2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

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Routine Opt-out HIV Screening and Detection of HIV Infection among Emergency Department Patients

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[1]University of Nebraska Medical Center; [2]East Carolina University

Disclosures

I have received grant/research support from Gilead Sciences, Inc.

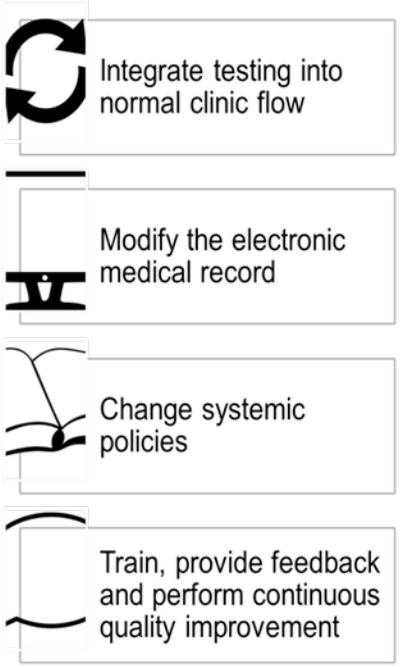
I **do not** intend to discuss off label use of any drug or treatment during this discussion.

Presentation Objectives

- Review rationale for routine HIV testing in various healthcare settings

- Implementation processes using 4 pillars:
  - Routinize HIV screening into normal clinic flow
  - Integrate automated testing with other diagnostic screens
  - Change systemic policies that normalize routine testing and linkage
  - Collect information related to quality improvement and best practices to motivate staff

- Describe lessons learned and review testing results of Vidant Medical Center's Emergency Department & East Carolina University's routine HIV testing program

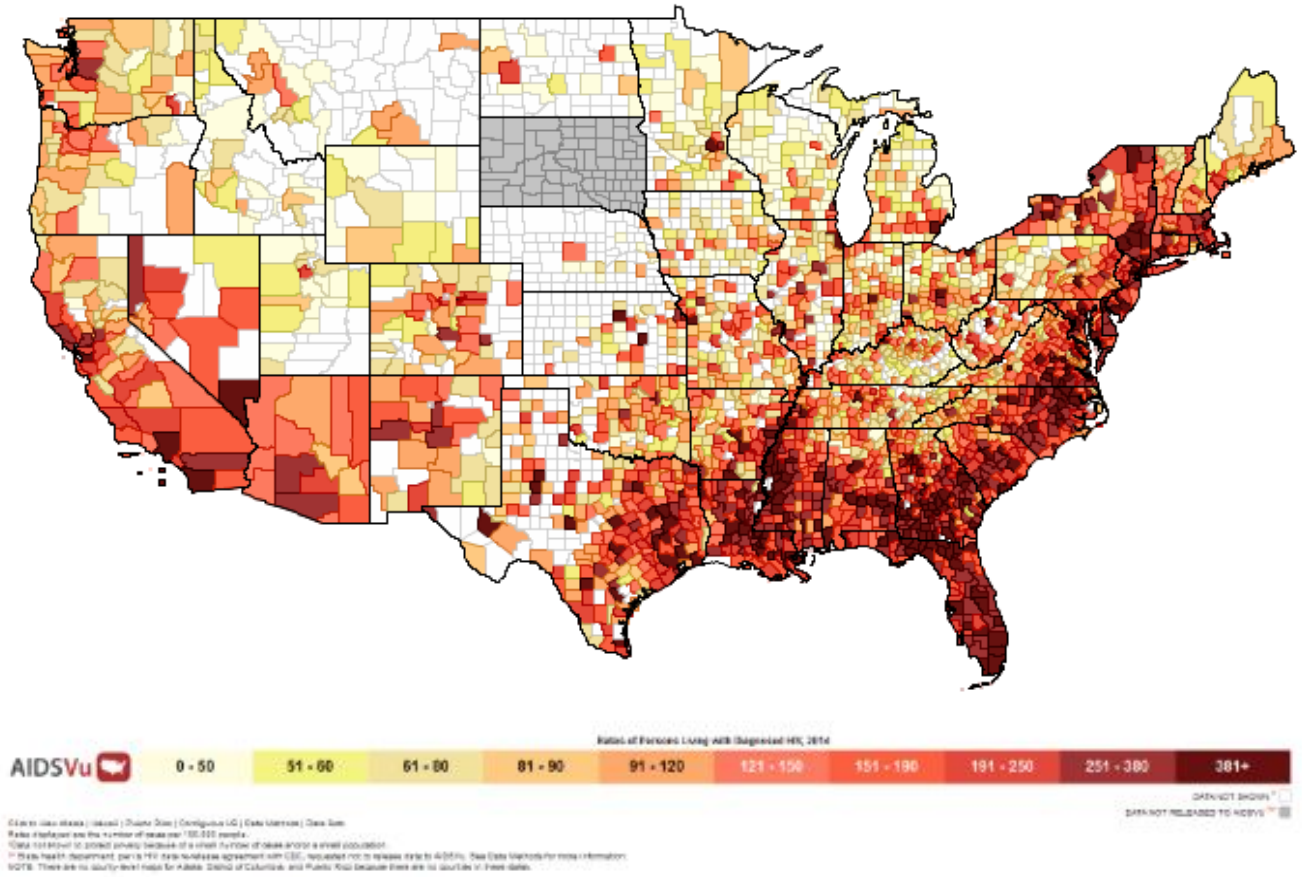


WHO Screening Criteria

- Important health problem for individual & community
- Natural history of disease understood
- Latent or early symptomatic stage
- Acceptable screening test
- Treatment exists & more beneficial if started earlier
- Facilities for diagnosis and treatment available
- Agreed policy on whom to treat
- Cost economically balanced vs. other medical expenditures
- Continuing process

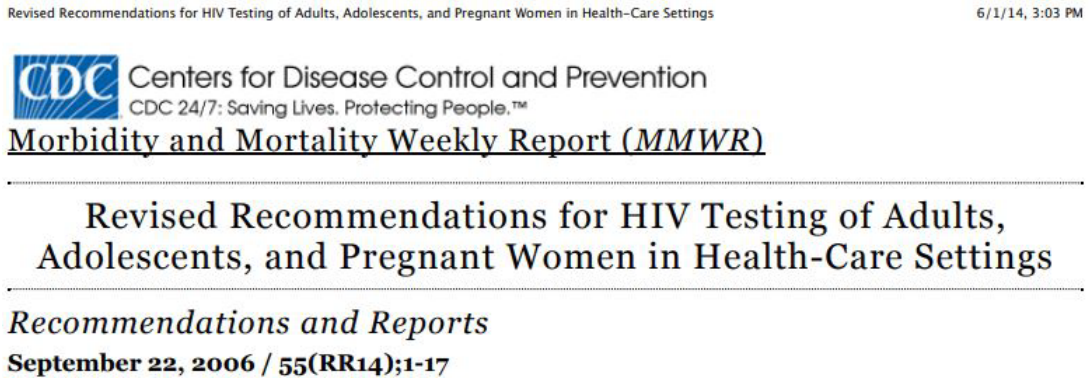
Background of HIV in the U.S.

- Lack of timely testing is a significant contributing factor to the HIV spread and lower quality of healthcare.
- Almost half of all new HIV infections are found in the Southern U.S.
- Routine testing reduces missed opportunities for diagnosis and timely treatment into HIV care and supportive services.



2006 CDC Recommendations

- Routine, opt-out HIV testing of all persons 13-64 years of age in various healthcare settings
- Repeat HIV screening of persons at least annually
- Opt-out HIV screening with opportunity for patient to decline testing
- Include HIV consent with general medical consent for care
- Communicate tests results in similar way as other diagnostic tests
- Prevention counseling not required


Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings 6/1/14, 3:03 PM

CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives. Protecting People.™

Morbidity and Mortality Weekly Report (*MMWR*)

Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings

Recommendations and Reports

September 22, 2006 / 55(RR14);1-17

Rationale: Why the ED?

- CDC recommends routine Opt-out HIV testing at *in all health-care settings.*
- Emergency Department (ED) is one of the high utilization areas for routine medical care for underinsured, uninsured and those undiagnosed or at risk for HIV.
- Missed opportunities for diagnosing Acute HIV infection

Implementing Routine Testing

- ECU and VMC-ED have been implementing targeted testing in 2016
- By the end of 2016, 126 HIV tests were performed in the ED

- 2015 cross-sectional survey among 72 ED providers found:
  - 51 greed that HIV screening in EDs would benefit patients
  - 46 never discussed HIV screening with patient in last 6 months

- Concerns regarding HIV screening included:
  - Encouraging misuse of the emergency department
  - Putting additional strain on limited ED resources
  - Arranging adequate follow up for positive patients
  - Time constraints

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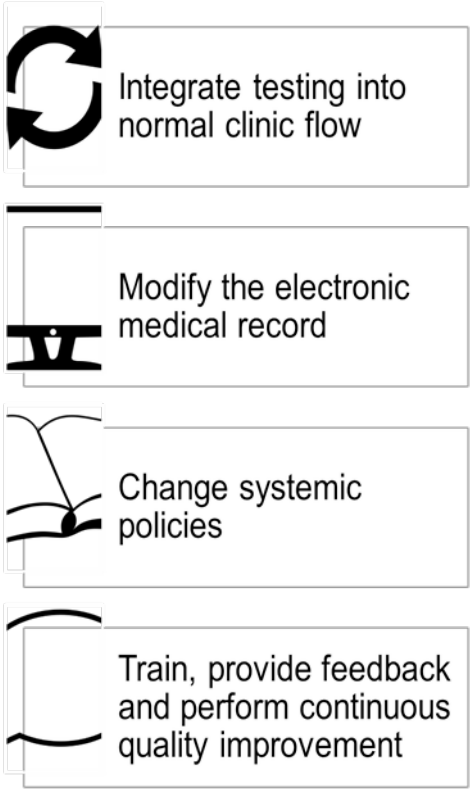
Considerations for Successful Program Development

Program Development

- Key Ingredients for Success:
  - Working within a multidisciplinary team
  - Develop EMR best practice alert or algorithm
  - HIV Consenting Process and opt-out language
  - Automate Testing
  - Seamless Linkage to Care Process



Key Personnel Buy-in

- Develop a working group
  - Medical Directors, ED Directors, and/or Department Chairs
  - Nursing Directors
  - Laboratory Directors or Managers and/or pathologists
  - HIV Clinics
  - Health Department Directors
  - Sponsored Programs/Grants' Directors and/or Departments
  - Ryan White stakeholders

Funding

- Be prepared to write proposals/letters:
  - Insurance Companies
  - Public Health Departments
  - Private Sectors
  - HIV FOCUS Program
  - Centers for Disease Control and Prevention

Protocol Development / Consent / Disclosure

- Develop a testing protocol
- Consent Issues
  - Review state laws as they may apply
  - Be wary of hospital policies that differ from state laws
- Create a script for medical providers who obtain consent
- Disclose test results and develop sustainable process

Script for Testing

HIV Testing Script for Staff

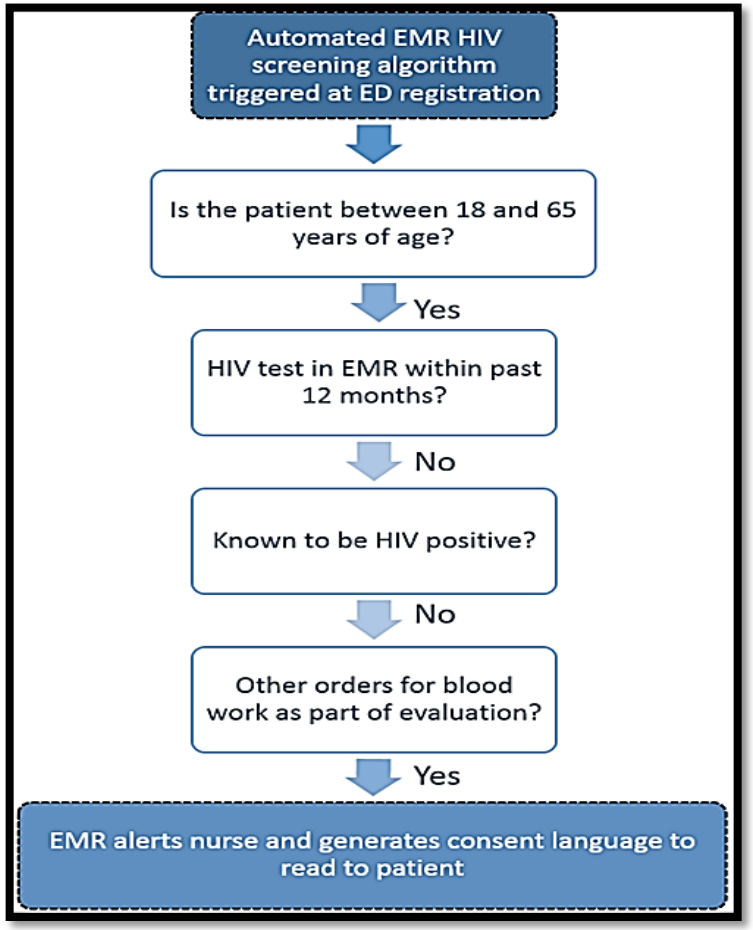
- "As part of our routine blood work, an HIV test will be done during your visit today."
- "Everyone who comes into the ED will be tested for HIV regardless of reason for visit."
- "I see you're having some blood work done today. An HIV test will be done as part of that blood work."

