2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

NATIONAL 2018 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Supporting and Retaining both Staff and Patients through Organizational and Programmatic Change

Alexis Marbach, Abt Associates; Alicia Downes, AIDS United

Elaine Ruscetta, MPH & Dr. Luz Amarilis Lugo, MD, Mount Sinai Institute for Advanced Medicine

Laura Riley, Alaska Native Tribal Health Consortium

Workshop Objectives

- Demonstrate methods of supporting and sustaining staff time and resources through organizational and programmatic change.
- Discuss methods for retaining patients in care during times of organizational change.
- Identify ways to support grant-funded staff through the inherent role instability of a time-limited initiative.
- Describe possible strategies for maintaining patient engagement in care while minimizing staff burden during periods of provider turnover.

Disclosures

Presenters have no financial interest to disclose.

Obtaining CME/CE Credit

If you would like to receive continuing education credit for this activity, please visit:

http://ryanwhite.cds.pesgce.com

NATIONAL 2018 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Challenges of Hiring and Sustaining Staff on Grant-Funded Programs

Alexis Marbach, Abt Associates; Alicia Downes, AIDS United

Agenda

- Demonstrate ways to support and sustain grant-funded program staff through recruitment, hiring, ongoing professional development, and role transition.
- Compare examples of the challenges of hiring and sustaining grant-funded staff once the grant period ends, and discuss successes of staff support and sustainability at DEII sites.
- Discuss alternative funding streams, such as community agencies, private funds, or changes in reimbursement strategies to support successful staff and programs.

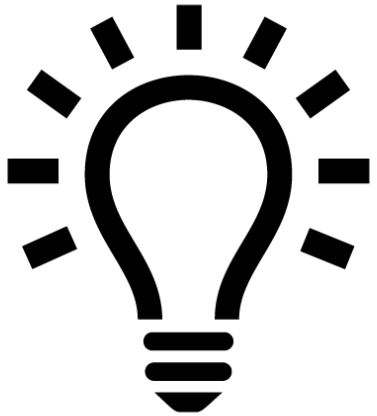
Project Background

- Four-year Cooperative Agreement with HRSA's Special Projects of National Significance (SPNS)
- Funding amount of $3 million/year for the ITAC, with $2.4 million going to implementing sites
- Replicates four previously-implemented SPNS initiatives

Interventions

AIDS United: Implementation and Technical Assistance Center (ITAC)

Select & Fund 12 Sites

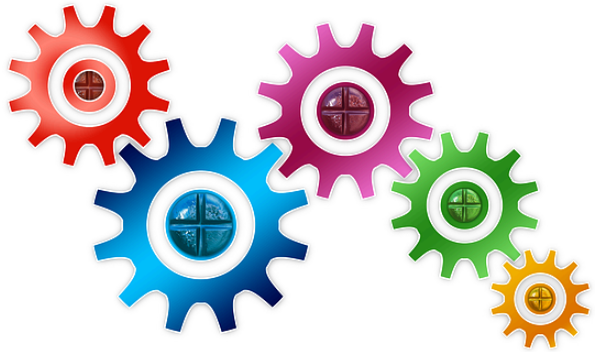


Provide TA

Coordinate Experts

Boston University: Dissemination and Evaluation Center (DEC)

- Adapt and design 4 intervention models for replication.
- Design and implement multi-site evaluation
- Studying both patient outcomes (including retention in care and viral suppression) and implementation findings (what works in practice and what facilitates/hinders implementation)
- Publish and disseminate final adapted interventions and study findings



Positions Funded Through DEII

Transitional Care Coordination

- 2 care coordinators (1 FTE each)
- 1 data manager (.5 FTE)
- 1 administrative supervisor (.5 FTE)

Peer Linkage and Re-Engagement

- 2 peers (1 FTE each)
- 1 data manager (.5 FTE)
- 1 clinical supervisor (.2 FTE)
- 1 administrative supervisor (.5 FTE)

Positions Funded Through DEII

Integration of Buprenorphine

- 2 prescribing providers (.2 FTE)
- 1 clinical coordinator (1 FTE)
- 1 data manager (.5 FTE)

Enhanced Patient Navigation

- 2 patient navigators (1 FTE each)
- 1 data manager (.5 FTE)
- 1 clinical supervisor (.15 FTE)
- 1 administrative supervisor (.4 FTE)

Benefits of Hiring From Within The Health System

- Employees committed to the organization, culture and team
- Employees familiar with the patient population
- Timeline for hiring easier, quicker and manageable pool of high caliber candidates
- By hiring within, you already know the capabilities of the candidate and have a better idea of how they will perform
- Promoting staff from within the company can be motivating for employees and recognition of their work ethic

Hiring: Lessons Learned

- Hiring from within the agency is expedient as staff are committed to the agency and maybe familiar to you
- Provide support to staff whose gainful employment can affect their benefits (SSDI, housing assistance, ADAP)
- Vacancies allow opportunity to re-assess staffing needs and suitability for a program
- Hiring can take a long time so develop an interim plan to support the team

Sustaining Staff: Providing Professional Development

- Continuing their education via CEUs, Higher Education
- Participating in professional organizations
- Additional role responsibilities
- Coaching/Mentoring
- Partnership with Human Resources for resume, interviewing support
- Introduction to Organization Vice Presidents

Sustaining Staff: Lessons Learned

- Hiring takes time, you want to find the right person who has existing relationships and trusted in the community
- Ensure that Human Resources understands the program and your staff needs
- Develop partnership with Human Resources to explore agency vacancies
- Encourage staff to assess their long term professional goals
- Provide opportunities for staff to showcase their skills through collaboration with other organizations, conference presentations

Retaining Staff: Finding Long-term, Sustainable Funding Streams

- Use data to showcase success with implementation of new projects
- Think sustainability at the beginning of any project
- Sustainability Assessment and Work Group
  - Domains
    - Environmental Support, Funding Sustainability, Partnerships, Org. Capacity, Prog. Evaluation, Communications, Strategic Planning
- Market program by use of a cost benefit analysis
- Assess viability of Program Income
- Brag to state and local partners about program success
  - Incorporate client stories

Retaining Staff: Lessons Learned

- Explore new funding opportunities with community partners by highlighting data that demonstrates positive outcomes
- Showcase your program outcomes to planning councils who may identify RW funding for program sustainability
- Highlight program impact to your Board, leading to program sustainability
- Engage with grant making institutions-Private and Federal

Questions?

