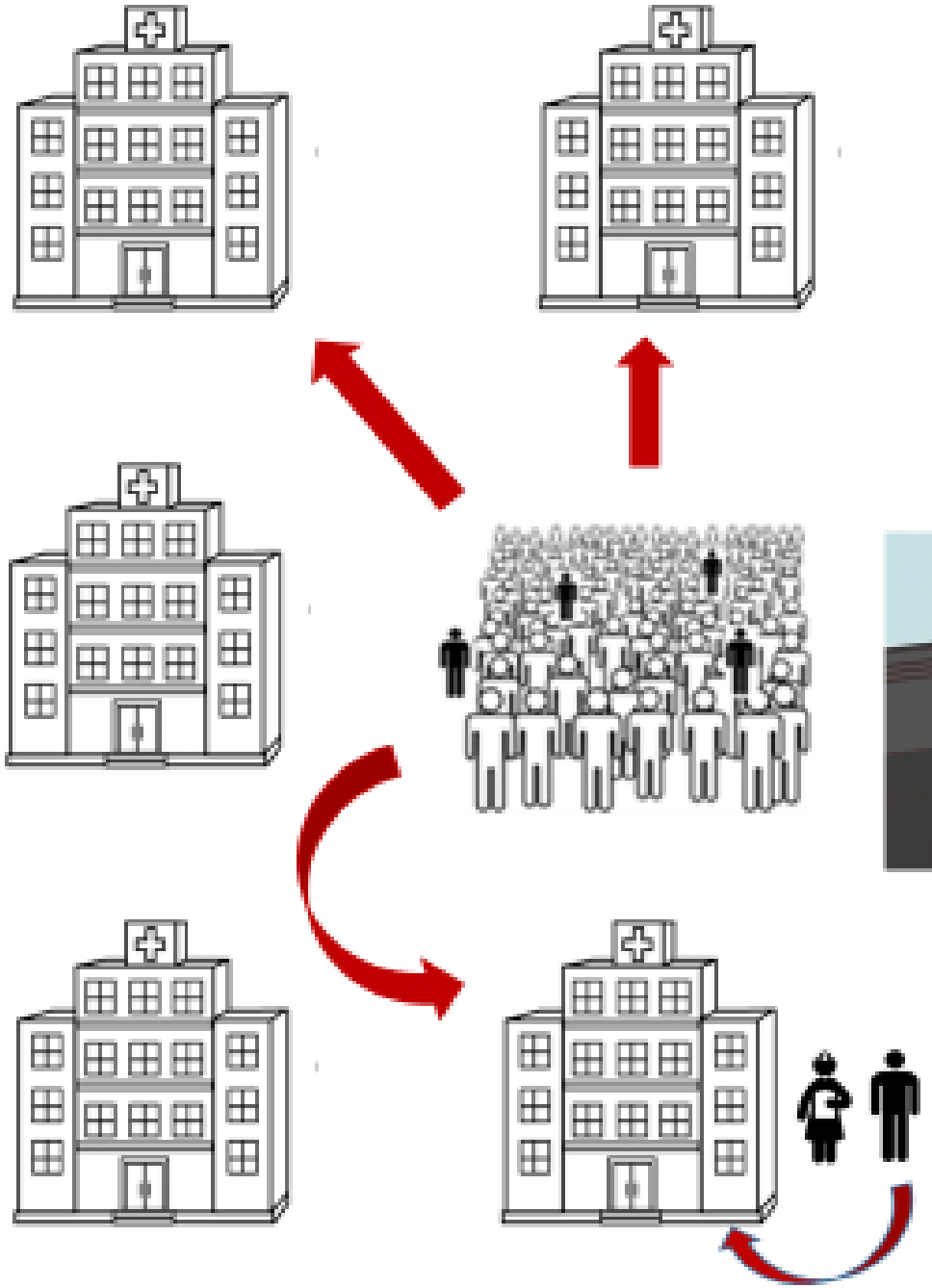
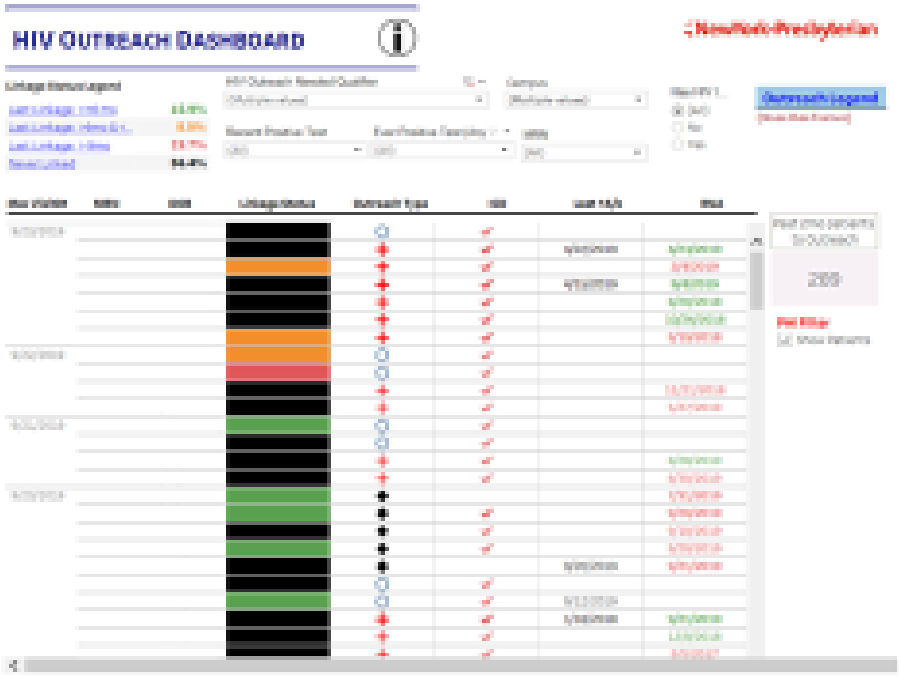