Before blood is drawn, the medical provider informs patients they will be tested unless they decline

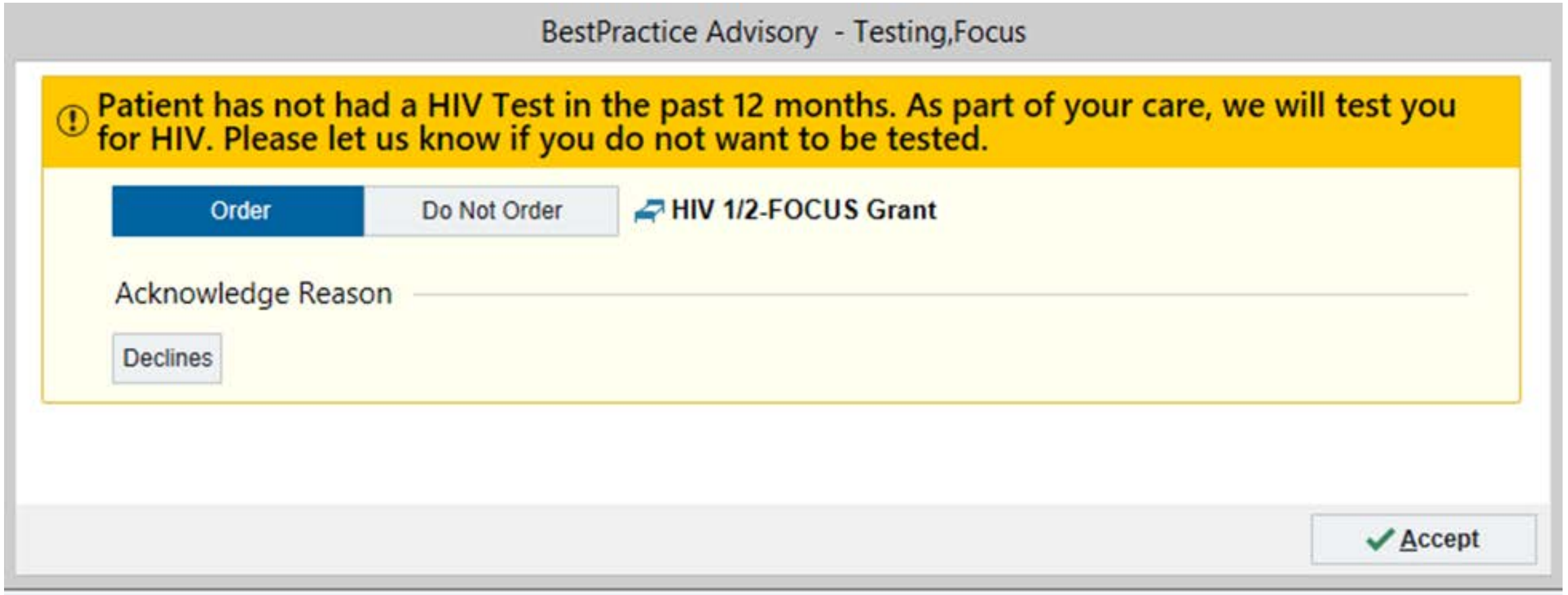
Policy-Driven EMR Algorithm

- Upon patient registration, an EMR algorithm automatically screens patients presenting to the ED for HIV screening eligibility

- <u>Eligibility Criteria:</u>
  - Ages between18-64 years
  - Not known to be HIV positive
  - No history of HIV test documented in EMR within the past 12 months
  - Bloodwork necessary as part of evaluation?



Automated HIV Screen EMR Order



Linkage to Care

- How to do it
  - Prior planning
  - Tight communication system
  - Close tracking of patient

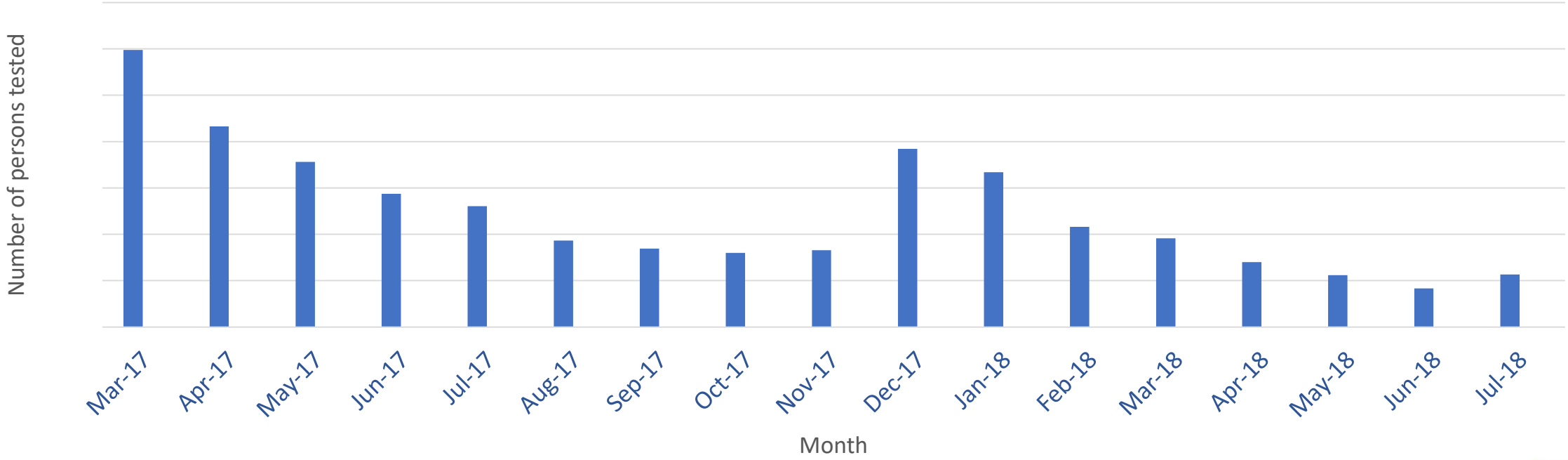
- Successful Linkage included:
  - Prior planning
  - Stakeholder involvement
  - HIV provider visits at or near time of diagnosis
  - Close tracking
  - Multiple phone calls and potential home visits

Key Components for Program Implementation

- Project Lead
- Knowing your data – patient demographics and prevalence
- Buy-in from key personnel
- Staff Education
- Funding
- Consent to test using Opt-Out language
- Testing and disclosure
- Linkage to care

Impact on ED HIV Screening

- HIV testing has increased exponentially due to routine testing compared to total tests provided prior to implementing routine screening program
  - 8,365 total tests performed over first 16 months
  - An average of 523 tests/month



Demographic Characteristics of Patients Testing Positive N = 51*,

3/2/2017 – 07/31/2018

	Newly Diagnosed, n = 21 n (%)	Previously Diagnosed, n = 7 n (%)
Average Age in years *(range)*	39 years *(18-64 years)*	32 years *(24-37 years)*
Male	18 (86)	6 (86)
African-American	19 (91)	7 (100)
MSM[1]	6 (29)	1 (14)
Cisgender	10 (48)	4 (57)
Linked or Re-linked to Care	20 (95)	3 (43)

[1] MSM = men who identify as gay, bisexual or none of the two but have/have had sex with males.

*Remaining persons were already diagnosed and linked to care, but found by EMR alert.

Chief Complaints Reported,
3/2/2017 – 7/31/2018

	# of times complaint reported
Chest/Abdominal pain or discomfort	12
Cough	8
Difficulty Breathing	6
Sore Throat	4
Fever/Chills /Flu-like symptoms	7

Impact on Linkage to Care

- Average of 1-2 new HIV diagnoses/month
- Total HIV+ tests in first 16 months = 51
  - Newly diagnosed = 21
    - Linked to care = 20 or 95%
  - Previously diagnosed = 30
    - Already in care = 23
    - Were out-of-care = 7
      - Total linked = 3 or 43%
      - Reasons patients not linked:
        - 2 refused to be linked or consistently deem “linked” to care
        - 1 incarcerated and 1 in progress to attend appointment after no-showing

Implementation Challenges

- Making HIV matter to everyone
  - Identify a champion team
  - “Train the Trainer” (Champion)
  - Add HIV on grand rounds/medical staff meetings
  - Anticipate debate

Conclusions

- Routine HIV testing is feasible using 2006 CDC guidelines
- EMR algorithm improves testing uptake and prevents disruption of workflow
- Linkage to care is an essential component of a testing program
- Staff buy in is important for programmatic success
- Sustainability of testing is currently under investigation

Next Steps…

- Continue to provide routine HIV testing with necessary changes
  - E.g., our program expanding testing to people as young as 16 years and as mature as 74 years
- Continue to monitor testing throughout program
- Determining the cost-effectiveness of our program is pending
- Add HCV testing with similar testing algorithm as HIV

Champions for Success

- Dr. Timothy Reeder – *ED Director*
- Dr. Nada Fadul – *PI/Ryan White Program Director*
- Dr. Diane Campbell – *Ryan White Program Administrator*
- Kirby Elmore – *Linkage Coordinator*
- Todd Stroud – *IT Lead*
- Richard Baltaro – *Pathology Lab Director*
- Chris Miller – *Pathology Lab Manager*
- Barry White – *Data Manager*
- Ari Mwachofi- *Department of Public Health*
- *ED and Ryan White Staff*

Resources

1. Reif S, et al. State of HIV in the US Deep South. *J Community Health*;2006.

2. Branson BM, et al. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. *MMWR*;2006.

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Optimizing HIV Care Coordination through the Integration of ED Visits in the Care Team Dashboard

Susan Olender, MD[1], Mila C. González[1], MPH, Jesse Thomas[2]

[1]NewYork-Presbyterian Hospital; [2]RDE Systems

Disclosures

I have received grant/research support from Gilead Sciences, Inc.

I **do not** intend to discuss off label use of any drug or treatment during this discussion.

Outline

- Describe process for integrating data within a Team-Based Care Model in the context of Practice Transformation
- Explain how data was utilized optimize HIV care coordination of patients in the Emergency Department (ED)
- Role of RN Care Managers in championing ED workflows to identify and re-engage patients into outpatient care
- Provide lessons learned

NewYork-Presbyterian Hospital's Comprehensive Health Program (CHP)

- Serving Pediatric (including exposed infants and children), Adolescent, Young People, and Adults
- Primary Care, Behavioral Health & Supportive Services
- Hepatitis C Treatment for Co-infected Individuals

- Serving individuals of all ages at risk of HIV infection
- STI Testing (including HIV & Hepatitis C)
- PrEP, PEP, Primary Care, Mental Health & Supportive Services

- Targeting individuals with Hepatitis C mono-infection
- Mental Health & Supportive Services while in Treatment
- Transition to Primary Care

In 2017, **NYP served 2,966 clients living with HIV** from New York City's Upper Manhattan and the Bronx

Funding for Programs:

HRSA

NYC Health

New York State Department of Health

GILEAD

Figure 1. New York City Map.

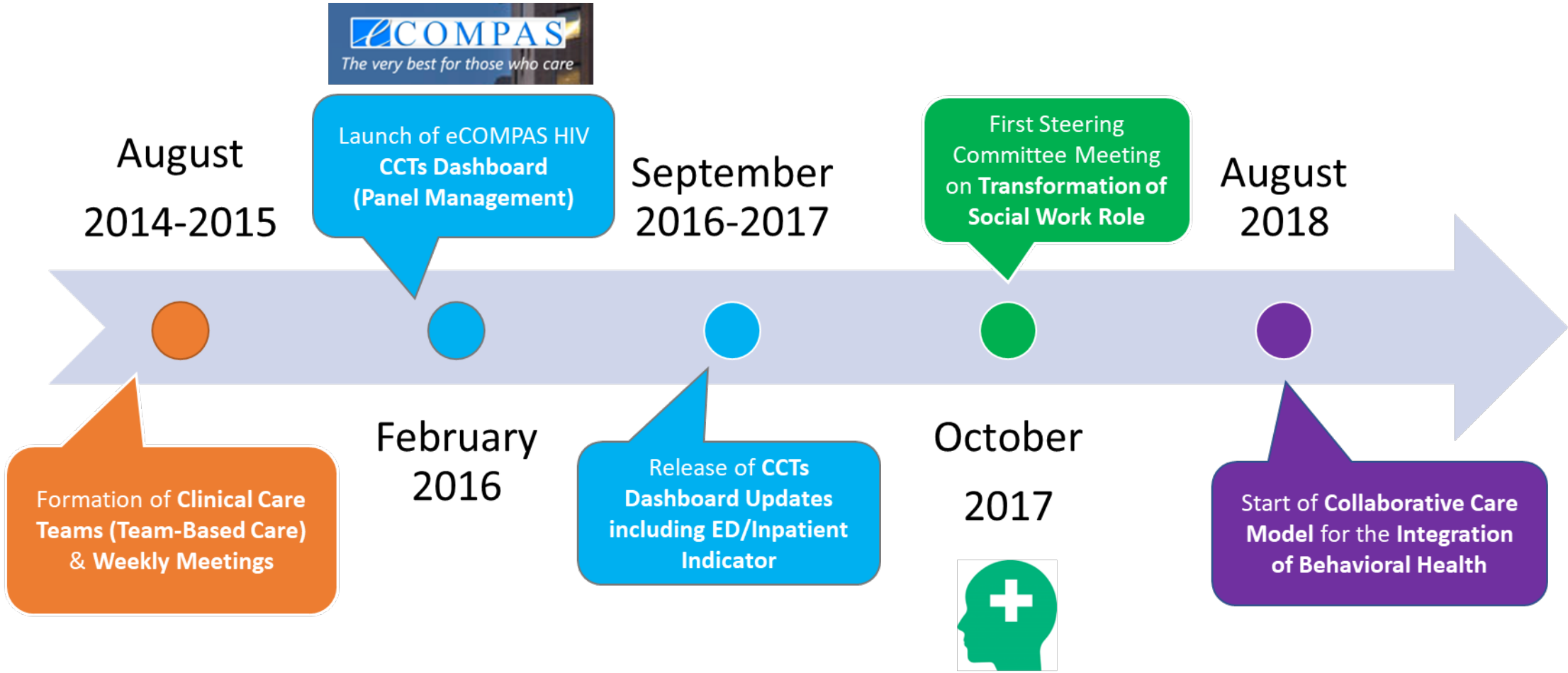
SPNS Workforce Initiative: 2014-2018

- Multi-site initiative with 15 demonstration sites across the United States funded to design, implement, evaluate, and disseminate a "Practice Transformation Models"
- NYP's Comprehensive Health Program (CHP) was selected as demonstration site
- Developed the "Stimulating Transformation of Technology and Team Structure to Reach People Living with HIV" (STaR) Project

