Using a data-driven approach to improve engagement across the HIV Care Continuum

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Learning Outcomes

1. Assess the importance of integrating and systematizing data analysis to clinical workflows to bring visibility to potential gaps in care.
2. Describe how the patient navigator program as well as the Management Information System supports the national HIV/AIDS Strategy (NHAS) primary goals of increasing access to care and optimizing health outcomes of PLWH, and reduce HIV-related health disparities and health inequities; and
3. Identify multi-tiered data driven strategies that can be used to address linkage and retention in care in border communities.

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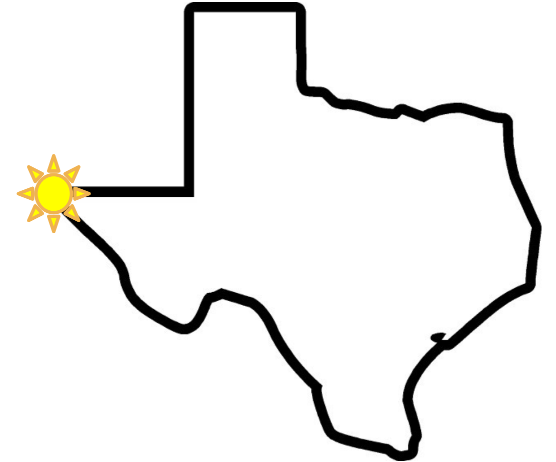
- Interventions
- Culture
- Results

Background

- The largest gap in the HIV Care Continuum exists between the initial diagnosis of PLWH and the transition to retention in care.
- HIV linkage and retention can be particularly challenging in the U.S. – Mexico border due to lower than average insured status, immigration status, language barriers, and a host of other issues.



Who we are

- We are 4 in 1!
- Sunset ID Care (Clinic)
- Southwest Viral Med (Non-Profit)
- Project Champs (RW Case Management)
- LabCorp (Labs)

Important Dates

2010

Dr. Alozie arrives to El Paso to start the HIV Clinic at Texas Tech

2015

Sunset ID Care/Project CHAMPS begin.

Dr. Heredia joins the team

2017

Patient Navigation Grant begins. Noemí joins the team in November.

2018

Focus on data driven culture. Armando becomes the clinical data manager.

2019

Rapid Start Program begins. Kenia and Jhoana join the team.

2020

PrEP/PEP Grant begins. Viri joins the team.

Status-Neutral Rapid Start Program Begins

2017 and 2018

- RWHAP Part C Capacity Development Program (FY17 & FY18)
- Patient Navigator
- Management Information System (MIS) tool
- Integrated with the aim to identify gaps in care, bring visibility to patients in need of targeted outreach efforts, and ultimately increase engagement in care across the HIV Care Continuum.

Why are we here

Finding gaps in care

Interventions

Gather results

Implement changes

Gaps in Care

- Identify patients
- Run Reports
  - Never Seen
  - Last seen 6 months
  - Last seen 6-12 months
  - Last seen 12+ months
- EMR
  - Diagnosis Code
  - Active/Inactive
  - Last Appointment
  - Upcoming appointment
  - Lab Value
- Cross-reference!

Learning Objective 1

- Patient ID
- When they did labs
- Their Viral Load
- Status (active/inactive)
- Name
- When they were registered
- When they were last seen
- Do they have an upcoming appointment
- Date of next appointment

printcsvreports (19)

Possible Data Loss Some features might be lost if you save this workbook in the comma-delimited (.csv) format. To preserve these features, save it in an Excel file format.

REPORT NAME : B20 VL Never Seen

patientid	labdate	labvalue	status	patient name	patientregd	patientlastseend	patientnextapptyn	patientnextappt
123	1/1/20	35000 COPIES/ML	a	NOEMI CORTEZ	1/1/20		N	

B20 = ICD10 Code for HIV

What I wish I knew

- Which data to pull from EMR
- Not straight-forward
- Learning curve
  - Patience is key
- Double-check, double-check, double-check

What’s next

- Interventions
  - Outreach
    - Patients
    - Health Department
  - Resources
    - UBER Health
    - Case Management
    - Twilio

Appointment Utilization

	Before the Visit (Step 1)	During the Visit (Step 2)	After the Visit (Step 3)
Completed Appointment	- Automated text messages - Phone Call - Assess Barriers to Care (e.g. Transportation)	- Trauma Informed Care Organization - Corroborate contact information	- Call to check-in (issues, questions) - Confirm medication attainment
Missed Appointments		- Call patient after missed appointment - Reschedule	- Set reminders for follow-up call in two weeks - Look for additional contact info - Reach out to Case Management - Home Visit - Health Department - Pharmacy Demographics

Central Worklist

- Integrated care coordination platform (Enli)
- Assign patients to different case managers
- Notify others when tasks are completed
- Set reminders for important dates
- Ability to send text messages utilizing Twilio services

Twilio

- Communications platform
- Integrates into Enli
- Non-Profit pricing
  - Impact Access Program
  - $0.00562/text message
- Capacity to select multiple patients that should receive text messages

Learning Objective 2

What does it look like?