Undo
Redo
Revert
Refresh
Pause
View: Original
Alerts
Subscribe
Edit
HIV Outreach Dashboard
Upcoming Appts
Patient Test History
Test Group QC
Test Outcome QC
HIV OUTREACH DASHBOARD v2.0
NewYork-Presbyterian
Linkage Status Legend
Last Linkage: <=6 mo 9.1%
Last Linkage: >6mo & <=9mo 32.1%
Last Linkage: > 9mo 24.1%
Never Linked 34.8%
HIV Outreach Needed Qualifier
(Multiple values)
Campus
(Multiple values)
Has HIV ICD
(All)
No
Yes
Recent Positive Test
(All)
Ever Positive Test (Any)
(All)
EMPI
(All)
Outreach Legend
(Hover Over For Info)
Outreach Legend
New NYP HIV+
Known HIV+ | Needs Linkage
Known HIV+ | No RNA Test History
No HIV ICD | Non-Linked +RNA
No HIV ICD | Multiple Positive Results
Past 2mo patients to Outreach
187
PHI Filter
Show Patients
Max Visit
EMPI
DOB
Linkage Status
Outreach Type
ICD
Last +A/b
RNA
7/28/2020 7/23/2020 7/23/2020
3/19/2020
9/11/2017 12/13/2017
3/22/2019 5/9/2019
5/25/2012 8/5/2019
10/17/2019
6/22/2020
2/21/2019 6/11/2019
6/30/2020
7/27/2020 4/6/2020
6/21/2020
7/7/2020
7/22/2020
4/4/2019 11/26/2019
3/20/2015 8/28/2019
5/26/2020 6/11/2020
7/26/2020 2/24/2009 6/19/2020
7/18/2020
11/28/2019 3/2/2020
7/25/2020
9/22/2018 8/5/2019