SPNS Workforce Initiative: 2014-2018

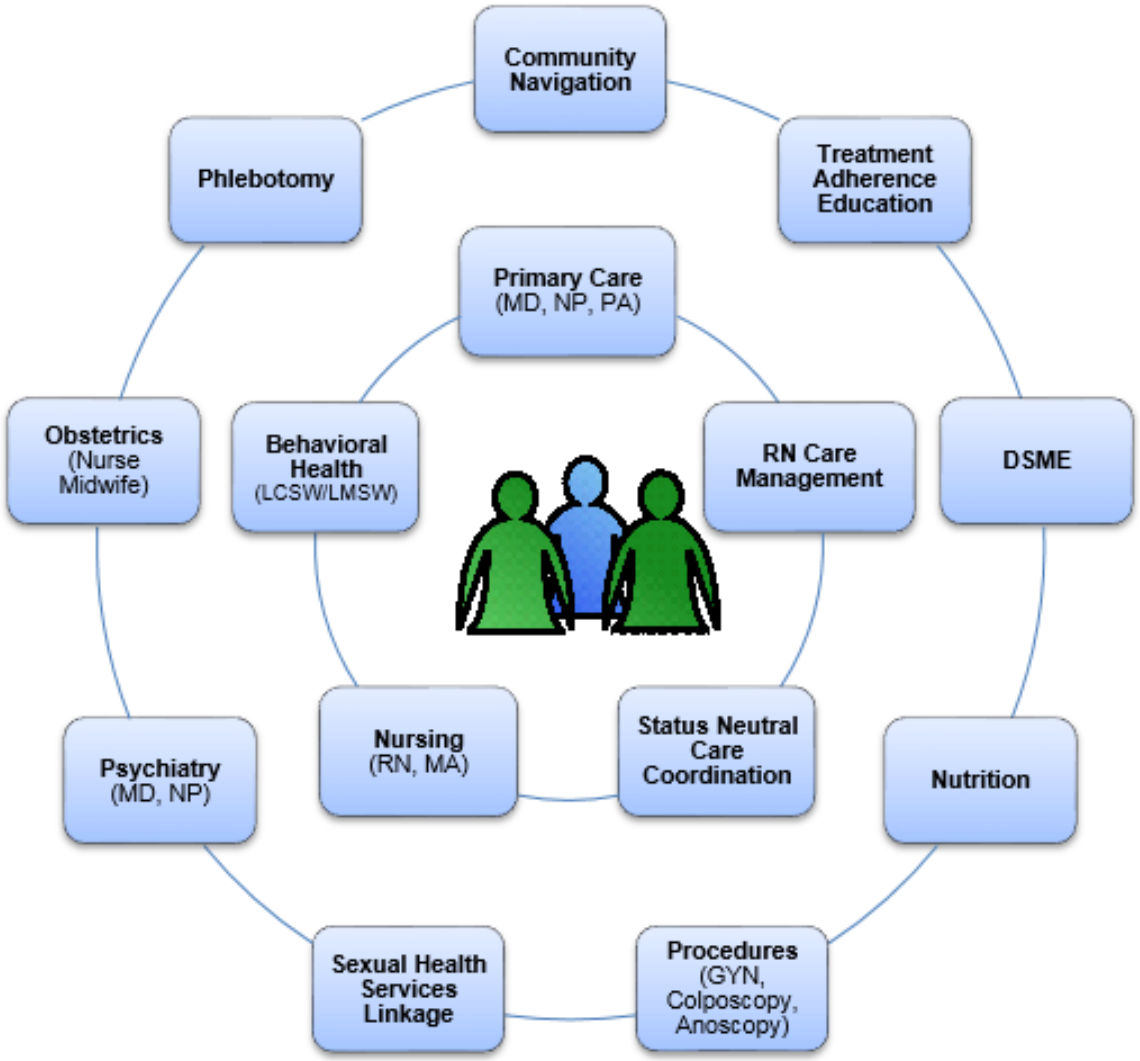
- The STaR Project "Practice Transformation Model" consisted of:
  - System level staffing changes heavily based on Patient Centered Medical Home (PCMH) standards
  - Improvements to Practice's capacity to care for people living with HIV, valuing efficiency and sustainability
  - Optimization of resources in changing landscape
  - Quality improvement efforts aimed at increasing the rates of linkage, engagement, retention in care, and viral load suppression

STaR's Practice Transformation



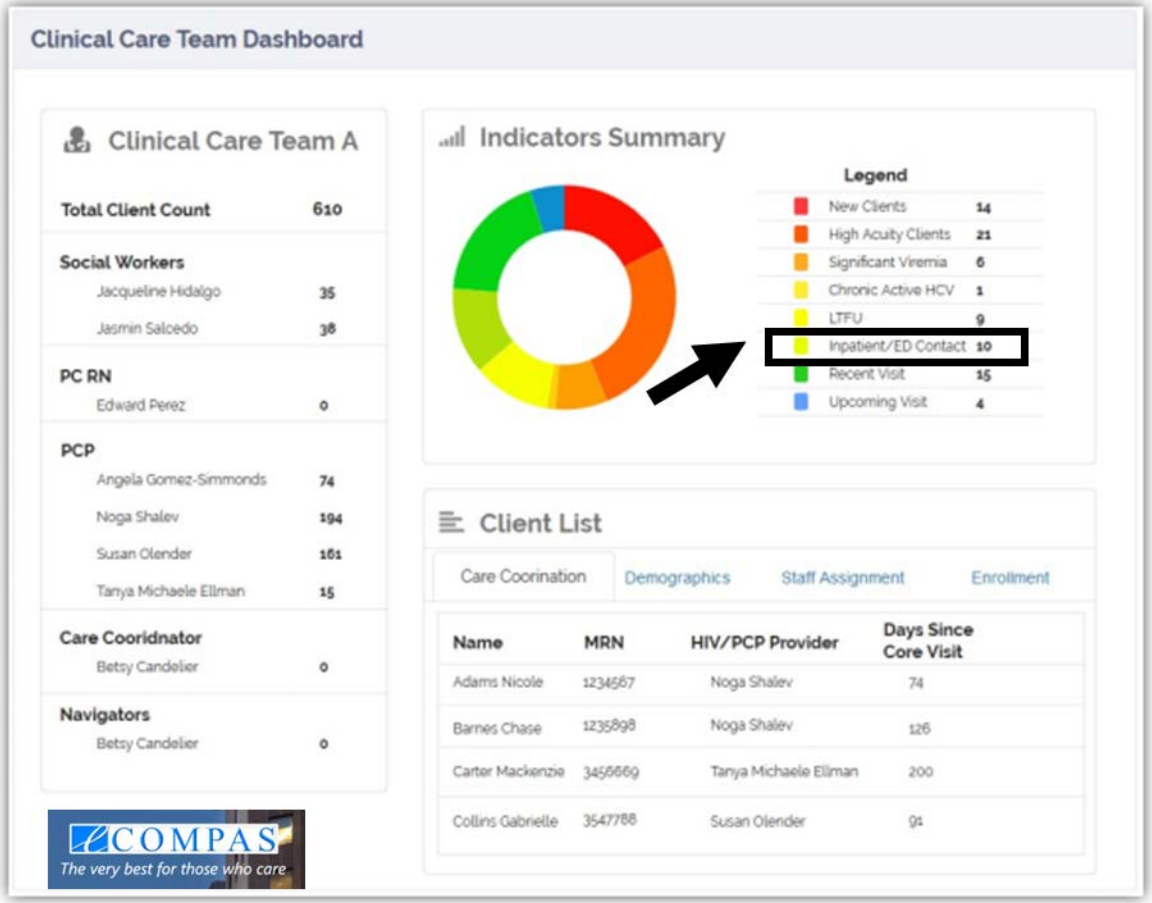
Imagine Credit: RDE Systems; Github.

Team Based Care Coordination Model



Data-Driven Panel Management Under Practice Transformation

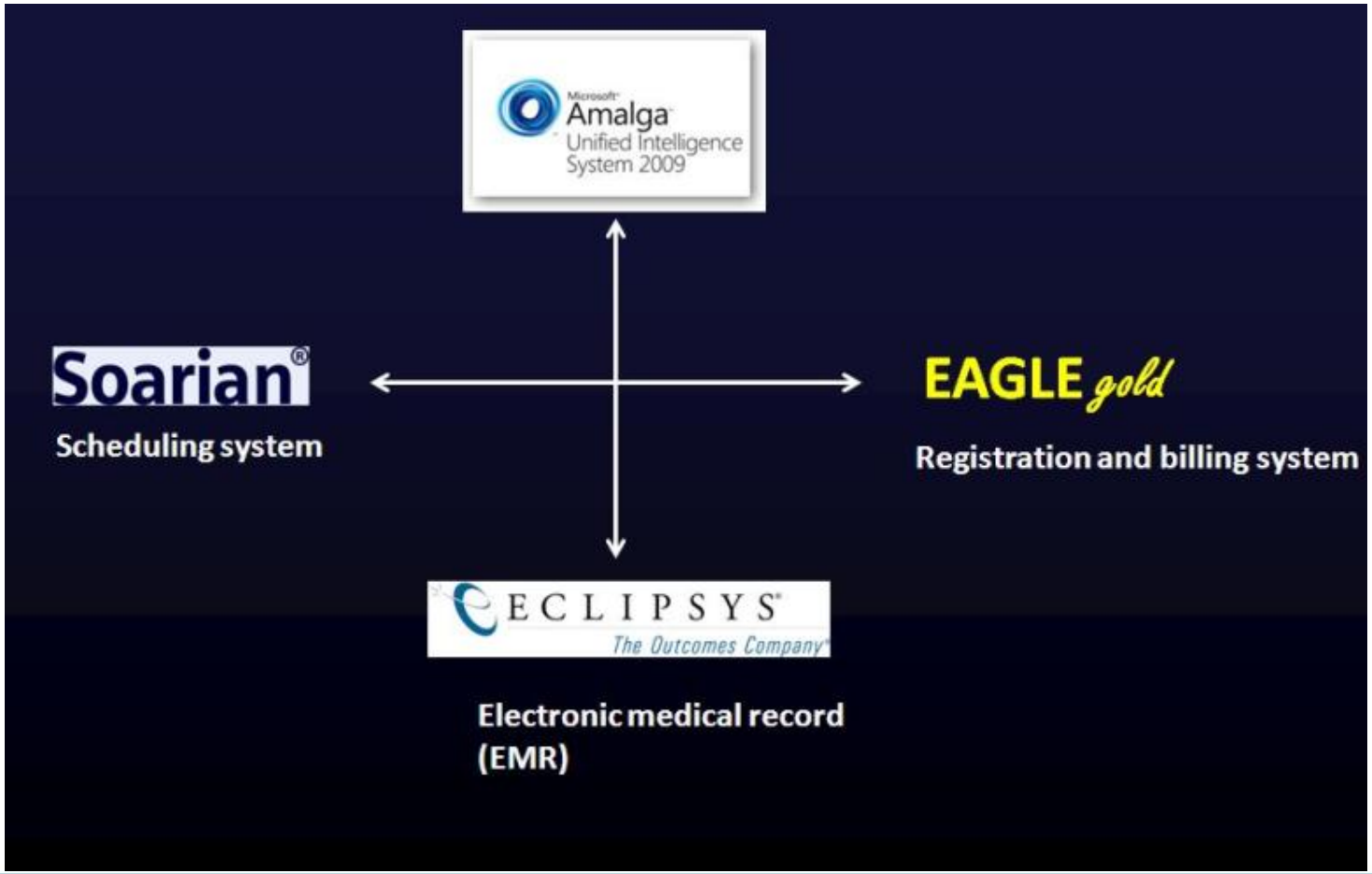
- Facilitated through *eCOMPAS Clinical Care Team Dashboard*
- Review of panel Quality data at weekly inter-disciplinary care team meetings
- Advantages:
  - Allows for expertise from all disciplines and roles
  - Optimization of resources to reach patients across settings for linkage & retention, reducing hospitalizations, etc.



Deeper dive into HIT & HIE

A Measure of the challenge…

The 'Medical Record' is typically an amalgamation of multiple electronic systems, tied together by an IT network that exchanges information –a form of Health Information Exchange



How much data?