2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Targeted Outreach During Care Provider Turnover:

An Example of Supporting Clients Through Organizational Change

Elaine Ruscetta, MPH
Dr. Luz Amarilis Lugo, MD
Jenny Mayer, LCSW

Mount Sinai Institute for Advanced Medicine

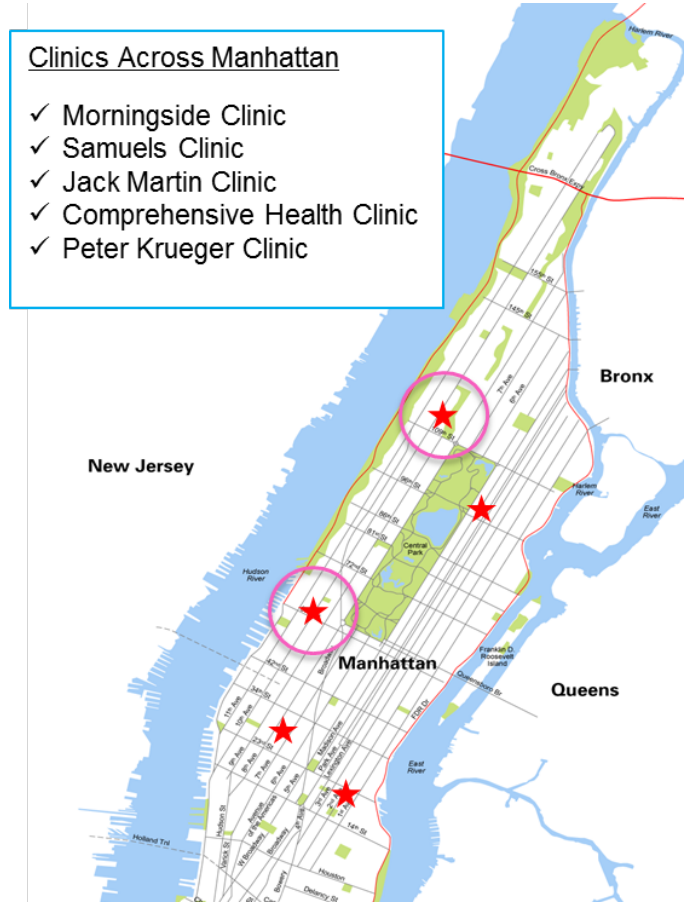
Acknowledgements

- Samuels Care Coordination Staff
  - Care Coordinator Cherry Jones, M.Ed.
- Samuels Social Work Staff
- IAM Quality Improvement Team:
  - Director of Quality Management & Evaluation: Shruti Ramachandran, MPH, MID
  - HIV QI Manager: Amy Newton, MPH
  - Senior Analyst, Quality Improvement: Rebecca Lindner
- Care Coordination Funders:
  - New York City Department of Health and Mental Hygiene (NYC DOHMH)
  - Public Health Solutions (PHS)

Background

The Institute for Advanced Medicine

- Five HIV prevention & treatment practices across Manhattan
- Represents the largest HIV primary care practice in New York and provides HIV primary care to ~10,000 people with HIV (PWH)



Samuels Clinic

- Outpatient clinic of Mount Sinai West hospital.
- “One Stop Shop” model with comprehensive services for HIV+ patients and patients at risk for HIV infection.
- Services include primary care, specialty care (OB/GYN, GI, neurology, STI testing/treatment, Hepatitis C treatment), mental health (individual therapy, group therapy, psychiatry), dental, social work & case management, nutrition education & counseling, complementary therapy (acupuncture, massage, meditation, yoga), and grant-funded programs.
- **Experienced high rate of turnover of Primary Care Providers (PCPs) in Jul 2015 – Dec 2016, but relative stability of Social Work and Care Coordination staff.**

Review: Retention in Care

- Retaining clients in care is a key step in the HIV care cascade (Gardner, McLees, Steiner, del Rio, & Burman, 2011).
- Retention in care is positively correlated with survival (Giordano et al., 2007), viral suppression (Lucas, Chaisson, & Moore, 1999), and lowered risk of HIV transmission (Metsch et al. , 2008).
- High rates of provider turnover have been shown to reduce retention in care, thus adversely impacting health outcomes (Lam et al. , 2016).
- **When provider turnover occurs, organizations must respond proactively to retain clients in care and target outreach efforts to the highest needs clients.**

Review: Impact of Outreach

- Both outreach (≥2 contacts) and case management services have been shown to increase retention in care, including for the most difficult-to-reach patients (Horstmann, Brown, Islam, Buck, & Agins, 2010).
- Phone-based outreach efforts have minimal impact on patient outcomes, relative to more intensive and complex strategies (Renders, et al., 2001).
- Personal phone calls have been shown to be more effective than automated calls for increasing HIV primary care show rates (Gardner, et al., 2014).
- **More research is needed to understand which types and features of outreach interventions have the greatest impact on retention in care and patient health outcomes.**

Process

Process: Before Intervention

- PCP Turnover:
  - More than 1,700 patients experienced at least one change in PCP (81% of total active patients) between July 2016 and December 2017.
  - Relative stability of non-medical care team staff (social work, care coordination, nursing, etc.)
- Patients receive automated calls:
  - Reminder call two days before scheduled appointment
  - Follow-up call one day after missed appointment
  - Patients can opt out if there are disclosure concerns.
  - Automated calls continued throughout intervention and into the present. Intervention added personalized calls.

Process: Cycle 1 (8/2016-1/2017)

- Retention in care defined as at least one PCP visit in first half of 2015 and one in the second half of 2015. (Based on New York State AIDS Institute Definition)
- Data from Electronic Medical Record (EMR) used to identify patients not retained in care.
- Unretained patients who has experienced a change in PCPs within the previous 18 months → received 1+ outreach calls. This list was then parsed into…
  - Patients with an unsuppressed (>200) HIV viral load (VL) at last measurement → called by CC staff
  - Patients with an suppressed (≤200) HIV viral load (VL) at last measurement → called by Social Work staff

Process: Cycle 1 (cont.)