Central Worklist

Noemi Cortez | Log Out

- Reminders
- Approvals
- **Workflow**
- Patients
- Programs
- Reports
- Preferences
- Setup
- Admin

Program: Patient Navigation | **Patient search:** | **My Patients:** | **Workflow frequency:** Every 90 Days | Apply | More

Bulk Action | Add Patient | Filters | Views

Workflow Frequencies: Every 90 Days | Every Six Months |

Refresh | Show Selector | Hide Admin Data | Hide Data Elements | Hide Actions |

Count: 2 | Last updated 7/27/2020 2:54:54 PM

Workflow Checklist

Patient	DOB (age)	Coordinator	Appointment	Inpatient Status	New/Transfer	Transfer From	Established Contact	Registered	Date of 1st Visit	Days between Registration and 1st Visit	Intervention	Insurance Status	Ryan White	CD4	Viral Load	Virally Suppressed	Barriers Care
		Noemi Cortez	8/26/20 1:40 PM (20 m) HIV Follow up Jhoana Quezada	Inpatient	Transfer	_	YES	12/18/2017	12/22/2018	4	Initial Linkage	Uninsured	ACTIVE	16	620,000	NO	Medica Adhere
		Noemi Cortez		_	Transfer	Austin	YES	01/24/2018	01/29/2018	5	Initial Linkage	Insured	INACTIVE	752	<20	YES	_

Record Action

×

Fields marked with an asterisk (*) are required

Patient Epion Test

Program Patient Navigation

Action * TXT MSG: Pre-Visit Planning English

Mobile Number * (915) 831-0645

Message * Do not send PHI

Hi, this is Kenia from Dr. Alozie's. I just called regarding an upcoming appointment, labs and referrals. Can you call me back at (915) 229-6448? Thank you. Do not reply to this message.

Message will be sent when action is saved. It cannot be edited or recalled.

CC Chart

Created by Noemi Cortez

Save & Add Another | Save & Close | Cancel

Record Action

×

Fields marked with an asterisk (*) are required

Patient Epion Test

Program Patient Navigation

Action * TXT MSG: Pre-Visit Planning Spanish

Mobile Number * (915) 831-0645

Message * Do not send PHI

Hola, soy Kenia del Dr. Alozie. Acabo de llamar para una próxima cita, laboratorios y referencias. ¿Me puede llamar al (915) 229-6448? Gracias. No responda a este mensaje.

Message will be sent when action is saved. It cannot be edited or recalled.

CC Chart

Created by Noemi Cortez

Save & Add Another | Save & Close | Cancel

* Reducing Patient Appointment No-Show Rate Using Text Messaging Systems in a Single Provider Ambulatory Care Clinic.

Record Action

×

Fields marked with an asterisk (*) are required

Patient: Epion Test

Program

Action *

Notes

CC Chart

Created by

Last modified

✓ --- Workflow Actions ---
Call Patient
Check Labs
Review Overdue Referrals
Place Order for Overdue Referrals
Check Ryan White Status
Obtain Medical Records
--- Standard Actions ---
Note
Opted-Out
Suspend patient
Stop program
Complete program
--- Custom Actions ---
Discharge Letter Sent
doxy-alozie-en
doxy-alozie-sp
doxy-heredia-en
doxy-heredia-sp
doxy-quezada-en
doxy-quezada-sp
Home Visit
Ins/RW Eligibility Verified
Outreach for Attestation
Send letter for Recert
Suspension Letter Sent
Test
Test2
TXT MSG: 6 Month Attestation
TXT MSG: Call Patient
TXT MSG: Med Notice - English
TXT MSG: No Follow Up - Outreach English
TXT MSG: No Follow Up - Outreach Spanish
TXT MSG: Pre-Visit Planning English
TXT MSG: Pre-Visit Planning Spanish
TXT MSG: Recertification

Cancel

ram

Event | Action (By
TXT MSG: Planning E (Armando

Dr. Alozie's. I ju ppointment, lab back at (915) this message

Comme

Create Reminder

×

Patient: Epion Test
Status: Active

MRN/Patient ID: 535
Provider: Ogechika Alozie (1)
Insurance: WELLMED GROUP - AMERIGROUP TX - AMERIVANTAGE SPECIALTY (MEDICARE REPLACEMENT HMO)