- **NYP/Columbia must track and manage over 800,000 data elements annually for grant and regulatory reporting purposes:**

- ❑ HRSA, NYC DOHMH, AIDS Institute, CDC RSR, AIRS, eSHARE
- ❑ 95 ‘users’ who need to contribute, add, manage, and export data

COMPREHENSIVE HIV PROGRAM (CHP)

ADULT PROGRAM | **WOMEN AND CHILDREN CARE CENTER** | **PROJECT STAY**

- 1800 individuals LWH
- Multidisciplinary, multifunctional, and evolving
- 2 clinical care sites, 2 community based care coordination sites, street level outreach efforts

RW support:
- Part A
- Part B
- Part D
- Part F

Data
Data
Data
Data
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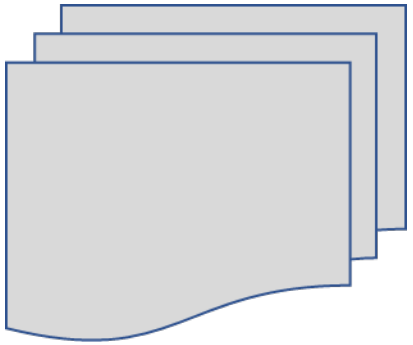
Data

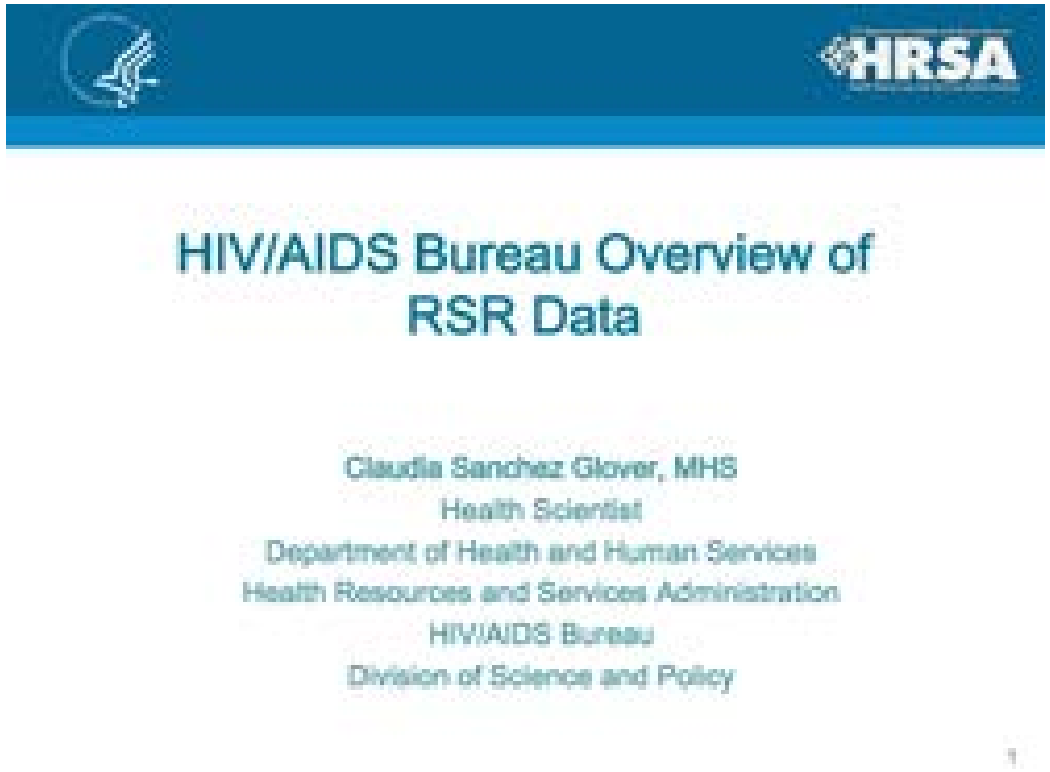
- RSR
- Patient Care (!)
- QA/QI
- Other grant and regulatory reporting



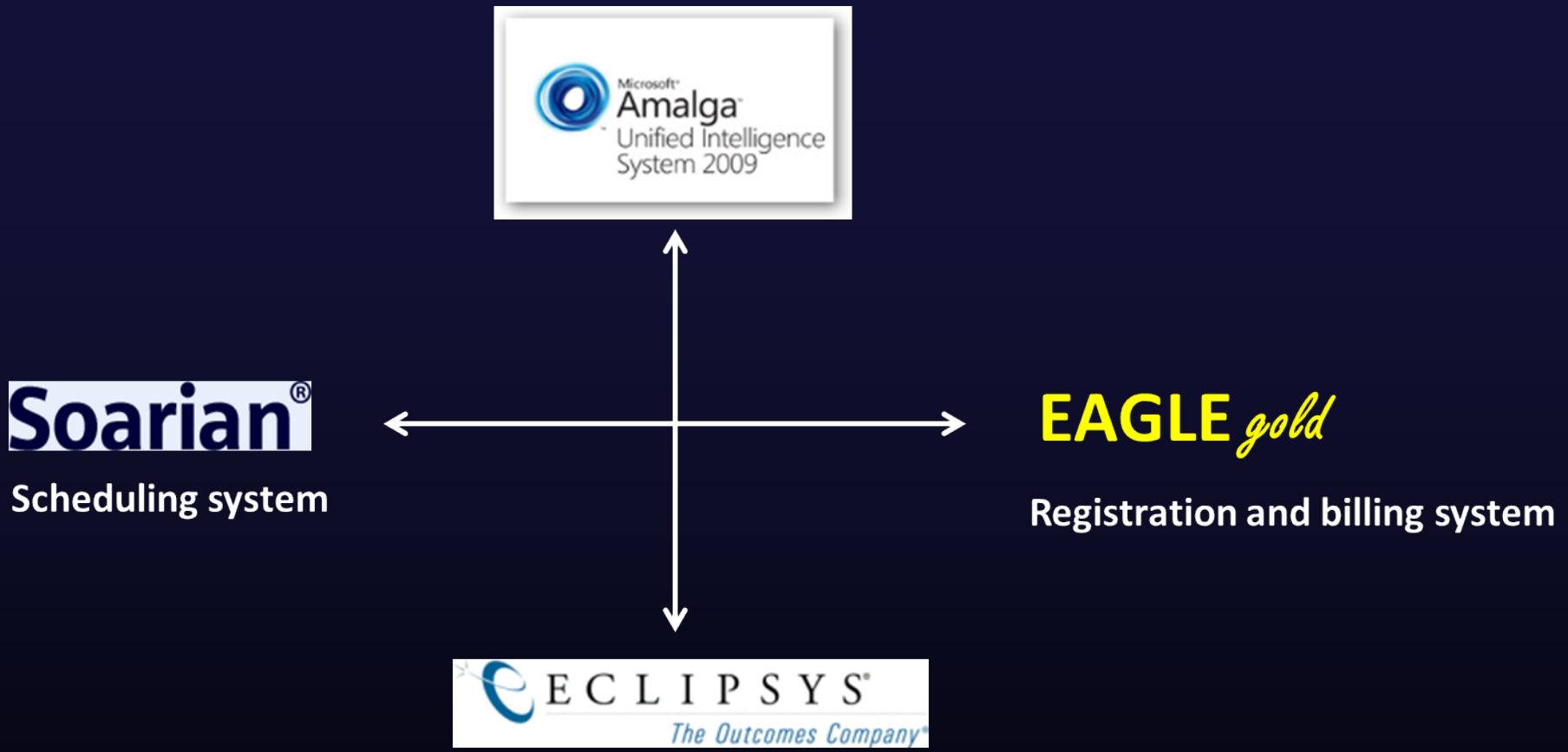
- Where does the information come from in *your* program?
- How much data?
- What is the data?

What is the data?

- *Demographic*
- *Services*
- *Clinical*
- *Care Coordination*



A typical workflow process at NYP/Columbia for how a patient gets scheduled, registered, documented in an EMR, and billed.



Microsoft Amalga Unified Intelligence System 2009

Soarian®

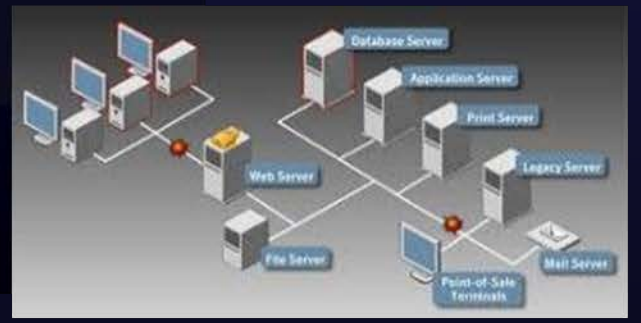
Scheduling system

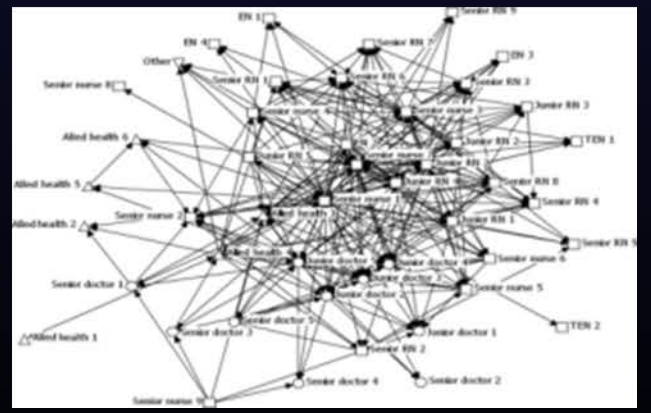
EAGLE *gold*

Registration and billing system

ECLIPSYS
The Outcomes Company

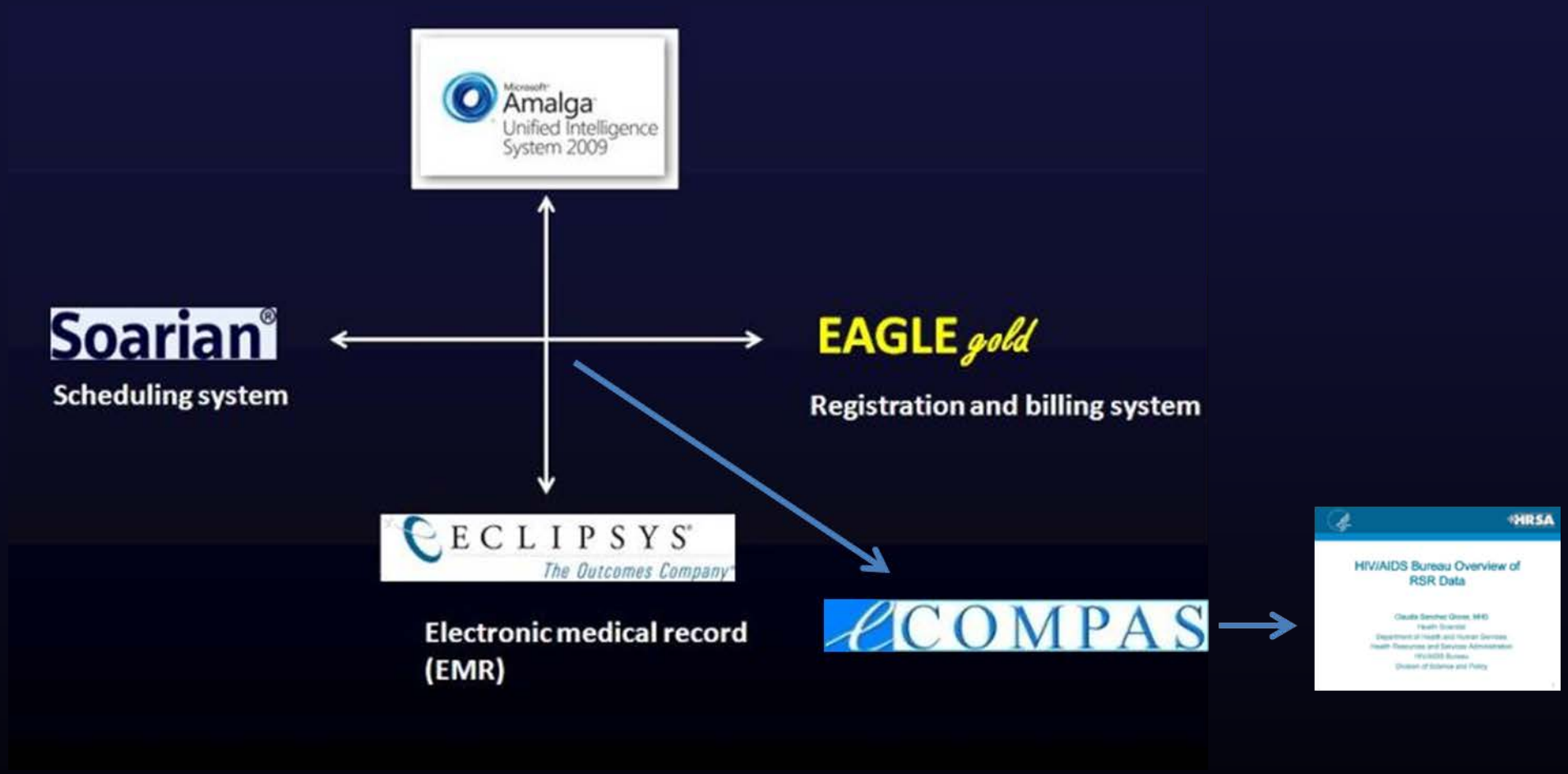
Electronic medical record (EMR)