Multi-Institutional Outreach Dashboards

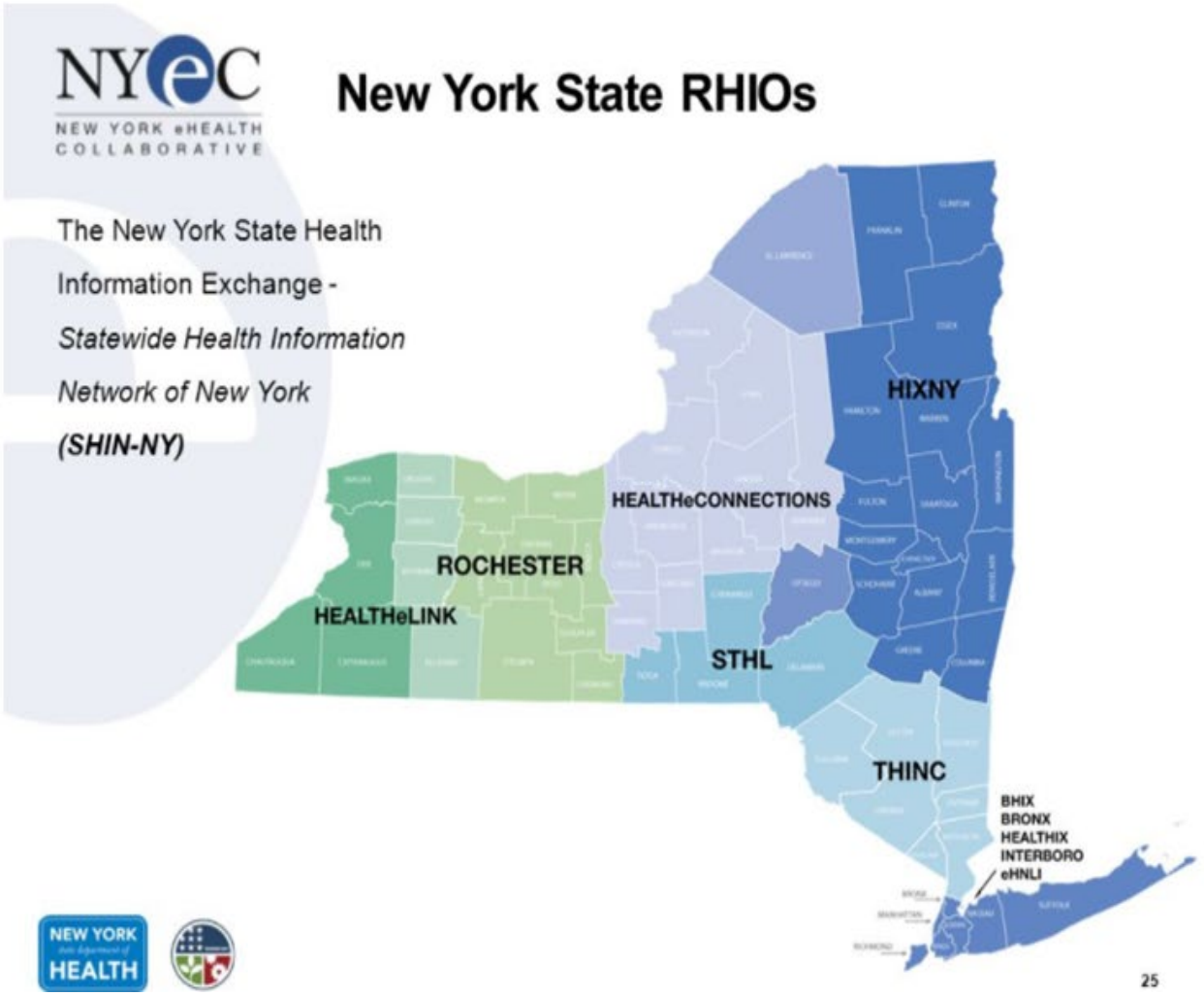


Dashboard Pilot



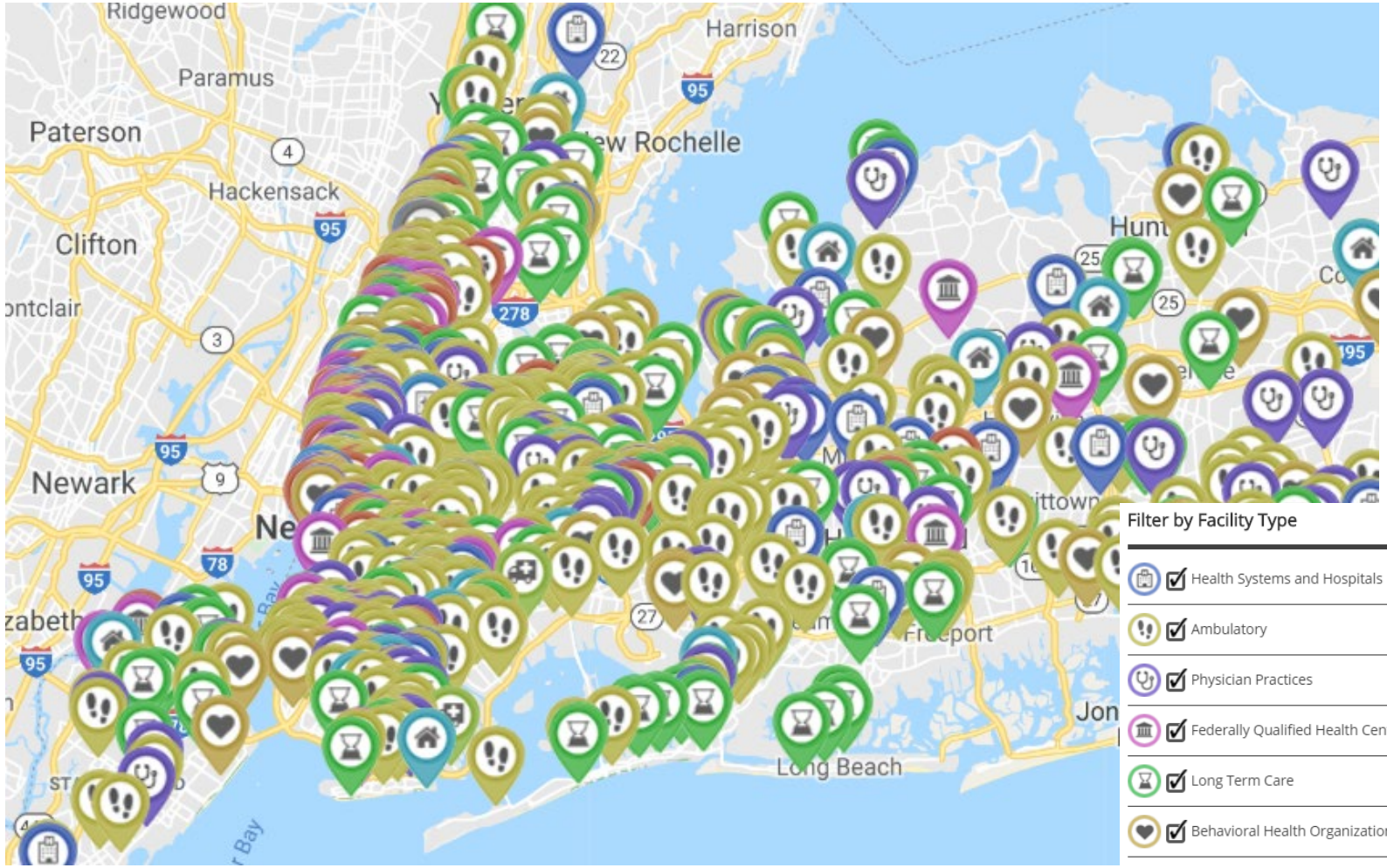
NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Using HIE's for Linkage to Care



- Identify unique patients that may move over a broad geographic area
- Between multiple institutions
- Amongst multiple providers