- All patients on either list received outreach calls to offer an appointment with new PCP. Unsuppressed patients were also offered a Care Coordination intake before or on the same day as the new PCP appointment. If staff member was able to leave voicemail, they left generic (non-disclosing) message with call center phone number.
- When a patient was not successfully contacted on the first attempt (number disconnected, left voicemail), a second attempt was made 1-2 weeks later.
- All contact attempts were documented in EMR progress notes (to prevent duplication of effort by other staff members)

Process: Cycle 2 (1/2017-5/2017)

- Expanded from Samuels to all 5 sites of IAM
  - Different sites delegated calls to different staff members, based on their own work flow and resources.
- In order to improve data on the impact of our efforts, a centralized outreach database was implemented to track all outreach attempts.
- Samuels staff adjusted their approach:
  - CC staff continued to make calls to unsuppressed and unretained patients with a recent change in PCP
  - Samuels SW team changed their focus to new clinic patients (first PCP visit within the last 6 months) in order to increase engagement proactively

Process: Strengths

- Segmented approach to population health
  - Higher intensity services (CC) offered to patients with higher medical need (unsuppressed HIV VL)
  - Social Workers have a connection with all patients in the clinic and are core members of the care team
- Focus on specific sub-populations/risk groups
  - Efforts focused on patients with recent PCP change.
  - Workload can be distributed according to resources available (time, skill set, staff continuity)
- Documentation
  - Prevents duplication of effort
  - Identifies patients who do not need further outreach (e.g. transferred clinics)

Process: Lessons Learned

- Limited data from Cycle 1
  - Lack of centralized tracking method made it difficult to measure the impact of the work done
- Documentation proved to be time-consuming
  - Writing notes took longer than actually making the calls.
  - Centralized database in cycle 2 was more effective/lower burden than individual progress notes, but utilization was low.
- Effectiveness of phone outreach limited due to transient patient population.
  - Many phone numbers were out of service or incorrect.

Outcomes

Qualitative Outcomes (Cycle 1)

- Effectiveness of phone outreach limited due to transient patient population.
  - Many patients had transferred their care to other clinics
  - Many phone numbers were out of service or incorrect.
  - Problems more common with patients who had not been to the clinic for several months.
- Most effective for…
  - Patients who wanted to be engaged but were experiencing barriers to obtaining/keeping appointments
  - Patients who were ambivalent about engaging after provider change. Call helped them feel reassured that clinic was committed to their continuity of care
- Lag between data pull and intervention often meant calls were made after patient had already re-enaged in care.

Quantitative Outcomes (Cycles 1&2 – All IAM)

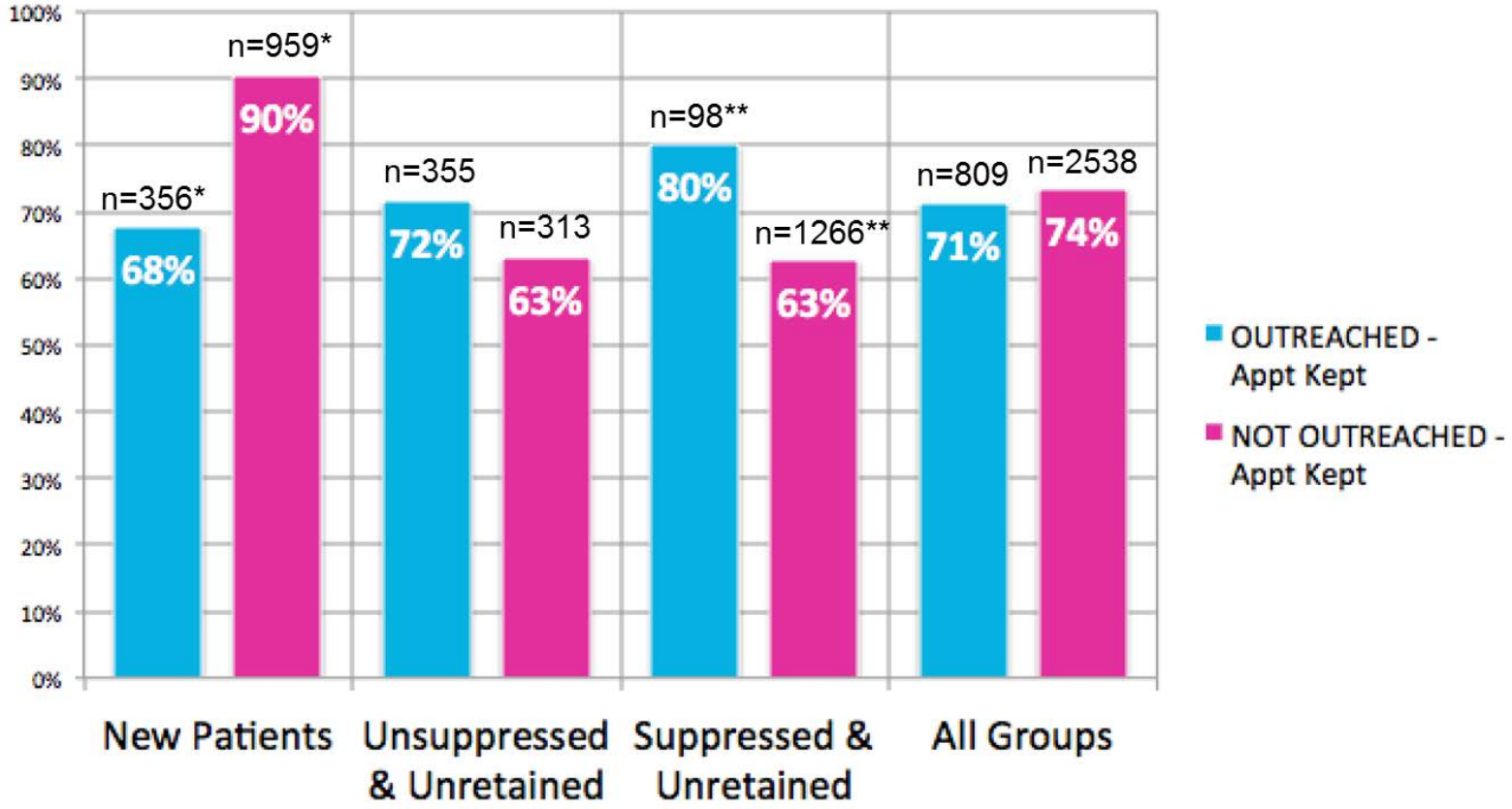
All IAM	# of Pts Outreached	# Pts Outreached Who Kept an Appointment	Percentage Pts Outreached Who Kept an Appointment	# Pts Retained by 8/1/2017 (3 mo. after cycle 2)	Percentage Pts Retained by 8/1/2017 (3 mo. after cycle 2)
New Patients	356	230	65%	122	34%
Unsuppressed & Unretained	355	192	54%	96	27%
Suppressed & Unretained	98	75	77%	50	51%
Total	809	497	61%	268	33%