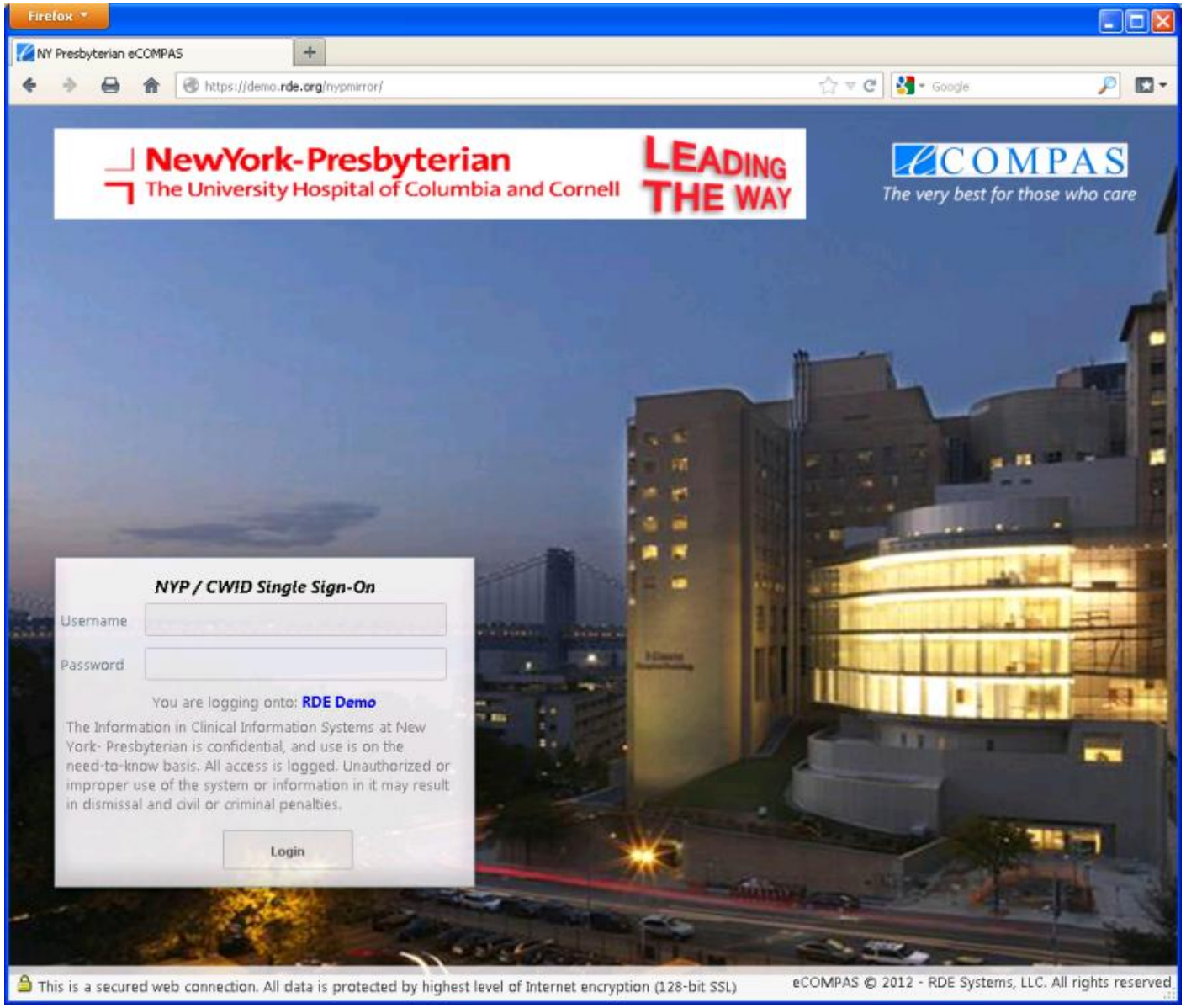




The eCOMPAS Approach

This is the way NYP/Columbia is making it work in the 'real' world of competing institutional priorities

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Google
NewYork-Presbyterian
The University Hospital of Columbia and Cornell
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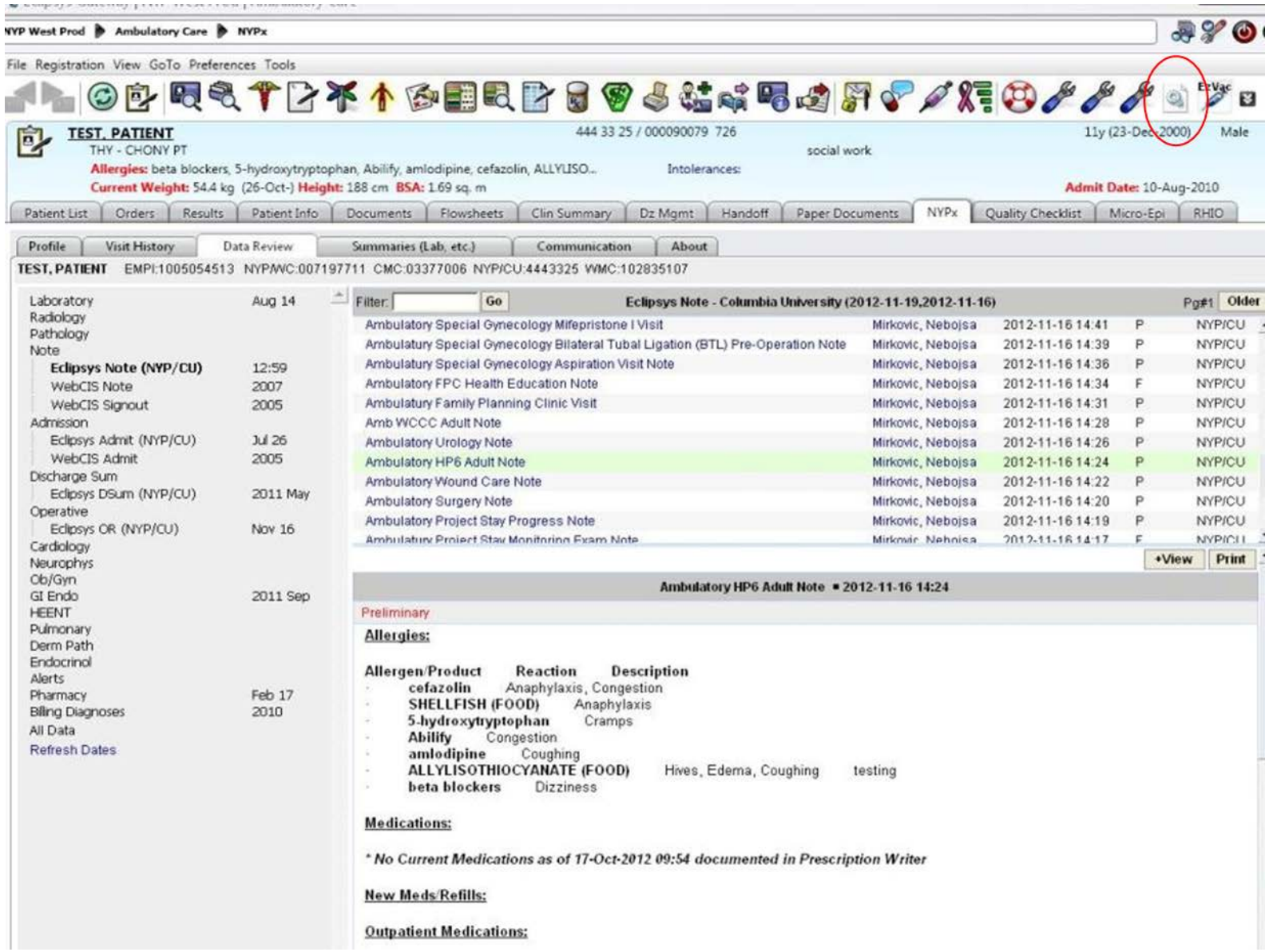
COMPAS
The very best for those who care
NYP / CWID Single Sign-On
Username
Password
You are logging onto: RDE Demo
The Information in Clinical Information Systems at New York- Presbyterian is confidential, and use is on the need-to-know basis. All access is logged. Unauthorized or improper use of the system or information in it may result in dismissal and civil or criminal penalties.
Login
This is a secured web connection. All data is protected by highest level of Internet encryption (128-bit SSL)
eCOMPAS © 2012 - RDE Systems, LLC. All rights reserved


NYP West Prod ▶ Ambulatory Care ▶ NYPx
File Registration View GoTo Preferences Tools
TEST, PATIENT
THY - CHONY PT
444 33 25 / 000090079 726
social work
11y (23-Dec-2000) Male
Allergies: beta blockers, 5-hydroxytryptophan, Abilify, amlodipine, cefazolin, ALLYLISO..
Intolerances:
Current Weight: 54.4 kg (26-Oct-) Height: 188 cm BSA: 1.69 sq. m
Admit Date: 10-Aug-2010
Patient List | Orders | Results | Patient Info | Documents | Flowsheets | Clin Summary | Dz Mgmt | Handoff | Paper Documents | NYPx | Quality Checklist | Micro-Epi | RHIO
Profile | Visit History | Data Review | Summaries (Lab, etc.) | Communication | About
TEST, PATIENT EMPI:1005054513 NYP/WC:007197711 CMC:03377006 NYP/CU:4443325 WMC:102835107
Laboratory Aug 14
Radiology
Pathology
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Operative
Eclipsys OR (NYP/CU) Nov 16
Cardiology
Neurophys
Ob/Gyn
GI Endo 2011 Sep
HEENT
Pulmonary
Derm Path
Endocrinol
Alerts
Pharmacy Feb 17
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Eclipsys Note - Columbia University (2012-11-19,2012-11-16)
Pg#1 Older
Ambulatory Special Gynecology Mifepristone I Visit Mirkovic, Nebojsa 2012-11-16 14:41 P NYP/CU
Ambulatory Special Gynecology Bilateral Tubal Ligation (BTL) Pre-Operation Note Mirkovic, Nebojsa 2012-11-16 14:39 P NYP/CU
Ambulatory Special Gynecology Aspiration Visit Note Mirkovic, Nebojsa 2012-11-16 14:36 P NYP/CU
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Amb WCCC Adult Note Mirkovic, Nebojsa 2012-11-16 14:28 P NYP/CU
Ambulatory Urology Note Mirkovic, Nebojsa 2012-11-16 14:26 P NYP/CU
Ambulatory HP6 Adult Note Mirkovic, Nebojsa 2012-11-16 14:24 P NYP/CU
Ambulatory Wound Care Note Mirkovic, Nebojsa 2012-11-16 14:22 P NYP/CU
Ambulatory Surgery Note Mirkovic, Nebojsa 2012-11-16 14:20 P NYP/CU
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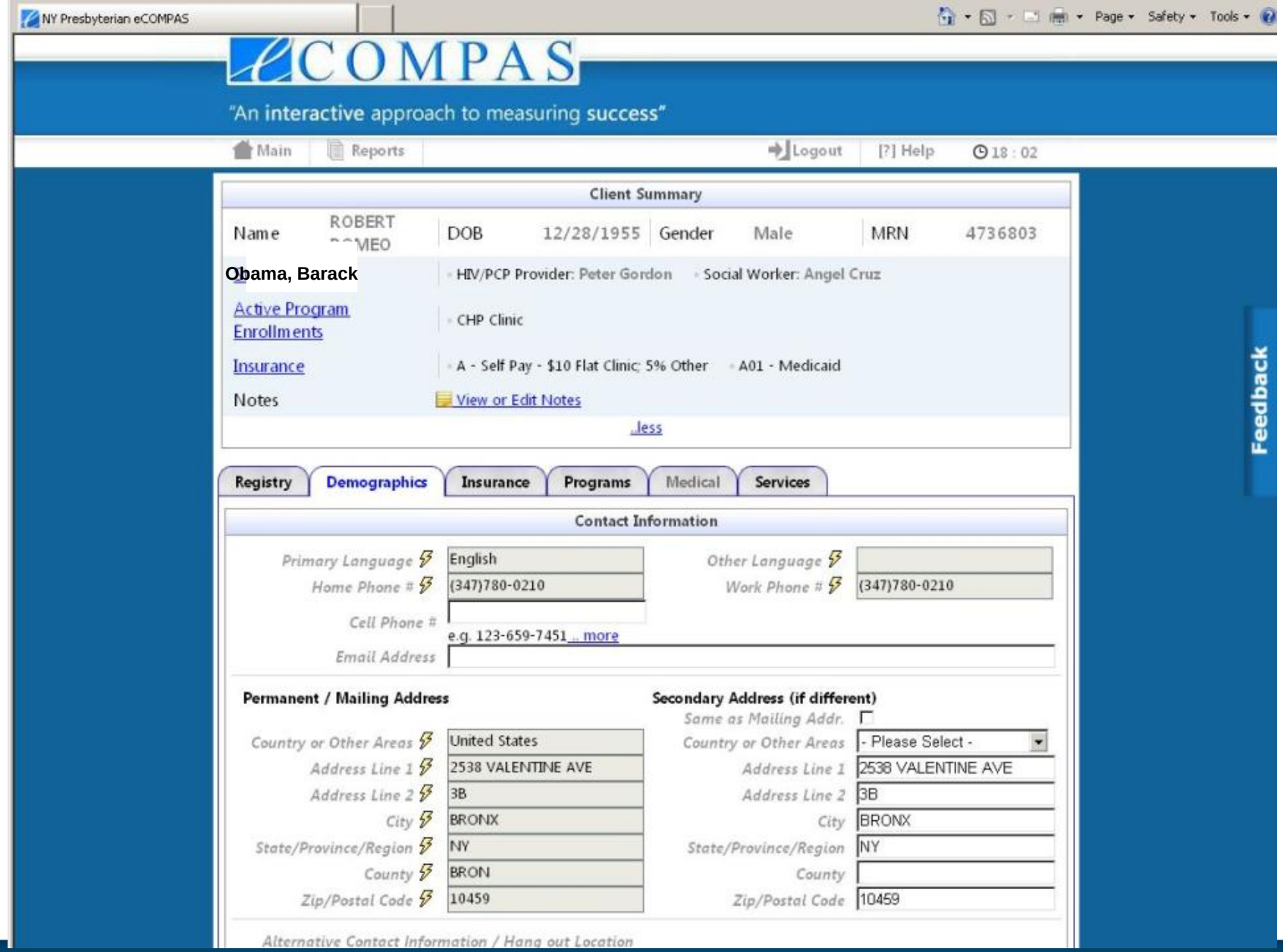
Ambulatory Project Stay Monitoring Exam Note Mirkovic, Nebojsa 2012-11-16 14:17 F NYP/CU
+View Print
Ambulatory HP6 Adult Note ▪ 2012-11-16 14:24
Preliminary
Allergies:
Allergen/Product Reaction Description
cefazolin Anaphylaxis, Congestion
SHELLFISH (FOOD) Anaphylaxis
5-hydroxytryptophan Cramps
Abilify Congestion
amlodipine Coughing
ALLYLISOTHIOCYANATE (FOOD) Hives, Edema, Coughing testing
beta blockers Dizziness
Medications:
* No Current Medications as of 17-Oct-2012 09:54 documented in Prescription Writer
New Meds/Refills:
Outpatient Medications:


NY Presbyterian eCOMPAS
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eCOMPAS
"An interactive approach to measuring success"
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18 : 02
Client Summary
Name ROBERT MEO
DOB 12/28/1955
Gender Male
MRN 4736803
Obama, Barack
HIV/PCP Provider: Peter Gordon
Social Worker: Angel Cruz
Active Program Enrollments
CHP Clinic
Insurance
A - Self Pay - $10 Flat Clinic; 5% Other
A01 - Medicaid
Notes
View or Edit Notes
..less
Registry
Demographics
Insurance
Programs
Medical
Services
Contact Information
Primary Language English
Other Language
Home Phone # (347)780-0210
Work Phone # (347)780-0210
Cell Phone #
e.g. 123-659-7451 ... more
Email Address
Permanent / Mailing Address
Secondary Address (if different)
Same as Mailing Addr.
Country or Other Areas United States
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Address Line 2 3B
City BRONX
State/Province/Region NY
County BRON
Zip/Postal Code 10459
Country or Other Areas - Please Select -
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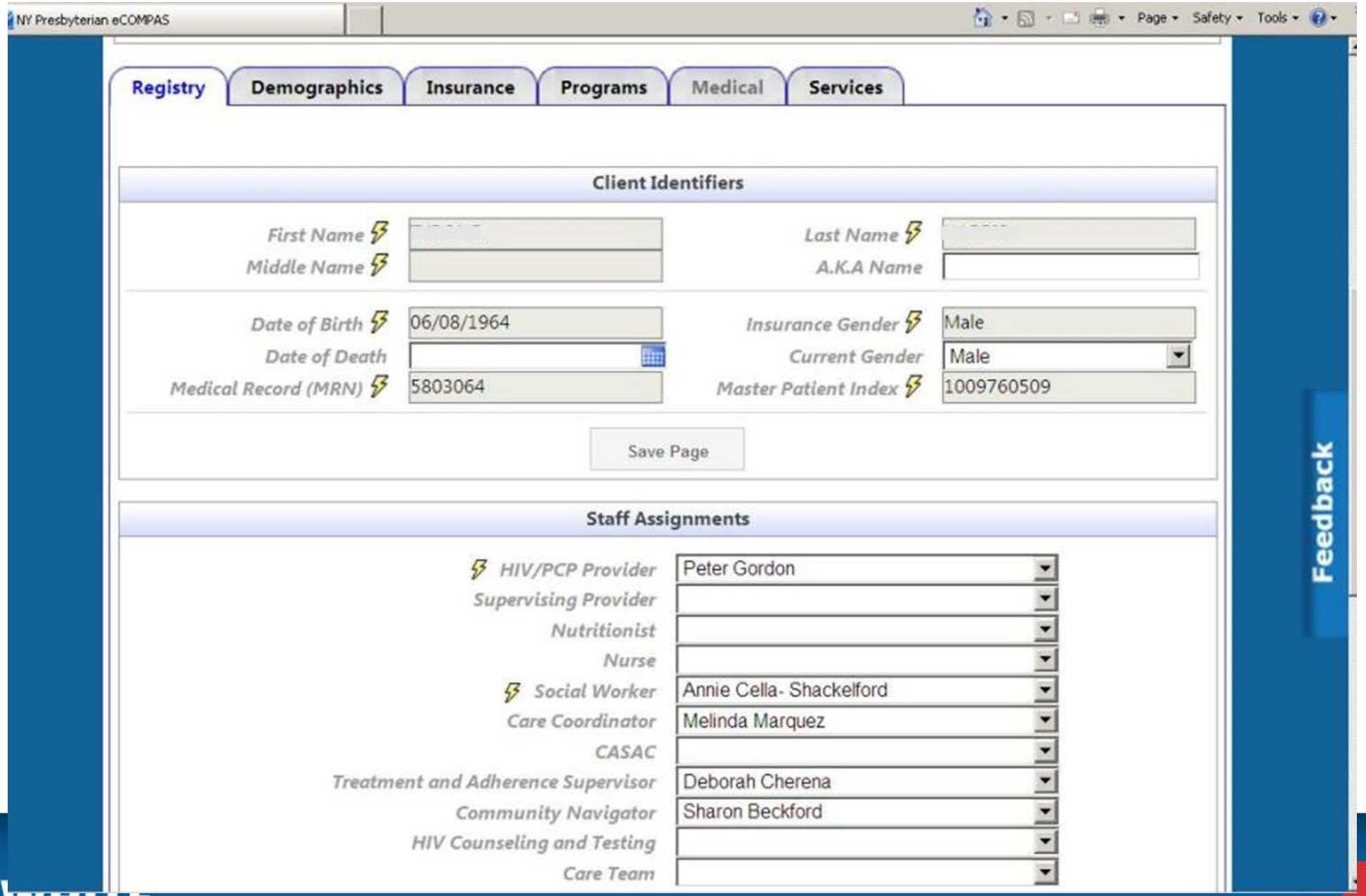
Feedback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Services
Client Identifiers
First Name
Middle Name
Last Name
A.K.A Name
Date of Birth
06/08/1964
Date of Death
Medical Record (MRN)
5803064
Insurance Gender
Male
Current Gender
Male
Master Patient Index
1009760509
Save Page
Staff Assignments
HIV/PCP Provider
Peter Gordon
Supervising Provider
Nutritionist
Nurse
Social Worker
Annie Cella- Shackelford
Care Coordinator
Melinda Marquez
CASAC
Treatment and Adherence Supervisor
Deborah Cherena
Community Navigator
Sharon Beckford
HIV Counseling and Testing
Care Team
Feedback

So what is the impact of this kind of HIE on NYP/Columbia's program?

Time

Reporting

Data Quality

Population Management

Time and Data Management: The Potential Impact of HIE

NYP/Columbia must track and manage over 800,000 data elements annually for grant and regulatory reporting purposes:

- HRSA, NYC DOHMH, AIDS Institute, CDC
- RSR, AIRS, eSHARE
- 95 'users' who need to contribute, add, manage, and export data

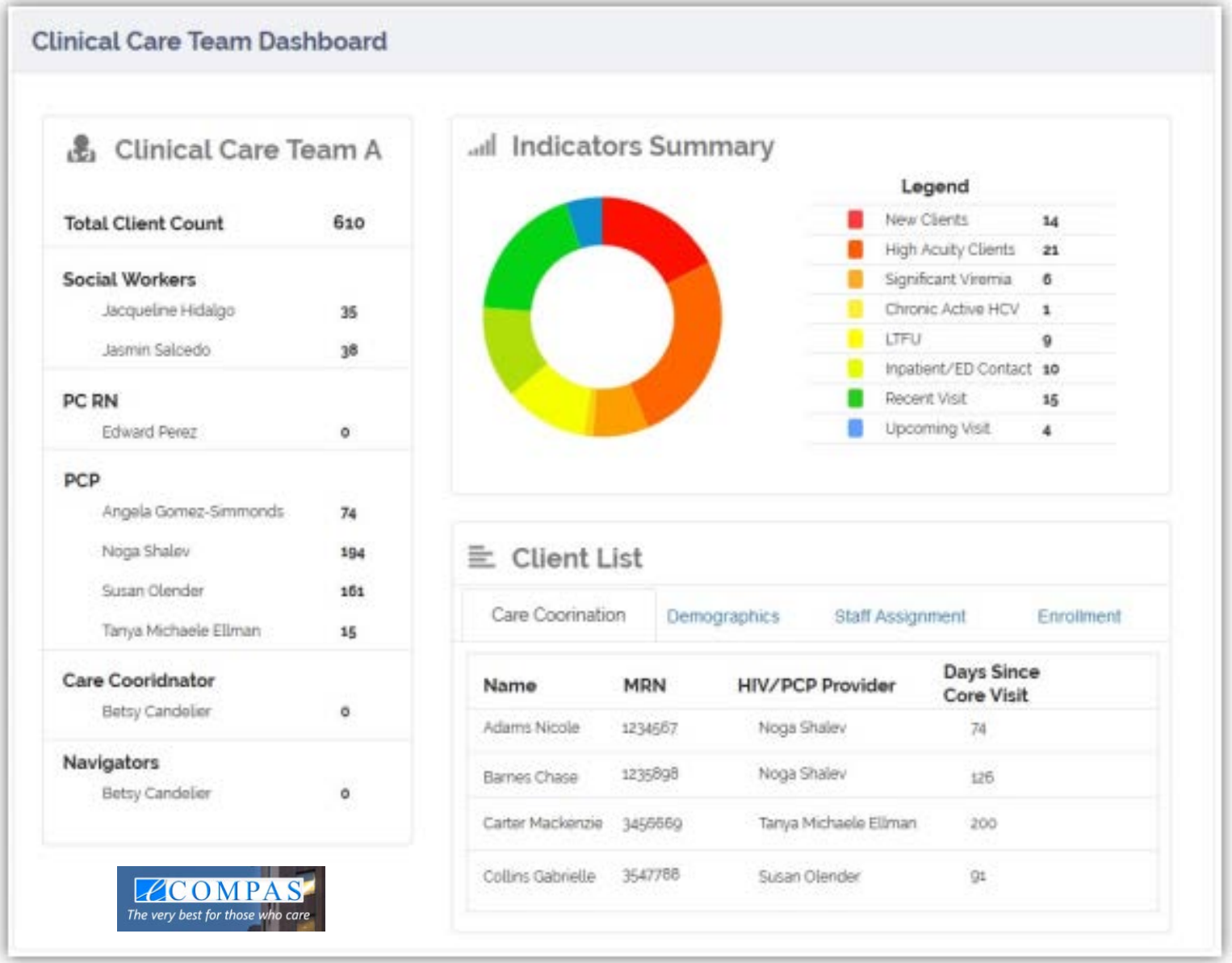
How utilizing HIE and implementing e*COMPAS* has impacted

- **125,293,634** data elements updated/added via HIE since March 2012 (demographics, visits/services, staff assignment)
- **1000+** hours of data entry saved (very conservative)

Benefit 1

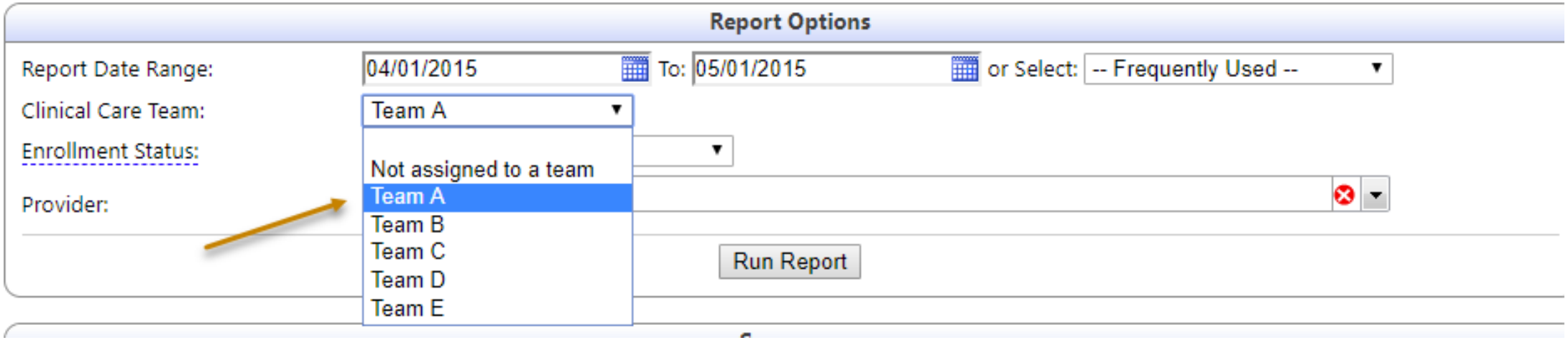
Feature: Integration of Health Information Technology (HIT) for Population Health Management

Benefit: Time saving. Data from different hospital systems are pulled into eCOMPAS thus making it a single stop for all client information.