Healthix



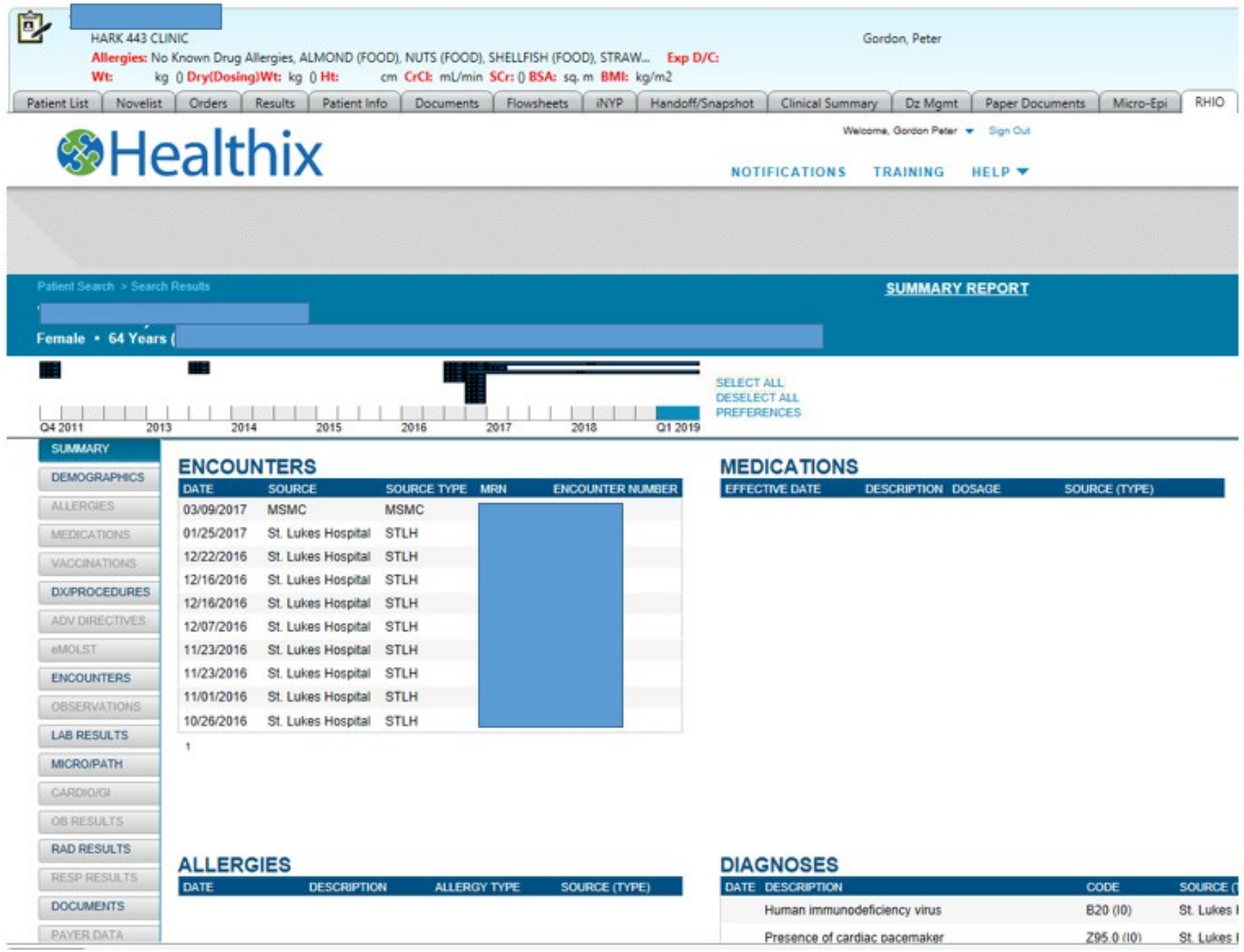
Healthix

Healthix
40 Worth Street, 5th Floor
New York NY 10013
1-877-695-4749
Contact Us

Filter by Facility Type — Select All

- Health Systems and Hospitals
- Community Based Organizations
- Emergency Management Services
- Ambulatory
- NYS Medicaid Health Homes
- DSRIP PPS
- Physician Practices
- NYC and NYS Public Health Organizations
- Pharmacy
- Federally Qualified Health Centers
- Health Plans
- SHIN-NY HIEs
- Long Term Care
- Home Care
- Behavioral Health Organizations
- Laboratory/Radiology

Healthix Clinical Portal Integrated into an Institutional EMR



Two Examples of How Healthix / HIEs Can Drive LTC Efforts

- Institutional
  - Healthix Clinical Portal as a source of unique information
    - Working telephone numbers
    - Updated addresses
    - Clinical information (labs, providers, current and past hospitalizations)
- Regional
  - Healthix *Clinical Alert Notifications*
    - Real-time alerts generated when an individual 'touches' anywhere in the Healthix network of participating institutions
    - NYPH-Alliance-HASA-Healthix Demonstration Pilot

Healthix Clinical Portal as a Source of Unique Information

- Healthix consent
- HIV or HCV test

Sometime later….

Initial HIV or HCV test positive, confirmatory test positive

NYP

1. HIV/HCV navigator attempts to contact patient but inaccurate contact information
2. Navigator logs onto Healthix:
   - Checks contact information
   - Checks care engagement site or current hospitalization/SNF

Outreach and linkage to care

Healthix *Clinical Alert Notifications*

How it works…

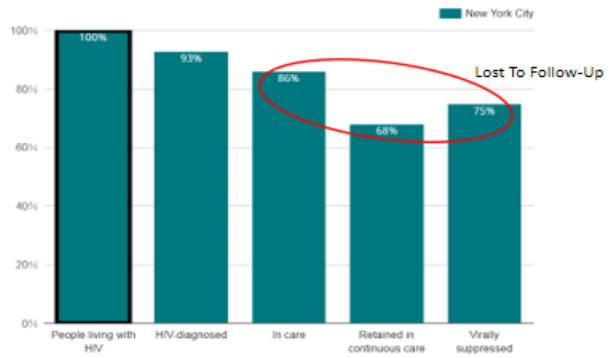
LTFU Subscription File

Primary Event Notification

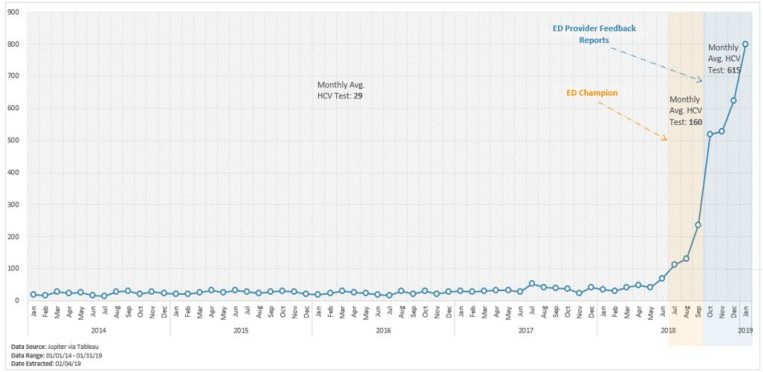
- Registration event
  - ED visit
  - HASA
- Lab value