Data Source: SWVM

DOB: 01/01/2000 (20)
Address:
123 Main Street
EL PASO, TX 79902

Home: (915) 831-0645
Mobile: (915) 831-0645
Work:
Employer:

Preferred Contact: MOBILEPHONE
Email: armgallgtz84@gmail.com
Location: Main Office
Preferred Language: English

Description *

Program *
Patient Navigation

Due *
07/26/2020 12:32 PM

Notes

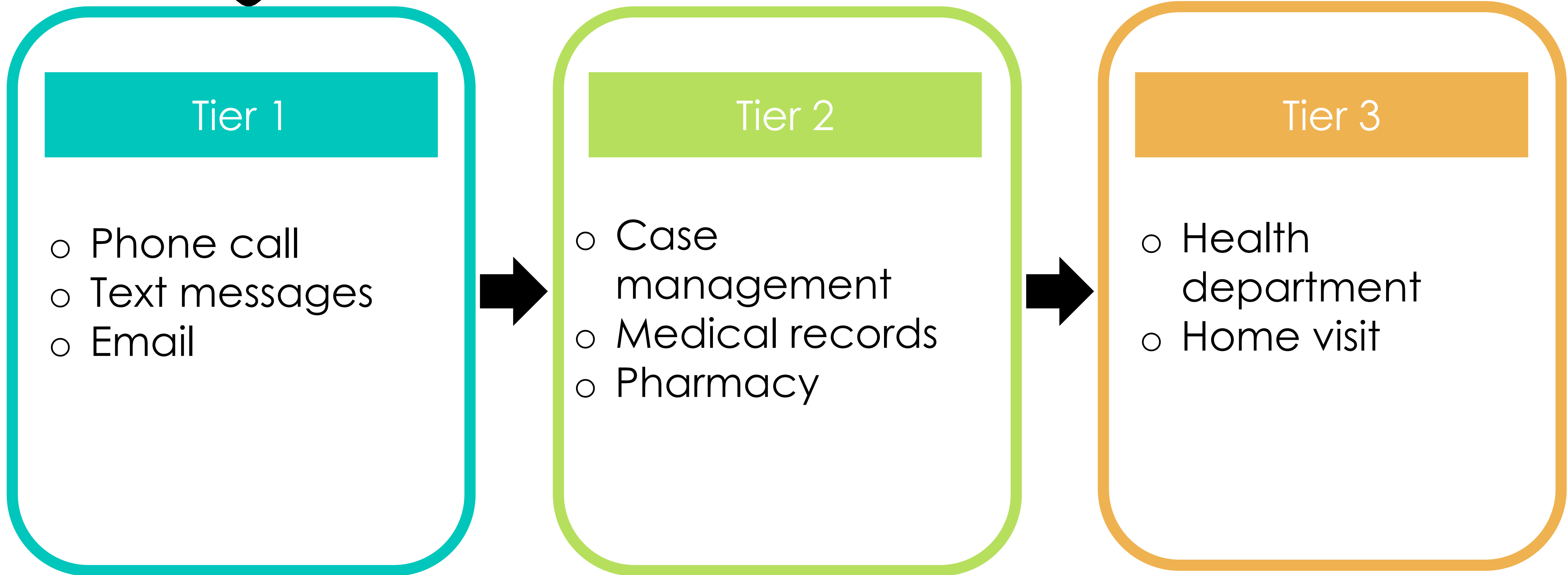
For *
Me
User -- Select --
Group -- Select --

Save | Cancel

Case Scenario

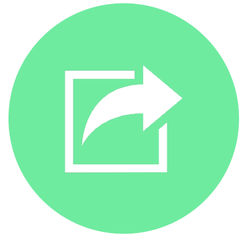
- Thirty-one-year-old woman who registered on June 15th was able to do the enrollment with Project CHAMPS (Ryan White Program) and did labs the following day on June 16th. Patient did not show up to appointment on June 23rd. It is now July 7th, the patient's number is not working, the voice mail has not been set up yet and there's no other person we are authorized to call.

Interventions



Learning Objective 3

Change in Culture



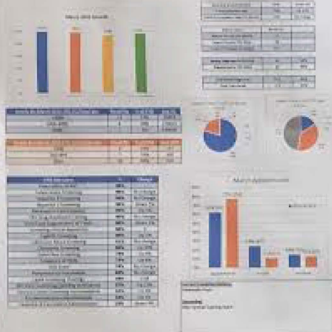
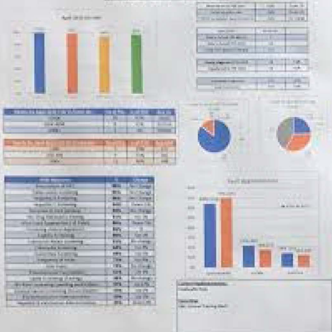
FORWARD-THINKING