Clinical Care Team Dashboard
Clinical Care Team A
Total Client Count 610
Social Workers
Jacqueline Hidalgo 35
Jasmin Salcedo 38
PC RN
Edward Perez 0
PCP
Angela Gomez-Simmonds 74
Noga Shalev 194
Susan Olender 161
Tanya Michaele Ellman 15
Care Cooridnator
Betsy Candelier 0
Navigators
Betsy Candelier 0
COMPAS
The very best for those who care
Indicators Summary
Legend
New Clients 14
High Acuity Clients 21
Significant Viremia 6
Chronic Active HCV 1
LTFU 9
Inpatient/ED Contact 10
Recent Visit 15
Upcoming Visit 4
Client List
Care Coorination
Demographics
Staff Assignment
Enrollment
Name MRN HIV/PCP Provider Days Since Core Visit
Adams Nicole 1234667 Noga Shalev 74
Barnes Chase 1235898 Noga Shalev 126
Carter Mackenzie 3456669 Tanya Michaele Ellman 200
Collins Gabrielle 3547788 Susan Olender 91

Feature 2

Feature: Dashboard for each Clinical Care Team that displays number of clients belonging to each Care Team.



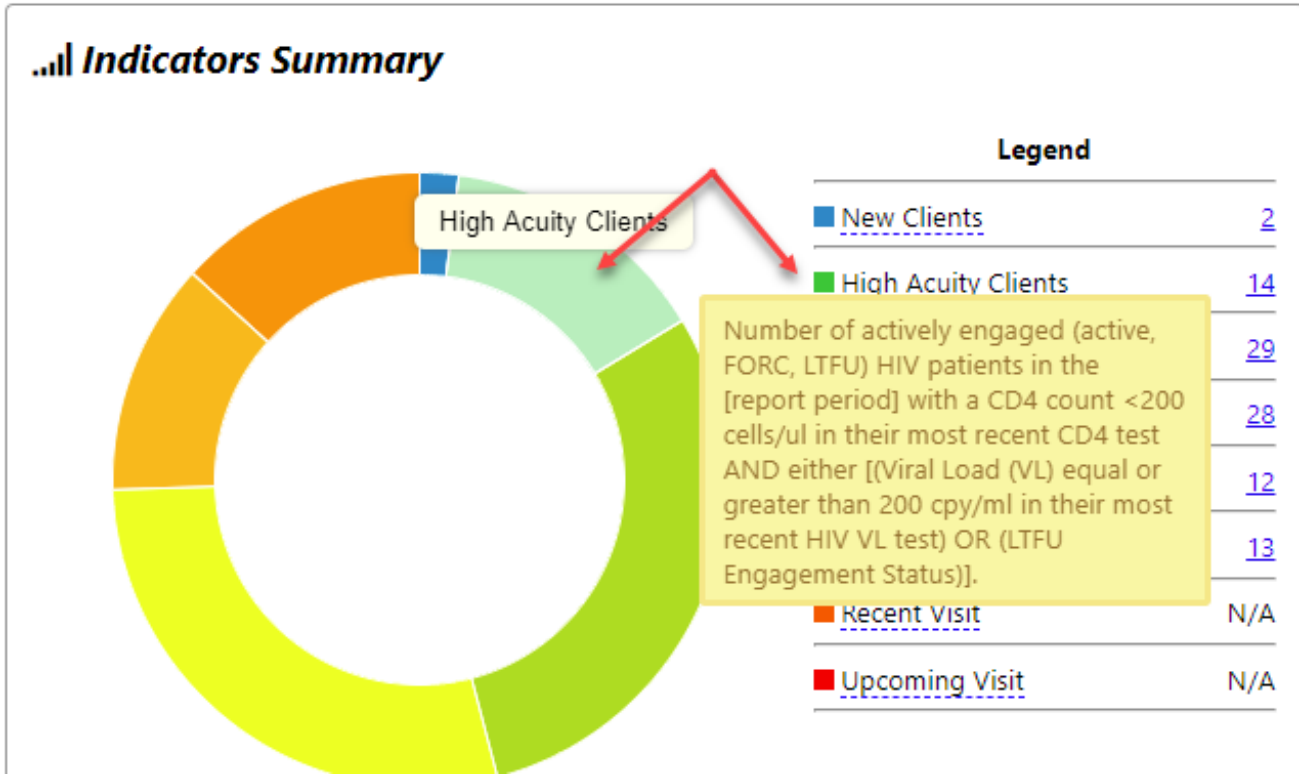
Benefit 2

Feature: Dashboard for each Clinical Care Team that displays number of clients belonging to each Care Team.

Benefit: Improved care coordination and communication

Feature 3

Feature: Dashboard displays total number of clients with High Acuity for each Clinical Care Team



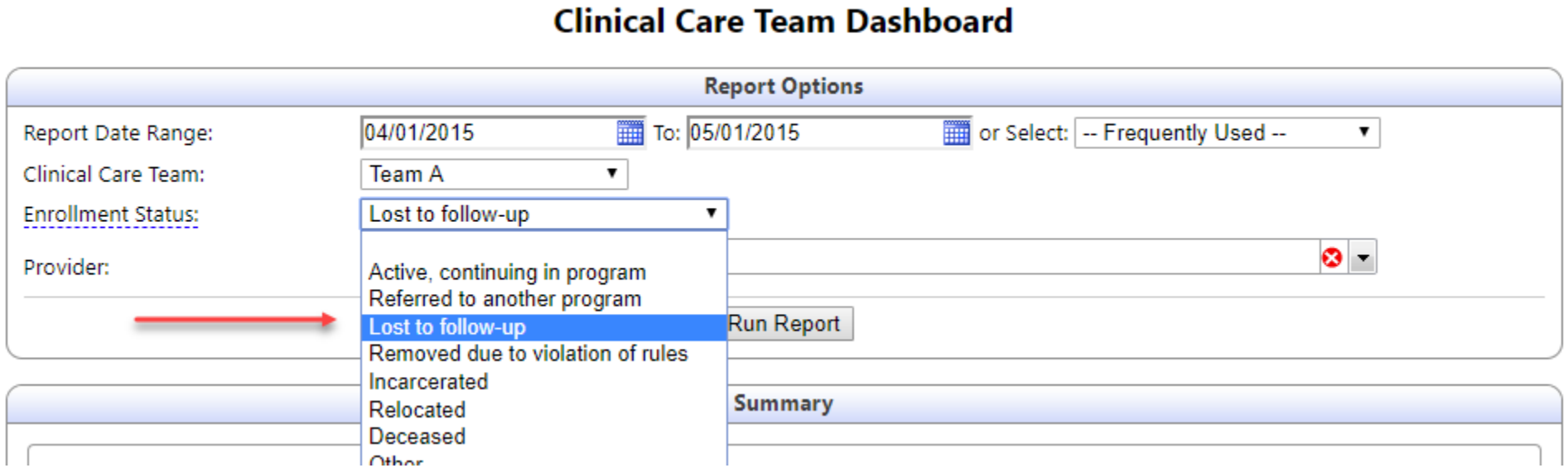
Benefit 3

Feature: Dashboard displays total number of clients with High Acuity for each Clinical Care Team

Benefit: The Care Team can automatically see their most at risk clients in one click.

Feature 4

Feature: Dashboard displays total number of clients who are Lost To Follow up for each Clinical Care Team



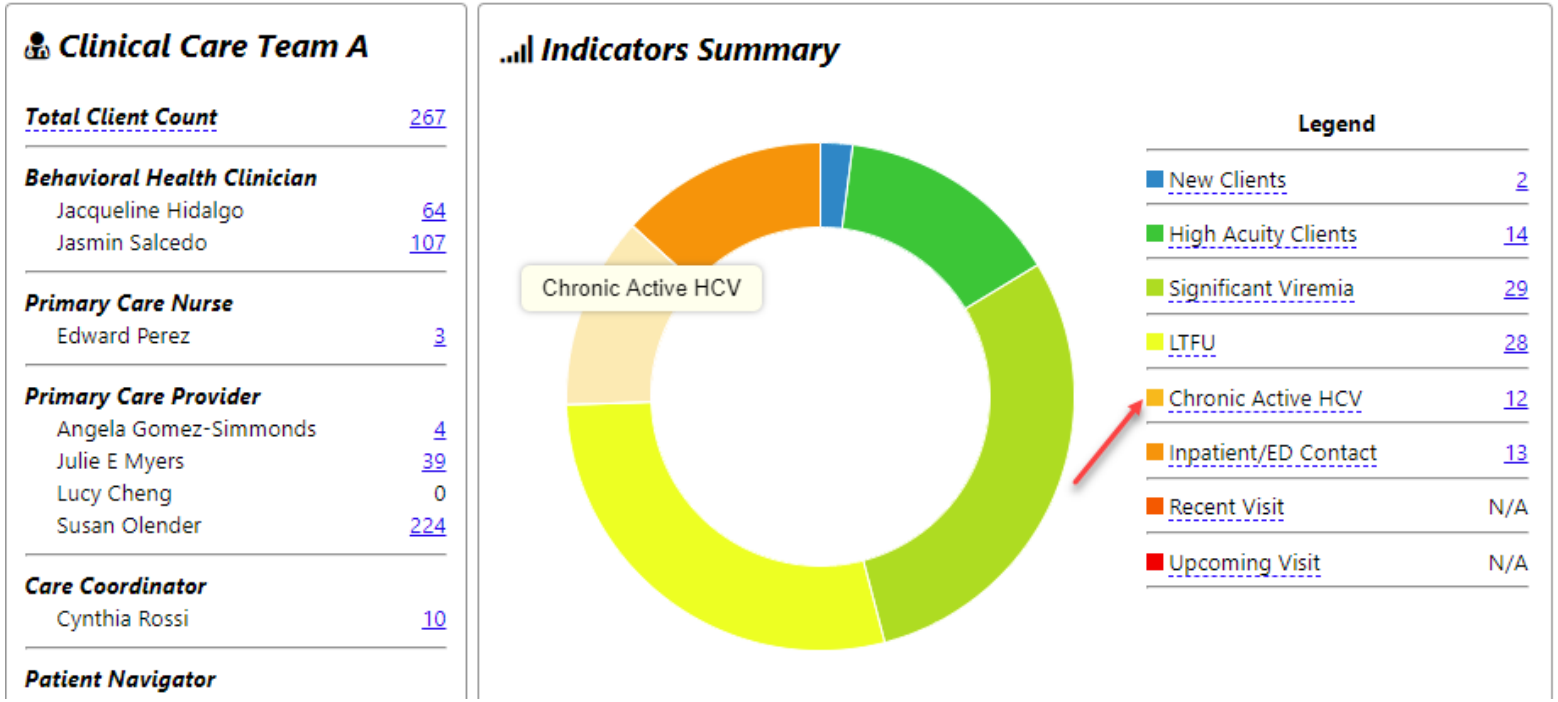
Benefit 4

Feature: Dashboard displays total number of clients who are Lost To Follow up for each Clinical Care Team

Benefit: Helps identify which clients are falling out of care. The team breakdown help see which teams are not doing as well as others

Feature 5

Feature: Dashboard displays total number of clients who are Chronic Active HCV for each Clinical Care Team



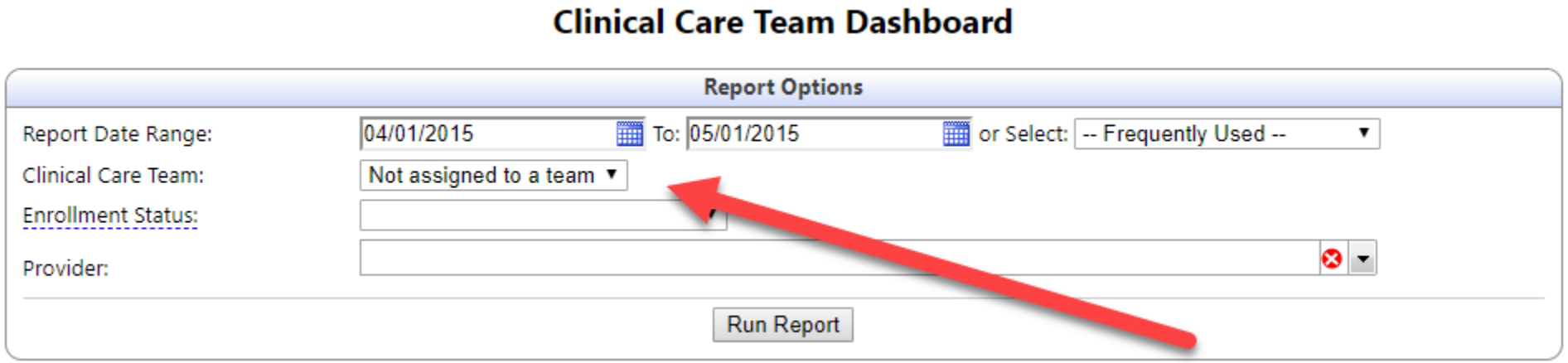
Benefit 5

Feature: Dashboard displays total number of clients who are Chronic Active HCV for each Clinical Care Team

Benefit: Helps care team and managers see which teams have most clients with Active HCV and which team don’t. Further review can help identify patterns and make decisions on team assignment.