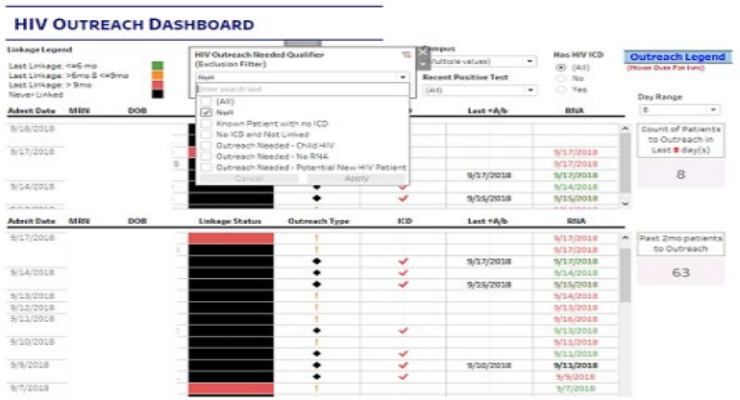
EMR (SHM), Care Coordination Dashboard, Outreach Team

2017 NYC HIV Care Cascade



NYP/Columbia ED HCV Testing 2014 -2019





Healthix *Clinical Alert Notifications*

How it works…

LTFU Subscription File

Primary Event Notification
- Registration event
  - ED visit
  - HASA
- Lab value

EMR (SHM), Care Coordination Dashboard, Outreach Team

NYPH-Alliance-HASA-Healthix Bottom-Up Pilot Project

- Collaboration involving:
  - Alliance for Positive Change
  - NYP/Columbia
  - Housing Works
  - CUNY Center for Implementation Science
  - Healthix
  - HASA
- Supported by NYC City Council and DOHMH/PHS

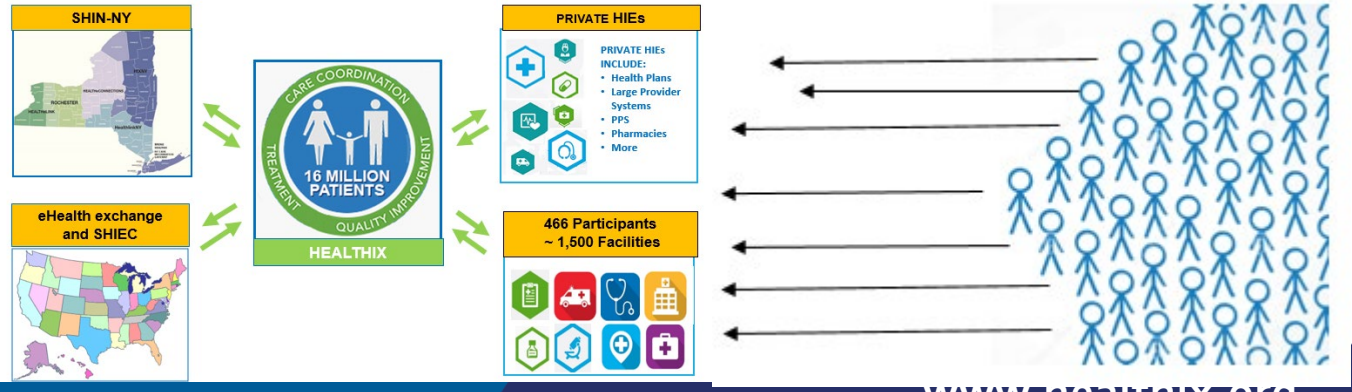
- Build interface between HASA and Healthix → Registration and demographic data flows into RHIO
- Obtain client/patient consent while at HASA
- Generate real-time LTFU and clinical alerts
- Field a Rapid Response Care Coordination team to respond to alerts
- Engage LTFU patients in real-time, attempt to re-engage in care, enroll in Health Home program
- Carefully evaluate

NYP

Primary Event Notification

The Alliance for Positive Change

Open Population

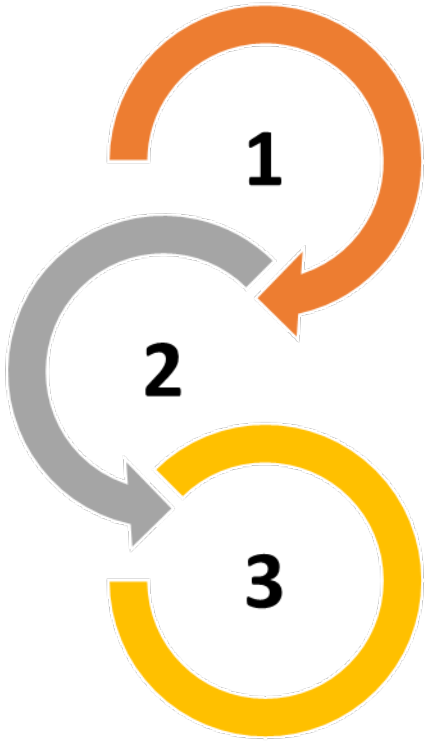


Data Points Provided by NYPH

NYPH generates a monthly list of people living with HIV (PLWH) who have received been lost-to-follow-up (LTFU), defined as having no visits in the prior 9+ months.