Quantitative Outcomes (Cycles 1&2 – All IAM/Samuels)

Samuels (with PCP Change)	# of Pts Outreached	# Pts Outreached Who Kept an Appointment	Percentage Pts Outreached Who Kept an Appointment	# Pts Retained by 8/1/2017 (3 mo. after cycle 2)	Percentage Pts Retained by 8/1/2017 (3 mo. after cycle 2)
New Patients	73 (45)	56 (37	77 (82)	25 (17)	34 (38)
Unsuppressed & Unretained	55 (34	30 (24)	55 (70)	14 (11)	25 (32)
Suppressed & Unretained	n/a*	n/a*	n/a*	n/a*	n/a*
Total	128 (79)	86 (61)	67 (77)%	39 (28)	30 (35)

*does not include suppressed & unretained data from cycle 1 because we were not able to retroactively extract that information

Quantitative Outcomes (Cycles 1&2 – All IAM/Samuels)



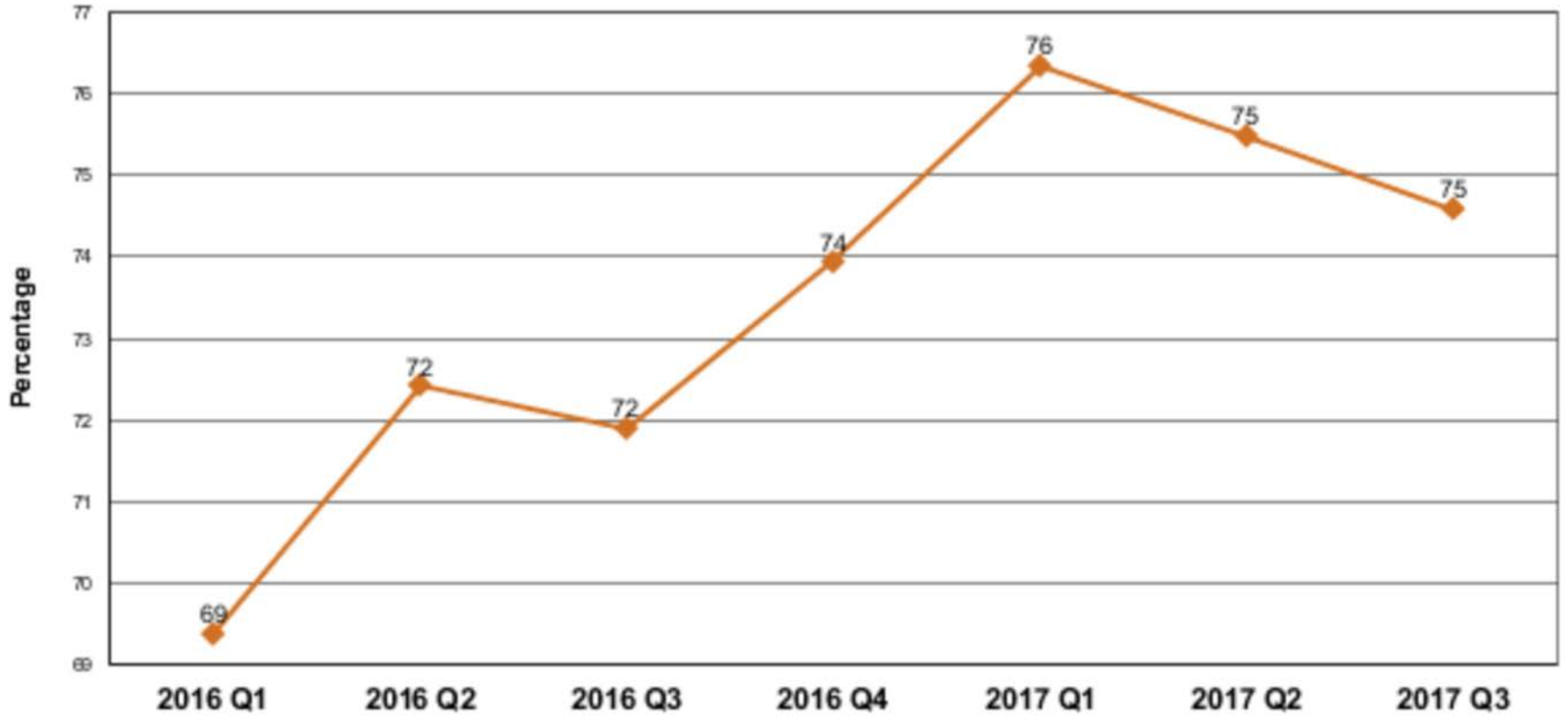
*comparison challenging because of differing baseline

**comparison challenging because of differing group sizes

Quantitative Outcomes (Cycle 2 – Samuels Clinic)

Details from Samuels	
Permanently Out of Care (deceased, transferred, etc.)	9 of 85 calls made (11%)
Unreachable (number incorrect/disconnected)	22 of 85 calls made (26%)
Outreach Successful (made contact or left VM)	54 of 85 calls made (63%)
Appointment Scheduled After Outreach	21 of 54 successful calls (39%)
Appointment Kept After Outreach	28 of 54 successful calls (52%)
Patient Took Action After Outreach (scheduled or Kept Appointment)	35 of 54 successful calls (65%)
Case Management Enrollment (CC/HH)	12 of 54 successful calls (22%)

Impact on Retention (Cycles 1 & 2 – Samuels Clinic)



Results

- While the general evidence shows that phone outreach is not usually successful in increasing retention in care, our results show that targeted phone calls that focus on specific sub-groups may maximize the impact of outreach efforts.
  - Unsupressed
  - Suppressed & Unretained (?)
  - Experiencing change in care team

Current Efforts

- We have continued making targeted, personalized calls to patients in certain high-needs groups:
  - Unretained and/or unsuppressed patients with a recent change in PCP
    → Care Coordination and/or Nursing
  - Patients with low engagement in mental health services
    → Assigned Mental Health Provider
  - Chronically unsuppressed (multiple consecutive HIV viral load >200)
    → Care Coordination
- We continue to document outreach efforts in the EMR to prevent duplication of effort.
- We have also begun targeting outreach to patients with multiple no-shows (thus aiming to reduce no-show rate)

Areas for Future Growth

- Evidence shows that other forms of outreach (text message, field-based) may be more successful than phone calls
  - We are currently expanding automated reminders to include text messages on an opt-in basis.
  - We are also expanding our utilization of “MyChart”, a messaging and information-sharing system through the EMR that patients can access through email or a smartphone app.
  - When possible, we work with insurance providers that offer field outreach to unretained patients.

