2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

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# Use of Patient Empanelment to Increase Engagement and Retention in Virally Unsuppressed HIV Positive Patients

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## *Ruth M. Rothstein CORE Center: Chicago, IL*

**Cook County Health and Hospitals System – Public "Safety-Net" Facility**

**>4,000 active patients, >12,000 primary care visits annually**

**It is estimated that we provide care to 30-35% of PLWA's known to be in care in Chicago**

**64% African American and 24% Hispanic/Latino**

**Male 74% Female 26%**

**>90% have incomes less than *200% FPL***

***Frequent history of drug use, incarceration***

***One-stop shopping model/wrap-around* services**

# CORE Center Clinics

- **14 clinics per week**
  - Avg of 5 Virally Unsuppressed Pts per session
- **50-60 patients per 3.5 hour clinic session**
  - Pt wait times and movements reduced
- **Improved Clinic Flow**
  - Resource Attending, Medical Providers,  Pharm D, Charge Nurse/RNs,/MAs, Medical Case Managers, Behavioral Health, EIS/CHW, Health Educator, Peer Navigator, Clinic Team Leader
- **PCMH Model implemented by Multi-disciplinary Team**

# Rationale for Patient Empanelment and Clinic Team Leaders

- Support for establishing a seamless healthcare delivery system for patient living with HIV/AIDS using a Patient-Centered Medical Home (PCMH) Model
- Focus on retention in care, care coordination through multidisciplinary teams, improved CQI measures and development of PCMH policies and protocols

# Why Utilization of Patient Empanelment

- No prior automatic identification of virally unsuppressed patients and only manual chart reviews were taking place
- Needed a coordinated system for prioritizing patients identified as “high risk” for adherence issues, elevated viral load, comorbidities and psychosocial issues
- Active vs. Passive patients
- Discussion of patients with VL >1,000=Individualized plan for each patient
- Discussion of patients with VL increase from <40=Proactive intervention

# Power BI

- Power BI by Microsoft is an industry leader in the business intelligence space, combining data analytics, a user-friendly interface, and powerful data visualization capabilities
- Power BI can connect to many data sources and the list is continually expanding. In CORE Center's implementation, it is connected to a SQL database provided by CRU.  Standard SQL queries are used to build each dataset
- Dashboards and reports are easily shared on the cloud with data refreshing on a daily schedule
- Power BI is included with CORE Center's existing Microsoft Office 365 Enterprise which provides seamless access with strong security

# EMPANELED PATIENTS CLINICAL MARKER DATA

Next Appt Date
- Monday, October 1, 2018
- Tuesday, October 2, 2018
- Wednesday, October 3, 2018
- Thursday, October 4, 2018
- Friday, October 5, 2018

Clinic Session
- Core Adolescent
- Core Adult
- Core Bilingual
- Core Pediatrics
- Core Women

AM-PM
- Evening
- PM

Toggle
- Current High Risk
- Historical High Risk
- Never High Risk

Deceased Filter
- Alive Only

| PTMEDREC | First Name | Last Name | Gender | Birth Date | High Risk | Last VL | Last VL Date | Last High VL | Last High VL Date | Last CD4 | Last CD4 Date | Last A1C Result | Last A1C Date | Last Fibroscan Date | No Shows Last Year | TotalWeight | Next Appt |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Female | | Never | 40 | 3/23/2018 | | | 463 | 7/11/2018 | | | | 1 | 2.00 | |
| | | | Female | | Never | 40 | 8/25/2017 | | | 681 | 1/22/2018 | 5.90 | 4/3/2018 | | 1 | 3.00 | 10/3/2018 8:10:00 I |
| | | | Male | | Historical | 40 | 5/8/2017 | 263920 | 9/28/2015 | 708 | 5/8/2017 | 5.50 | 2/6/2017 | | 1 | 5.00 | |
| | | | Male | | Historical | 40 | 7/9/2018 | 3181 | 6/15/2011 | 317 | 7/9/2018 | 5.10 | 2/27/2017 | | 1 | 3.00 | |
| | | | Male | | Current | 19859 | 4/13/2018 | 19859 | 4/13/2018 | 1007 | 4/13/2018 | 6.40 | 3/9/2016 | | 3 | 2.00 | |
| | | | Male | | Historical | 40 | 9/20/2018 | 7535 | 9/16/2015 | 167 | 9/20/2018 | | | 10/19/2015 | 3 | 6.00 | |

# Power BI for Pre-Clinic Planning

Carminati Consulting Group and CRU work together to extract data for virally unsuppressed patients from Cerner EMR to create patient empanelment

CD4 and Viral Load (VL) data are transferred into Power BI and checked daily by Clinic Team Leaders who conduct a thorough chart review in Cerner EMR and make recommendations to medical team

Medical Team discuss virally unsupressed patients at pre-clinic huddles and make an action plan for patient care with the goals of medication and treatment adherence

# Clinic Team Leaders (CTL) and the Patient Empanelment

- Multi-disciplinary communication during and between clinic sessions
- Coordinate clinic flow and PCMH implementation
- Conduct chart review to identify barriers to care to Patient Centered Plan
- “Pre-Clinic Follow Up Note” in EMR
- Data exported into Excel file on share drive for team