Contact Information	Demographics	Patient ID #'s	Medical Contact	Viral Load Information
Name	Date of Birth	Medical Record Number	HIV/Primary Care Provider	Last Viral Load Date
Address		Insurance Identification Number	Last Visit Date	Last Viral Load Result
Cell/Home Phone Number				

Alliance Data Utilization Strategy



Alliance **utilizes numerous data sources** to locate hard to reach clients:

1. **Medicaid Portals—Healthix & MAPP**
   - Updated address and phone number
   - Insurance Eligibility
   - Last billing date and/or site
2. **Google Maps**
   - Cluster addresses by zip codes to maximize outreach efficiency
3. **Criminal Justice Databases**

Role of Alliance Peer Navigators

- Shared Lived Experience
  - Culturally
  - Linguistically
  - Socially
  - Economically
- Reduce Barriers to Care
- Foster Trust
- Promote Long-term Engagement
- Guide Patients Toward Health and Stability

Photo: David Nager/Alliance

Role of Alliance Peer Navigators

Linkage to Care:

- Peer coaching and motivational interviewing
- Reminder calls and accompaniment to clinic and specialty appointments
- Conduct home visits and community field work
- Complete environmental assessment
- Address social determinants of health
- Enroll in HH care management and provide "warm hand-off"

Photo: David Nager/Alliance

Role of Alliance Peer Navigators

Outreach:

- Utilize the demographic and contact information contained in the file to attempt to contact the client telephonically and via field-based outreach
- Utilize Healthix portal to obtain new demographic information
- Respond to Healthix alerts
- Educate patients on different Alliance programs and supportive services

Engagement:

- Consent patients to Alliance, NYP, Health Homes and Healthix
- Initiate the linkage to medical care process by identifying preferred medical site and scheduling an appointment.
- Accompany patient to first medical appointment, as needed

Alignment:

- Documentation of minimum one medical appointment within two months of program enrollment

Photo: David Nager/Alliance

Successful Engagement Techniques

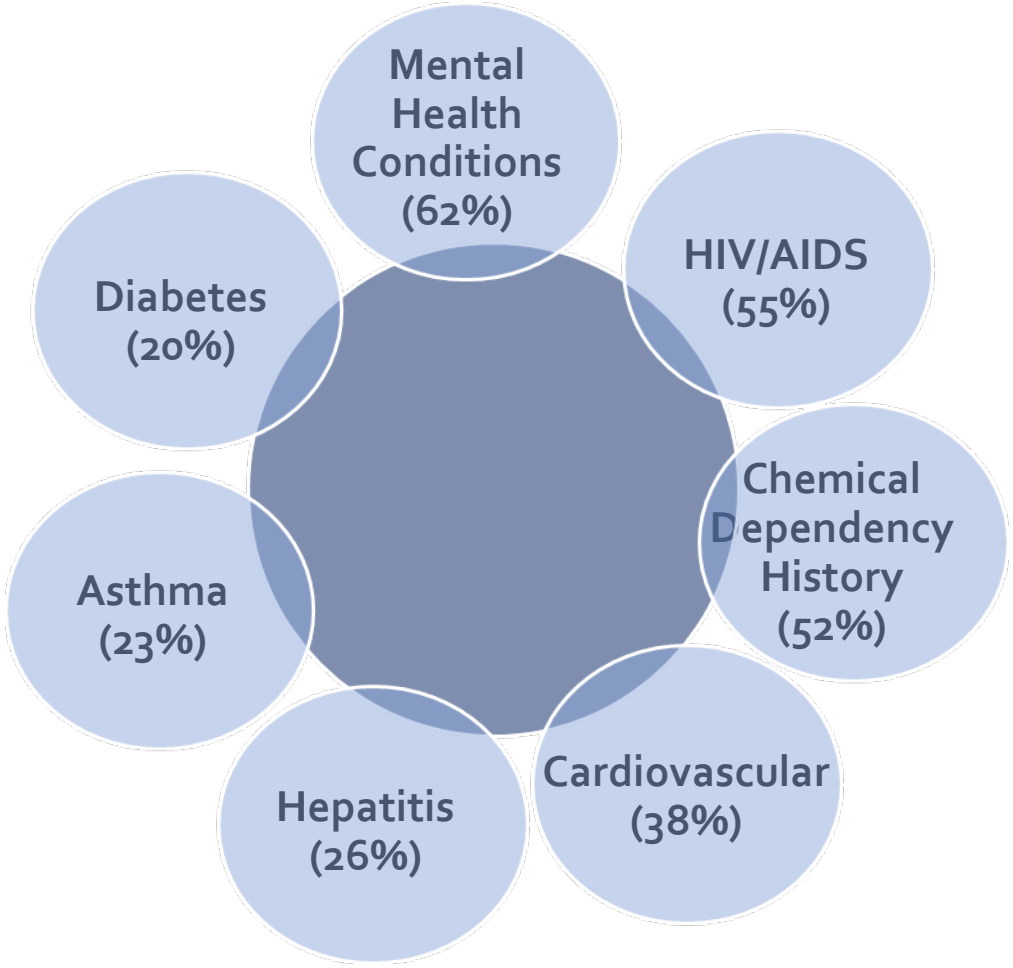
- **Mapping**: Utilize Google Maps to organize outreach activities by neighborhood-- helps to increase the number of home visits in one day. This strategy enables Peers to make up to 15 home visit attempts in one day.
- **Matching**: Try to match the Peer to the demographic characteristics/life experience of the client (e.g., pair women with female Peer Navigator)
- **Motivational Interviewing**: Meet the client where they are, to create trust and engagement in medical and social support services, with Peer as health coach
- **Personal Experiences**: Shared lived experiences of Peer Navigators help the client to open-up
- **Whole Person**: Focus is broader than HIV diagnosis. Clients feel more comfortable when you speak about their life in general, and offer help to overcome barriers
- **Confidentiality**: Speak in code when you are around family members/roommates, or public spaces
- **Incentives**: Help to open the conversation and build trust