References

Gardner, E.M., McLees, M.P., Steiner, J.F., del Rio, C., Burman, W.J. (2011, March 15). The Spectrum of Engagement in HIV Care and its Relevance to Test-and-Treat Strategies for Prevention of HIV Infection. Clinical Infectious Diseases, 52(6), 793–800. Retrieved from https://doi.org/10.1093/cid/ciq243

Gardner, L.I., Giordano, T.P., Marks, G., Wilson, T.E., Craw, J.A., Drainoni, M.L. … Mugavero, M.J. (2014). Enhanced personal contact with HIV patients improves retention in primary care: A randomized control trial in 6 US HIV clinics. Clinical Infectious Diseases, 59(5), 725.-734. Retrieved from: https://doi.org/10.1093/cid/ciu357

Giordano, T.P., Gifford, A.L., White, A.C., Suarez-Almazor, M.E., Rabeneck, L., Hartman, C., Backus, L.I., Mole, L.A., & Morgan, R.O. (2007). Retention in care: a challenge to survival with HIV infection. Clinical Infectious Diseases, 44(14), 93-99. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/17479948

Horstmann, E., Brown, J., Islam, F., Buck, J., & Agins, B.D. (2010). Retaining HIV-infected patients in care: Where are we? Where do we go from here? Clinical Infectious Diseases, 50(5), 752-761. Retrieved from https://doi.org/10.1086/649933.

Lam, Y., Westergaard, R., Kirk, G., Ahmadi, A., Genz, A., Keruly, J., Hutton, H., & Surkan, P. (2016, July 18). Provider-Level and Other Health Systems Factors Influencing Engagement in HIV Care: A Qualitative Study of a Vulnerable Population. PLoS One, 11(7). Retrieved from http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0158759

Lucas, G.M., Chaisson, R.E., & Moore, R.D. (1999, July 20). Highly active antiretroviral therapy in a large urban clinic: risk factors for virologic failure and adverse drug reactions. Annals of Internal Medicine, 131(2), 81-87. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/10419445

Metsch, L.R., Pereyra, M., Messinger, S., Del Rio, C., Strathdee, S.A., Anderson-Mahoney, P., Rudy, E., Marks, G., Gardner, L., & Antiretroviral Treatment and Access Study (ARTAS) Study Group (2008, August 15). HIV transmission risk behaviors among HIV-infected persons who are successfully linked to care. Clinical Infectious Diseases, 47(4), 577-584. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/18624629

Renders, G.M., Valk, G.D., Griffin, S.J., Wagner, E.H., Eijk Van, J.T, & Assendelft, W.J. (2001). Interventions to improve the management of diabetes in primary care, outpatient, and community settings: A systematic review. Diabetes Care, 24(10), 1821-1833. Retrieved from: http://care.diabetesjournals.org/content/diacare/24/10/1821.full.pdf

2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Mobile Reminders OnTimeText

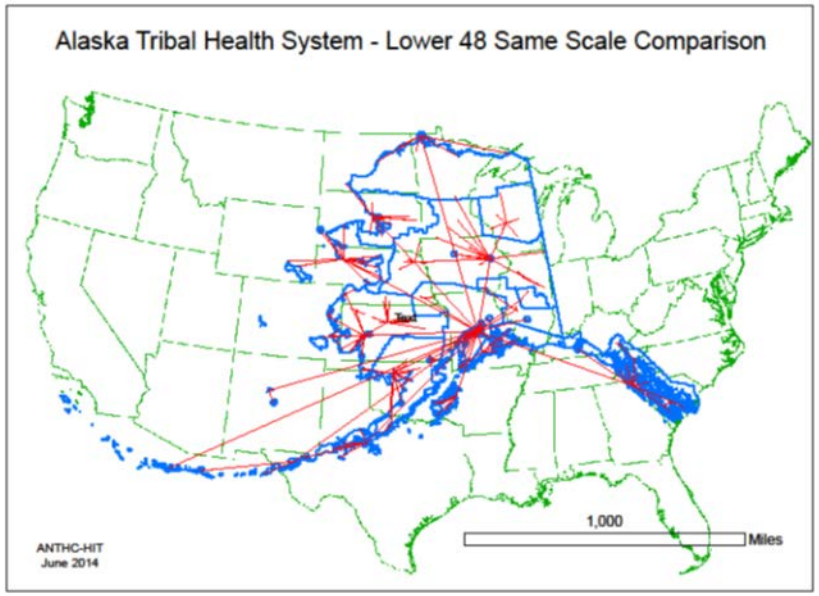
Laurali Riley – MS Program Manager

Improving Access and Engagement In Care

Receive a daily text for meds and reminder texts for upcoming appointments. This program is designed and operated by your EIS team at ANTHC

Patient Demographics

- 245 patients total
  - 130 living in ASU
  - 115 living throughout the state
- 35 patients unsuppressed
- 18 not on ARVs- 85% outside of ASU
- 85 separate DNKA tracking since 1.1.2017 (including felid clinic)

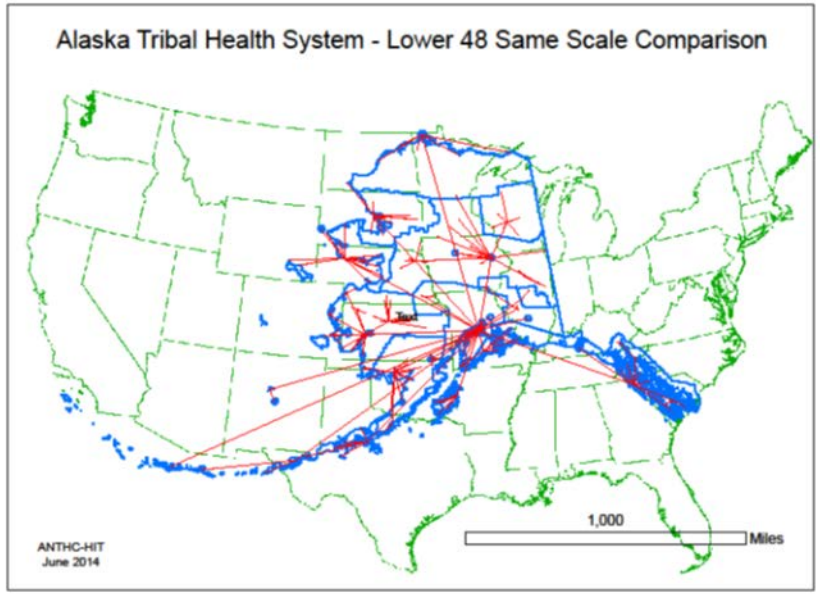


Current methods of patient engagement

- In person clinic visits at ANMC
  - Gift Cards, transportation and Meal tickets available
- In person Field Clinics to the statewide THOs
- Follow up VTCs
- Reminder calls and Texts for appointments and medications from EIS staff
- Cerner reminder system for appointments
- On-call phone for medical case management