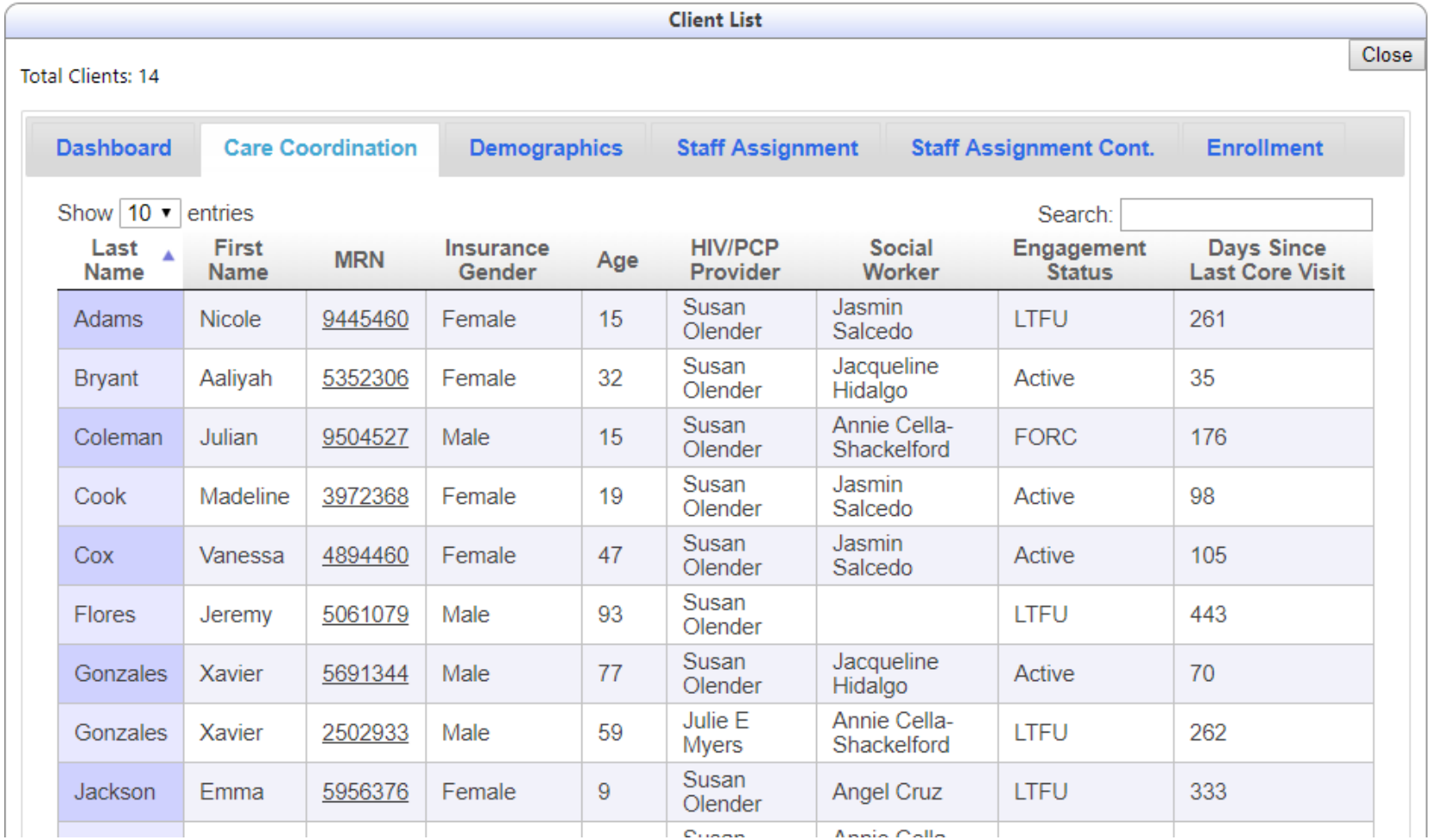
Feature 6

Feature: Dashboard displays total number of clients not assigned to any Care Team



Feature 7

Feature: Client Drill Downs



Last Name	First Name	MRN	Insurance Gender	Age	HIV/PCP Provider	Social Worker	Engagement Status	Days Since Last Core Visit
Adams	Nicole	9445460	Female	15	Susan Olender	Jasmin Salcedo	LTFU	261
Bryant	Aaliyah	5352306	Female	32	Susan Olender	Jacqueline Hidalgo	Active	35
Coleman	Julian	9504527	Male	15	Susan Olender	Annie Cella-Shackelford	FORC	176
Cook	Madeline	3972368	Female	19	Susan Olender	Jasmin Salcedo	Active	98
Cox	Vanessa	4894460	Female	47	Susan Olender	Jasmin Salcedo	Active	105
Flores	Jeremy	5061079	Male	93	Susan Olender		LTFU	443
Gonzales	Xavier	5691344	Male	77	Susan Olender	Jacqueline Hidalgo	Active	70
Gonzales	Xavier	2502933	Male	59	Julie E Myers	Annie Cella-Shackelford	LTFU	262
Jackson	Emma	5956376	Female	9	Susan Olender	Angel Cruz	LTFU	333

Benefit 7

Feature: Client Drill Downs

Benefit: Ability to view the client list and related information thus saving time and minimizing effort to look for client information

ED QI Project Motivation

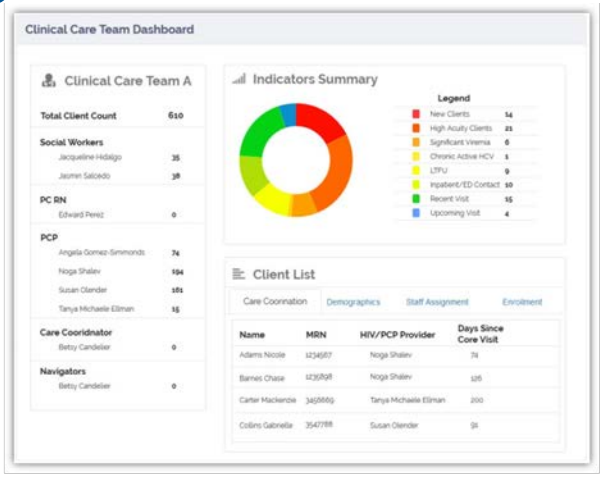
- High rates of ED utilization and hospital readmissions
- Prior authorizations for medications when in the ED
- Patients needing care outside CHP's clinic hours
- Patient education in the ED on HIV treatment vs pre-/post-exposure prophylaxis (e.g., ARVs and resistance)
- Limitations around PEP dose distribution in ED

ED QI Project Aims

- Reduction in avoidable hospital and ED use
- Improve outcomes across HIV Care Continuum

Identifying and Re-Engaging Patients

- Workflow 1: Established Known HIV Patients
  - *Twice daily checks* by RN Care Managers of patients in the ED via *CCT Dashboard*



- Workflow 2: New to Care Patients Visiting the ED
  - *ED Navigator Referrals* to RN Care Managers of:
    - HIV-infected patients never engaged in care or LTFU
    - Individuals at risk of HIV infection

ED Navigator

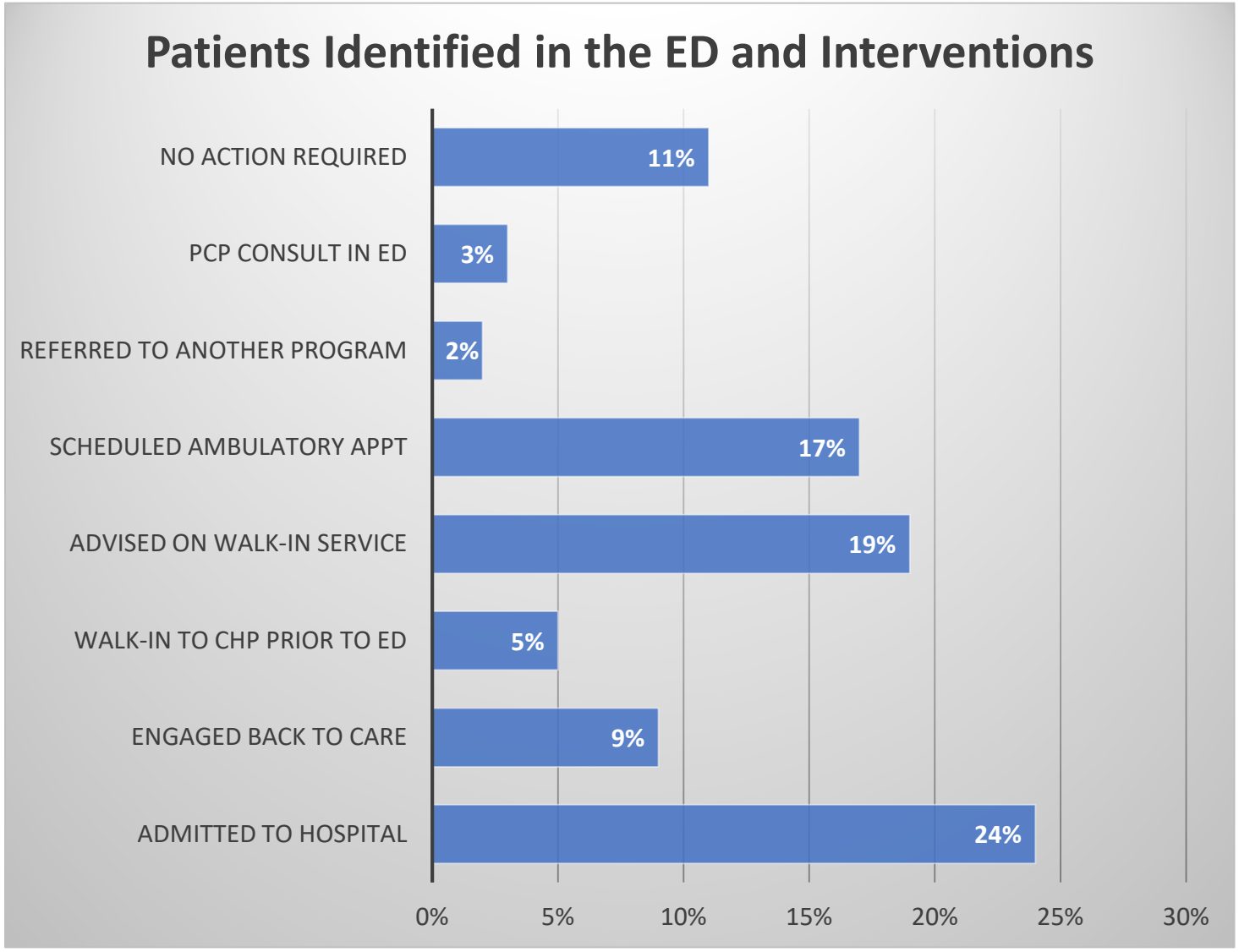
RN Coordinator

ED Population Management

- Conducted five stakeholder meetings to review baseline data on ED patients collected by RN Coordinators
  - Providers, RN Coordinators, Care Coordinators, Quality Manager
- Categorized ED patients by
  - Medical complexity
  - HIV care engagement
  - Health and psychosocial factors
  - High ED utilization and readmissions
- Identify potential intervention mix by ED patient type

QI Pilot Period: 9/30/16 – 12/5/16

- N = 159
- Average number per week of CHP patients with an ED contact = 15.5
- 9% patients identified through ED Navigator
- > 50 hours in staff time in patient engagement, education, and follow-up
- 13% patients enrolled intensive medical case management



RN Care Manager Average Time Spent on Daily ED Panel Review, Patient Outreach, and Re-Engagement	
Activity	Average Time Spent (Minutes)
Daily running of CCT Dashboard and review of patient charts	6.9
In-person outreach	18.5
Phone outreach	8.5
Patient education	9.1
Care coordination with Clinical Care Team	11.5

Care Team Activation through Dashboard Data

Prior to the ED QI Project, the **CCT Dashboard indicators were run 186 times in September 2016**.

After implementation, the CCT Dashboard indicators **were run an average of 346 times per month**.

Increase in Same Day Visits

"**The walk-in has increased because now we emphasize patients will end up in the ED only if absolutely necessary.** So we made an emphasis on all of those sorts of strategies. […] Especially when it's for something small. Obviously, if it's something urgent. But they have a walk-in. They want to come in. They come in the next day.

I just saw a patient yesterday in the ED, [...] **and he just switched meds.** I'm like; come in tomorrow. [Your provider is doing] walk-ins. You can tell her about your symptoms and what's going on. **And he came this morning**. […] **I just happened to look at the dashboard this morning, then Allscripts. And so he came in. So, you know, that communication matters**."

(Nurse Care Manager)

4 minute video

Our Journey Towards Practice Transformation through a Nurse Care Manager Perspective…

Lessons Learned from QI Project

- Panel-based ED visit data contributed to activation of care coordination resources for identification and real-time re-engagement of patients while in the ED
- Engagement of patients in real-time while at the ED is feasible and challenging (requiring ED champions)
- Re-engagement of patients in outpatient clinic was possible through same day services
- “Differentiated care” strategies by ED patient category can be used to optimize care team resources

STaR Practice Transformation ED QI Project Team

- Audrey Perez, *Nurse Care Manager, STaR Project*
- Stacey Gladstone, *Nurse Care Manager, DSRIP Project*
- Mila Gonzalez, *STaR Project Director/Quality Manager*
- Susan Olender, *STaR Principal Investigator/Quality Program Director*
- Steve Chang, *DSRIP Project Director*
- Peter Gordon, *Medical Director*
- Jesse Thomas, *RDE Systems, HIT Consultant*
- Anusha Dayananda, *RDE Systems, HIT Consultant*
- Wayne Stewart, *Principal Investigator, UCSF ETAC*
- Pamela Belton, *Project Officer, HRSA-SPNS*
- Comprehensive Health Program Staff

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Question?

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Panel Discussion