NYPH/Alliance Patient Demographics

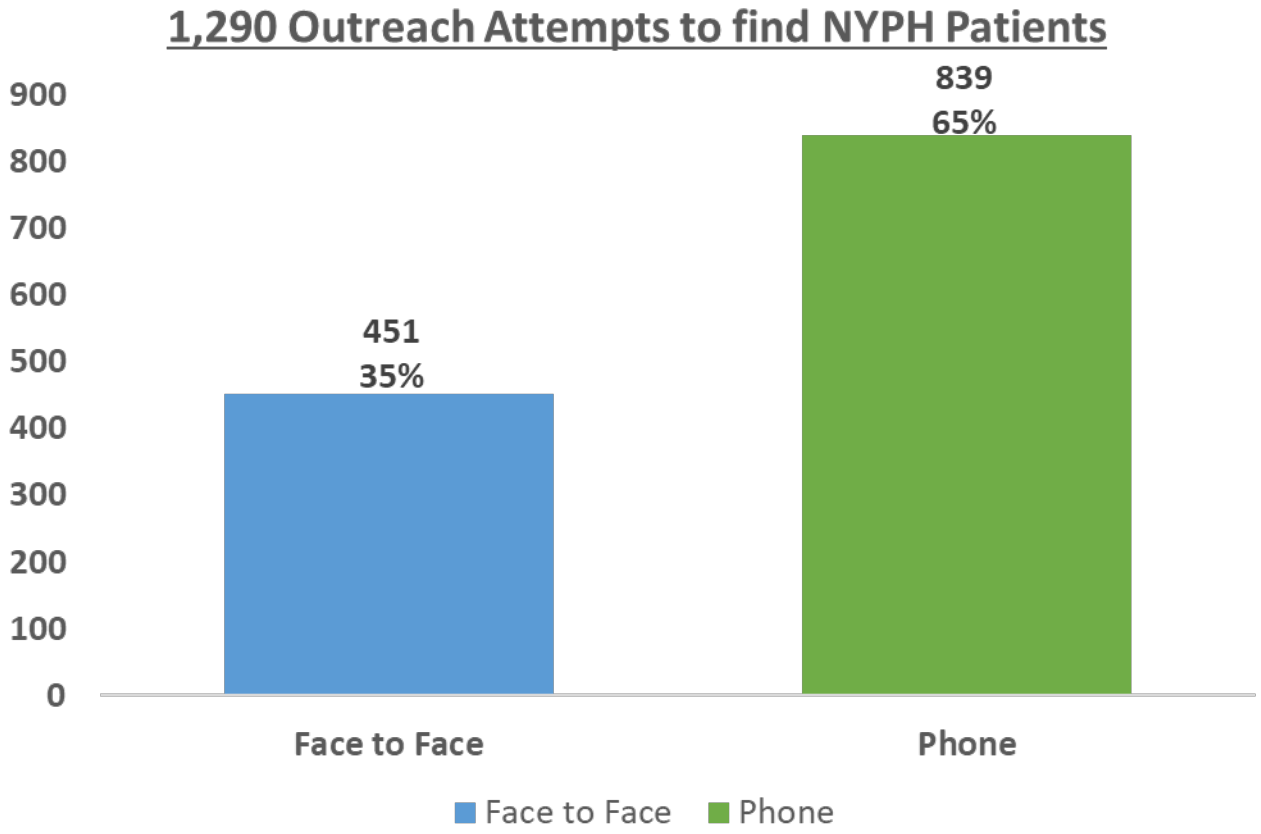
Most NYPH/Alliance patients have multiple chronic illnesses.

We address *Social Determinants of Health* to enhance access to needed care and support:

- **Housing:** unsafe, unstable, threats of eviction, rent arrears, needed repairs
- **Mental Health / Substance Use:** depression, anxiety, addiction
- **Food Insecurity**
- **Entitlements:** undocumented, Medicaid reactivation, spend-downs



Peer Navigation: Outreach to Found



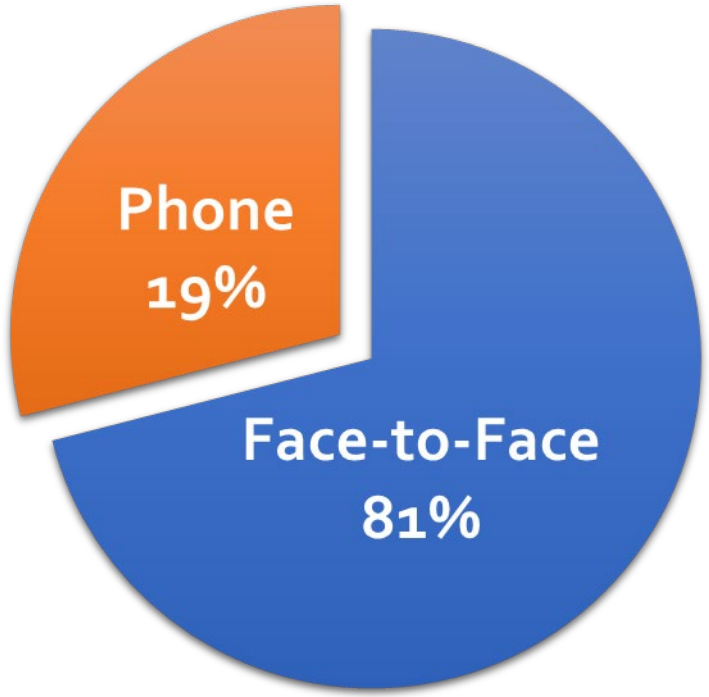
SUCCESSFULLY LOCATED 113 OUT OF 337

# NYPH OUTREACH Located N=113	# OUTREACH Activities	# NYPH Patients FOUND	% NYPH Patients FOUND
Face to Face	451 (35%)	92	81%
Phone	839 (65%)	21	19%
Total Outreach	1,290	113	100%
Average # Outreach Attempts Per Patient = 11.4			