# Barriers and Challenges

- Team can be resistant to changes implemented (i.e. tracking sheets were not being utilized properly at first)
- Some team members (mainly medical providers) expressed frustration with discussing same virally unsuppressed patients over and over—Pre-Clinic FUP Note has helped with this
- Challenging patients with complex psychosocial issues ( i.e. homeless, psych issues, no locating /contact information) can be difficult to develop a patient centered plan
- Technical difficulties with Power BI

# What Has Worked for Clinic Team Leaders

- Successful increased utilization of an In-Clinic Tracking Form to Incomplete Tracking Forms to managers
- Scheduling appts for urgent or lost to care patients
- Identify scheduling needs, make appropriate outreach referrals, general care coordination internally and externally
- Patients whose VL has reduced from >1,000 to <40 identified each session to acknowledge patient successes

**Team likes having a go to for clinic flow and functions!**

# Pre-Clinic Huddle Goal and Agenda

**Goal**: To improve the patients' experience and clinical outcomes through communication among all team members during and between clinic sessions

**Agenda:**

I. Planned absences/call ins and coverage plans

II. Review of new patients-discussion of key issues/barriers by discipline to Medical CM, Outreach, BH, Health Ed, Provider

III. Review of virally unsuppressed "high risk" patients-discussion of key issues/barriers by discipline to Medical CM, Outreach, BH, Health Ed, Provider

IV. Post Hospital Pt Visits and Pts with other at-risk needs-Floor is opened for team members to identify or suggest pts in need of specific interventions

V. Patients w/ HgBA1cs >9 and their needs to Referral to nutritionist, Diabetes Education program, eye exam

VI. Patients w/ no pap in last 3 years

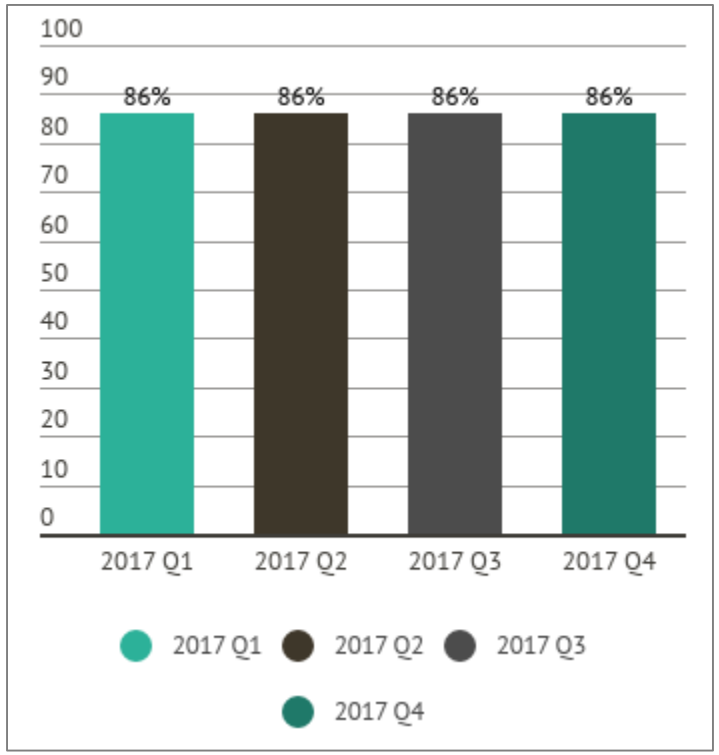
VII. General announcements to Operational announcements, QI/QC, Team building/Communication

# Case Example

- 35 year old African American woman
- Multiple hospitalizations, psych hx, DV, history of non-compliance to medical care and medications
- Referred back to care by CORE's Stroger Hospital inpatient linkage program- Project Connect
- VL >2 million in March 2018 to VL is undetectable November 2018
- Patient empanelment allowed team to identify patient and her multiple barriers to care at each medical visit
- Patient especially benefited from education from Pharm D after it was identified patient was taking ARVs incorrectly
- Patient was connected to medical case management services, behavioral health/psychiatry, health education at each visit and remains engaged

# Viral Suppression at CORE

**Viral Load Suppression at CORE Center**




**CORE Center exceeds national VL suppression standard of 80%**

# Moving Forward and Beyond

**Patient Empanelment has been expanded to include:**

- HCV VL
- HgA1c
- Syphilis
- Patient Empanelment has now been expanded to be used across CCHHS HIV Service Sites

**Clinic Team Leaders have begun to implement projects to increase communication and enhance patient care:**

- Increased Self-care=Great patient care to Surveys to gauge staff needs sent out and “Breathe Deep Day” created as a result (yoga, meditation, massage, healthy snacks)
- LGBTQ+ Working Group created to enhance overall medical care for LGBTQ+ identifying patients to Patient satisfaction survey implemented, ALL CORE pronouns in emails, LGBTQ trainings
- Women’s Clinic Working Group to Address unique needs of women as a group and create realistic strategies

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- *FOCUS funding supports HIV, HCV, and HBV screening and linkage to the first medical appointment after diagnosis; FOCUS funding does not support any activities beyond the first medical appointment and is agnostic to how FOCUS partners handle subsequent patient care and treatment.*


**Team Collaborators:**

- CORE Center Administration
- CORE Center Clinic Multi-disciplinary Care Team