Why people aren't engaged in care

- Patients may be unclear on when to take their medication
- Patients often forget to take their medication
- Patients may be unclear about an appointment time/location
- Patients refusing appointments and medications



Solution for medication reminders Mobile Medication APP

Medication Reminder Application PROs

- Fairly simple to operate
- Generally Free to download
- Built in calendar
- Build your own regimen

Medication reminder Application CONs

- Requires a data plan
- Some ARVs not available in preset apps
- Privacy Issues
- Non- interactive with EIS care team
- No incentives
- No way to communicate with care team through app

Developing a solution

A mobile med/appointment reminder system that was

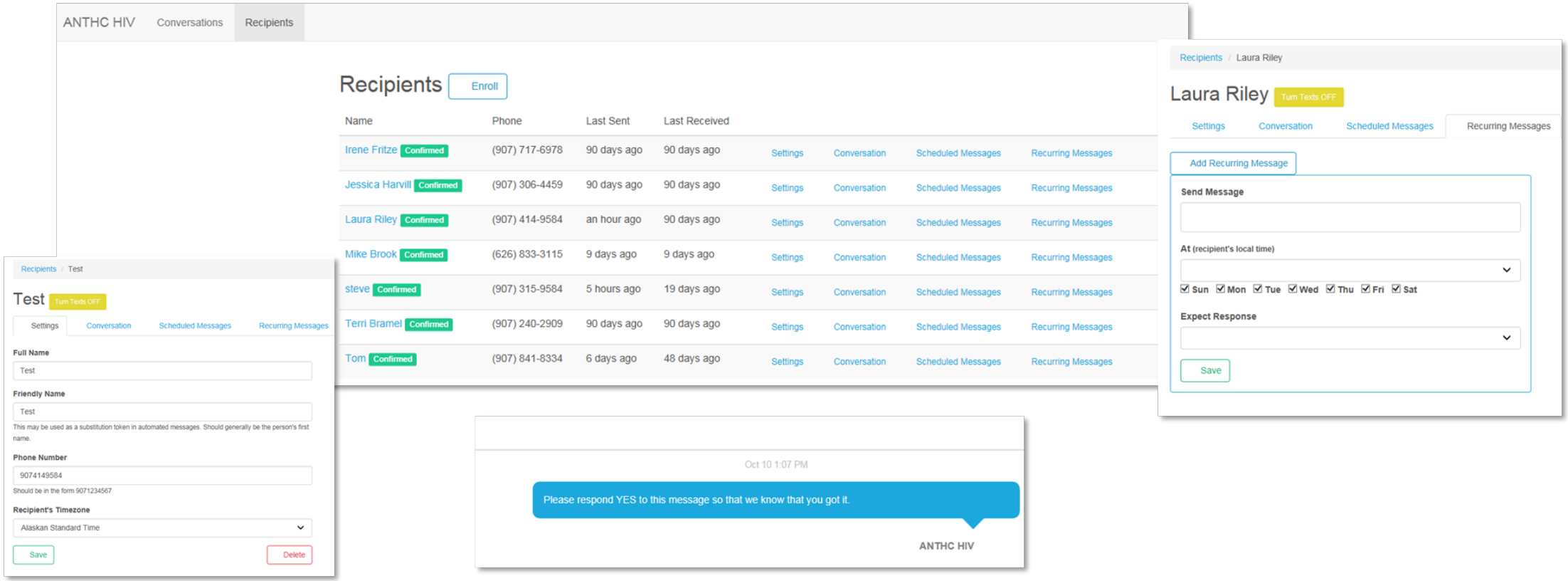
- ❑ Private
- ❑ Easy
- ❑ Did not require data
- ❑ HIPPA compliant and secure
- ❑ Could be tracked
- ❑ Linked to the EIS Care Team
- ❑ Could be used for multiple needs. Appointments, meds

OnTimeText

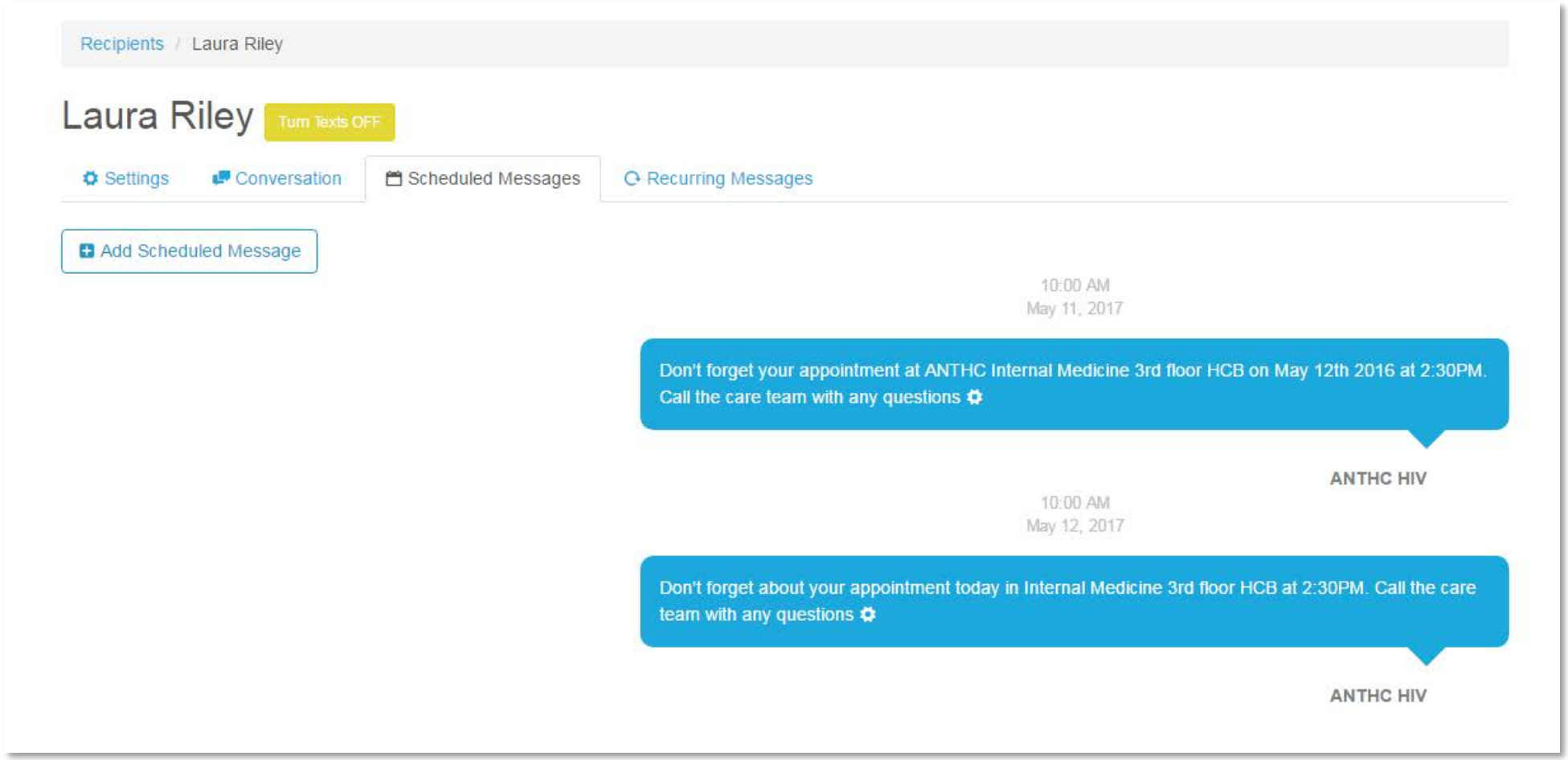
A cloud based text messaging system that allows us to:

- ❑ Enroll patients in an automatized reminder system from a computer- no third party management
- ❑ Set up multiple reminder messages to fit the person-(meds, labs, appointments) to say whatever makes sense to them
- ❑ Require a response after reminder for ‘flagging’ purposes
- ❑ Respond back to a patients in real time
- ❑ Stay secure and HIPPA compliant

What it looks like



How do you set up multiple reminders?



OnTimeText pros over standard medication app

- Generate/edit custom messages and times for meds, labs and appointments
- (assist with continuity and incentives)
- Customize user for a required response once receiving message
- Flags build into the system if response DOES NOT occur
- (this will assist us in being more proactive)
- Care team addressing messages and responses outside of just one person
- Ease of use on care team and patient

How does it stay secure?

- Our system is made up of a set of administrative screens (hosted in Microsoft Azure) for managing messages, recipients, etc., plus functionality to send and receive text messages (via Twilio plus the telecom companies).

- We use SSL certificates, strong password policies, and security auditing to protect our administrative area. In addition, we encrypt all data at rest (recipient information, message logs, etc.) using Microsoft's SQL encryption technologies.

- We realize that it is not possible to guarantee that a patient's cell phone hasn't been compromised or stolen, so we intentionally make outbound messages non-specific with respect to medications and treatments.

- Patients are also asked to sign an RIO during enrollment that lists the functionality of the program

Yea, but how much is it?

- Hosting: ~$50/month, but much cheaper if you can piggyback on some existing infrastructure. I expect ours to be about $10/month.
- - Text messaging (i.e. Twilio): $1/phone number/month + $0.01 per message sent/received
- - Custom domain (optional): ~$10/year
- - SSL certificate (optional, depending on whether a custom domain is used): $70/year
- Development:$5,000 contract with developer

How many people are using this service?

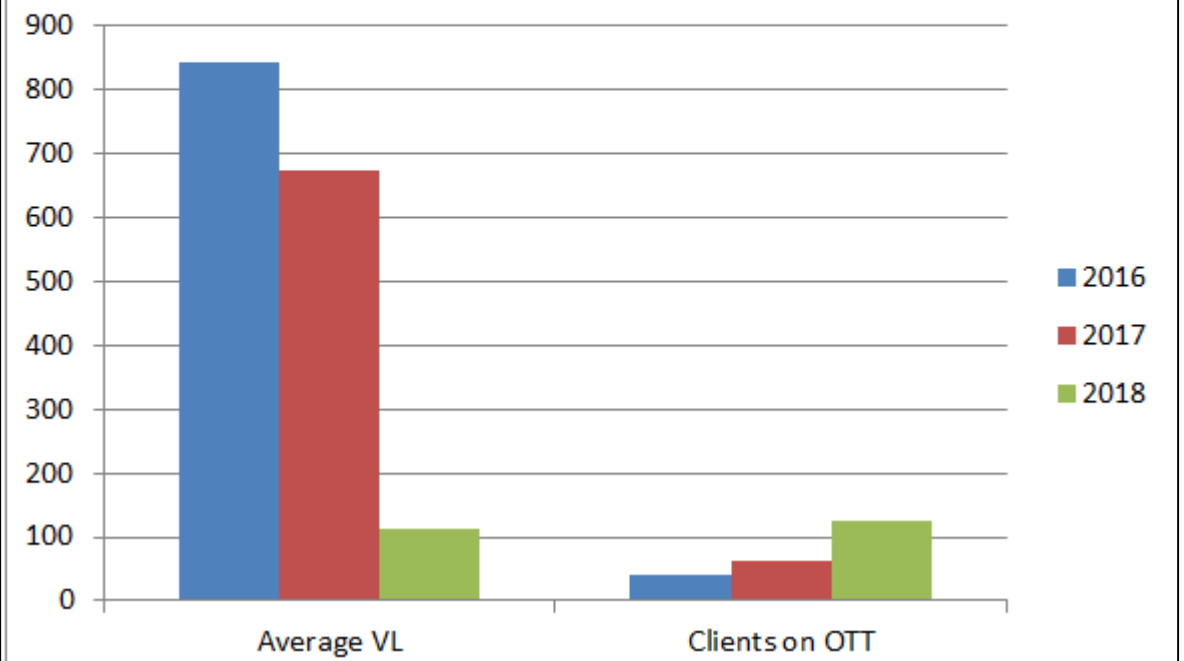
- 124 patients currently enrolled since September, 2016
  - Each patient is customized to a daily reminder, (in some cases 2) and appointment date and times

  - Goal will be to enroll all patients by December 2018
  - New case use for PrEP and PEP- VERY popular for partner services
  - We are also using the system for CAB meeting reminders and group project reminders

Let’s see shall we!