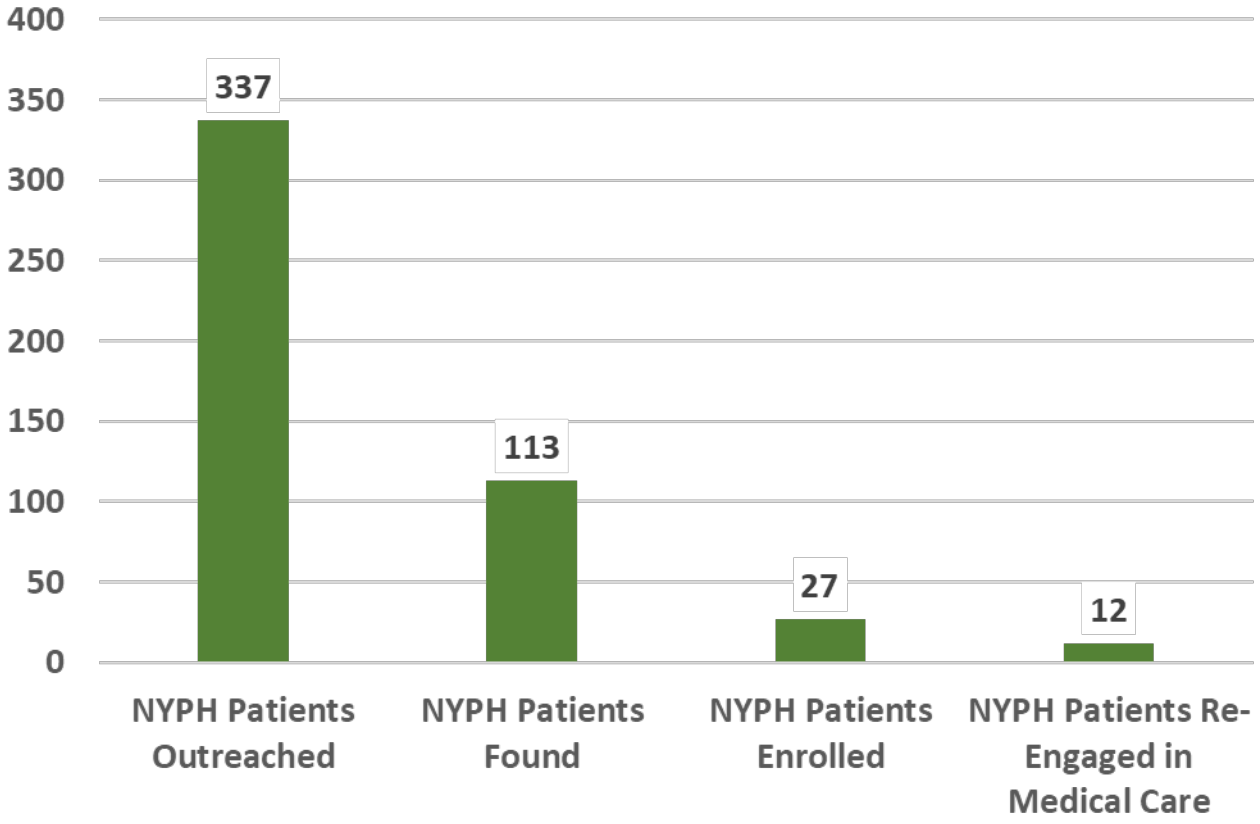
Peer Navigation: Outreach to Found

Alliance conducted 1,290 outreach activities over a 6-month period to find 113 out of 337 NYPH HIV-positive patients who were chronically lost-to-care (> 9 mos.)

81% of NYPH patients (92 out of 113) were found through **face-to-face** outreach encounters



Peer Navigation: Linkage to Care IMPACTS



In 6 months, Alliance conducted outreach and Linkage to Care services for 337 NYPH patients who were lost-to-follow-up (out of care for > 9 months)

- Of the 337 ***OUTREACHED*** members, **34% (113)** of members were ***FOUND***
- Of the 113 ***FOUND*** members, **24% (27)** of members were ***ENROLLED*** in Alliance's LTC program
- Of the 27 ***FOUND*** members, **44% (12)** of members were ***RE-ENGAGED*** in medical care

Peer Navigation: Linkage to Care IMPACTS

In 2019-20:

- Alliance **successfully located – *FOUND* – 34% of NYPH patients living with HIV who were lost to follow-up** (113 out of 337 NYPH patients)
- **24% of *FOUND* patients were enrolled in linkage to care services** (27 out of 113 NYPH patients)
- **81% of PLWHA patients were successfully located through face-to-face engagements**
- Successful engagement took an average of **11.4 attempts per patient**
- Staff Pattern: One Program Coordinator, Two Peer Navigators, plus Supervisor @ Alliance and NYPH

Photo: David Nager/Alliance

Peer Navigation: Linkage to Care IMPACTS

- **Individual Impact:** Alliance Peers consistently attest to the program's impact in enabling them to strengthen their recovery efforts, increase their commitment to HIV risk reduction, improve their access to services, and rebuild their self-esteem. These factors directly support the Peers' ability and motivation to maintain healthy behavioral changes over time.
- **Community Impact:** Peers act as role models for positive behavioral change and have an overwhelmingly positive impact on the communities they serve. Peer navigation and peer support services help increase health care utilization, connection to recovery and supportive services, reduced hospitalizations, reduced emergency room utilization, and improved health outcomes, such as viral load suppression and reduced rates of new HIV infections.

Collaboration in Action

- **Partnership** weekly planning calls to develop the evaluation and refine program protocols, attended by stake holders from each program
- **Cooperation** around data points and reporting metrics
- **Teamwork** in ensuring all data teams are trained to properly document and utilize each data system

THANK YOU!

VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

www.nyp.org

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Healthix www.healthix.org

www.alliance.nyc