BIG-PICTURE

DATA-DRIVEN

TRAUMA-INFORMED

CULTURALLY COMPETENT


March 2020

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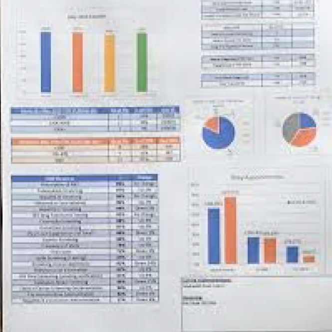
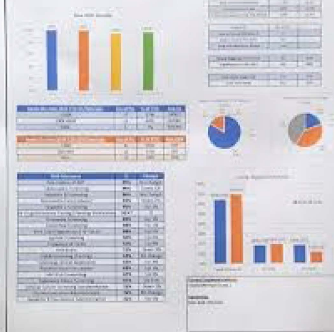
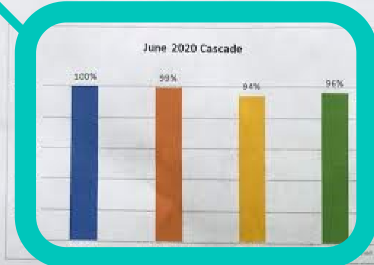

May 2020

June 2020

Cascade
- Diagnosed
- Linked/Diagnosed
- Retained/Linked
- Virally Suppressed/Retained

Newly Diagnosed Viral loads and CD4 counts

HAB Measures
-% of completion
-Change from previous month

June 2020



Same day encounter close	72%	Up 2%
Portal Adoption rate	83%	Up 5%
PreVisit Completion Rate This Month	53%	Up 7%

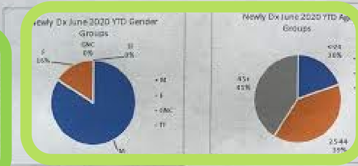
June 2020	No of Pts.	
New to Sunset This Month	9	
New to Sunset YTD 2020	61	
Total HIV Patients in Athena	740	

Newly Diagnosed YTD 2020	31	51%
Transferred in YTD 2020	30	49%

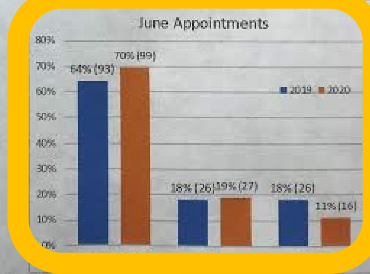
Total Newly Diagnosed	321	45%

Newly Dx June 2020 YTD VL/Total pts:	No of Pts	% of YTD	Avg VL
<100k	17	57%	24907
100K-499K	12	40%	260083
500k+	1	3%	939000

Newly Dx June 2020 YTD CD4/Total pts:	No of Pts	% of YTD	Avg CD4
<200	8	26%	105
200-499	11	35%	385
500+	12	39%	698



HAB Measures	%	
Prescription of ART	99%	No Chang
Tuberculosis Screening	96%	Down 1%
Hepatitis B Screening	96%	No Change
Retained in Care (athena)	94%	Down 2%
Hepatitis C Screening	95%	Up 1%
/ Drug Resistance Testing (Pending Verification	91%*	0
Chlamydia Screening	89%	Up 1%
Gonorrhea Screening	88%	Up 1%
Viral Load Suppression (of Total)	88%	Up 2%
Syphilis Screening	92%	Up 6%
Frequency of Visits	82%	Up 4%
Oral Exam	72%	Down 3%
Lipids Screening (Fasting)	63%	No Change
Screening clinical depression	65%	Up 3%
Pneumococcal Vaccination	63%	Up 1%
HIV Risk Counseling	67%	Up 6%
Substance Abuse Screening	67%	Up 11%
Cervical Cancer Screening Documentation	53%	Down 1%
Flu Immunization Administration	32%	No Change
Hepatitis B Vaccination Administration	22%	Up 5%



Current Implementations:
Telehealth Push (cont.)

Upcoming:
ENLI Bulk UPLOAD

Quick Stats
- Sentinel Metrics Tables
- New and Total Patients
- New/Transfer

Newly Diagnosed
- Gender (M, F, TF, GNC)
- Age (<24, 25-44, 45+)

Appointments
-% Completed appointments
-% No Shows
-% Cancellations due to no labs

	2017	2018	Difference
Diagnosed	100%	100%	---
Linked/diagnosed	99%	97%	-2%
Retained/linked	90%	94%	+4%
Viral Suppression	82%	96%	+14%

Results

- After the implementation of both programs (patient navigation and Management Information System tool)
  - Increase in viral suppression rates of 14% from 82% to 96%.
  - 94% of patients retained in care

SOUTHWEST VIRAL MED

Thank you!