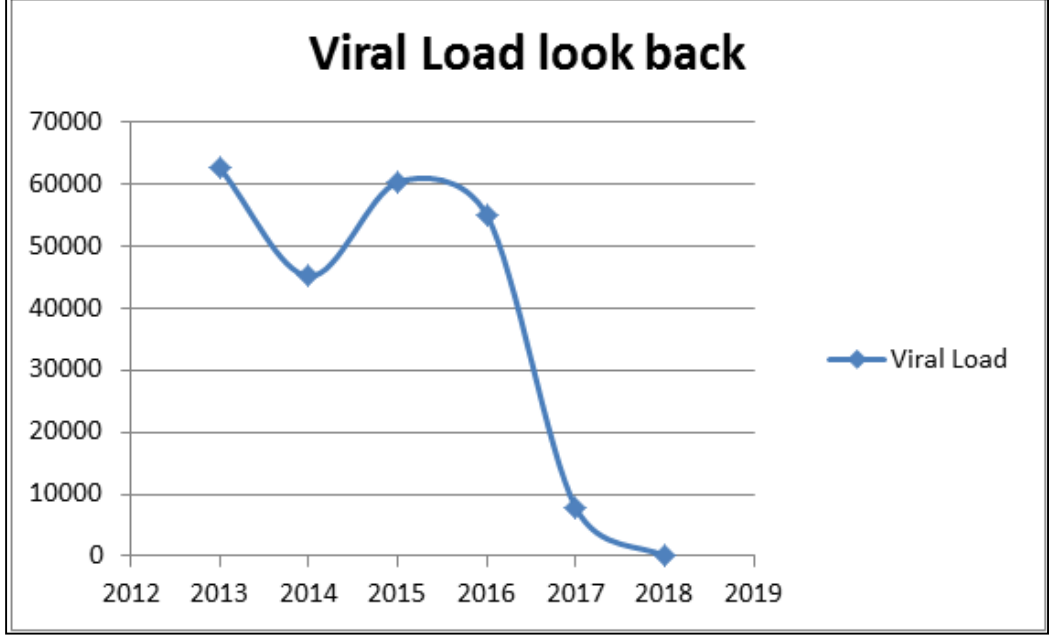
Client data

On Time Text begin late of 2016 with a controlled client population of 40. We notified clients during all appointments and by mailer of this service in 2017 for increased to 62. Thanks to the consumer advisory board and system consistency, we are now up to 124 with a goal of all clients enrolled by 2019.



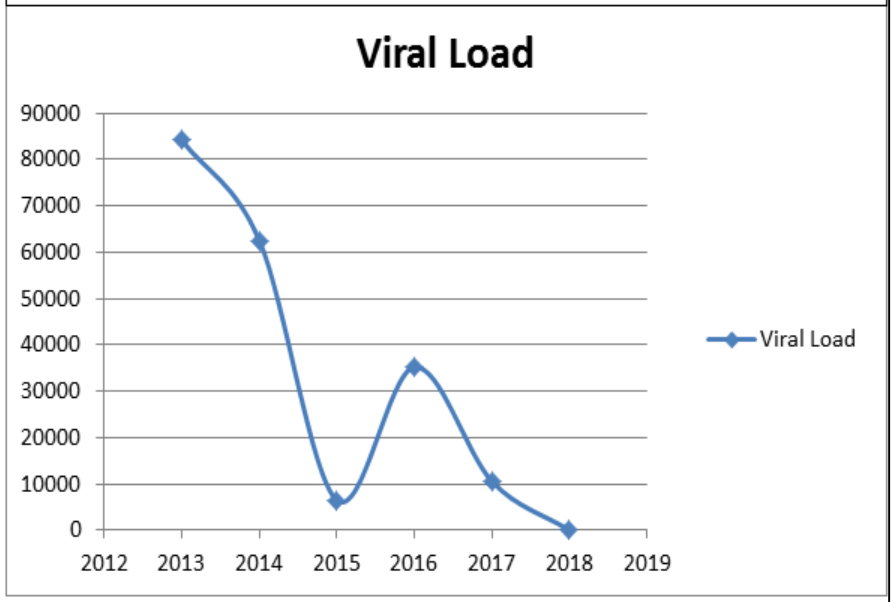
Client data look back

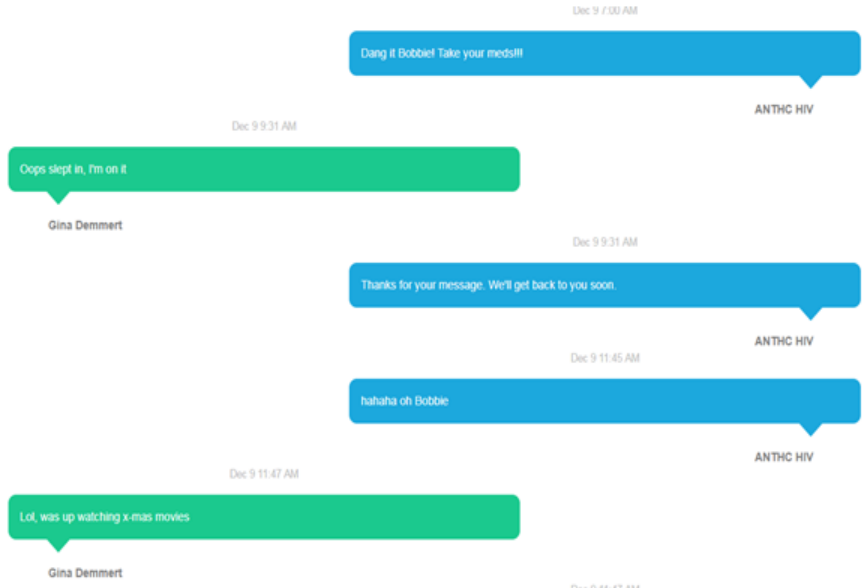
48 Year old male in the Anchorage area living with HIV for over 8 years. Has never achieved viral suppression. Issues with engagement have been unstable housing, transportation issues and missed appointments due to no follow up



Good morning its Wednesday at 9am. Just took my pills. Im doing good. Thank you for this medication reminder and caring about me and Thank you for caring about my heath I love all over u at Early intervention and Internal medicine and big thank u to tor for everything he dose for me and thanks to my doctors.

48 Year old female in the KIC area living with HIV for over 10 years. Has never achieved viral suppression. Issues with engagement have been medication adherence, appointment adherence and disconnect for the HIV/EIS team.





Meet the team!