NATIONAL 2018 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Practice Transformation Approaches from the Special Projects of National Significance Workforce Capacity Building Initiative (Institute 101)

Learning Objectives for the Session

At the conclusion of this activity, the participant will be able to:

1. To understand the purpose of practice transformation in HIV clinical care
2. To learn the common types of practice transformations and how they are intended to optimize HIV care
3. To observe the clinical contexts in which different models of practice transformation may be more or less appropriate

Obtaining CME/CE Credit

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

http://ryanwhite.cds.pesgce.com

2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Types of Practice Transformation: Findings from the Cross-Site Evaluation

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Disclosures

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Grant/research support from: Health Resources and Services Administration (HRSA) Special Projects of National Significance (SPNS) (Grant number U90HA27388)

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Initiative Objectives

- Anticipated challenge: HIV workforce is expected to decline relative to the demand for services

- Initiative Objectives:
  - To enhance the capacity and readiness of funded organizations to adapt and re-align their workforce systems to improve the provision of quality care to people living with HIV
  - To evaluate the efficacy and efficiency of efforts to enhance workforce capacity

Initiative Demonstration Projects

- ACCESS, Chicago, Illinois
- Brightpoint Health, New York, NY
- Coastal Bend Wellness Foundation, Corpus Christi, TX
- The Ruth M. Rothstein CORE Center, Chicago, IL
- Family Health Centers of San Diego, San Diego, CA
- Florida Department of Health, Osceola County, Kissimmee, FL
- Foundcare, Inc., West Palm Beach, FL
- La Clinica del Pueblo, Washington, DC
- MetroHealth Medical Center, Cleveland, OH

Initiative Demonstration Projects

- NYC Health + Hospitals - Correctional Health Services, Rikers Island, NY
- New York Presbyterian Hospital, New York , NY
- Special Health Resources for Texas, Inc., Longview, TX
- San Ysidro Health Center, San Diego, CA
- University of Miami Health System/Jackson Memorial Medical Center, Miami, FL
- University of Pittsburgh Medical Center, Pittsburgh, PA

Practice Transformation Strategies

- To address workforce challenges, sites implemented practice transformations, defined as: efficiencies in structural workforce systems that optimize human resources and improve health outcomes

- Three major strategies (not mutually exclusive)
  1. Expand the HIV workforce
  2. Share the care (task shifting or task sharing)
  3. Enhance reliable engagement of clients in care

Expanding HIV Care

- Approaches within the initiative include:
  - Training primary care clinicians to provide HIV care
  - Integrating HIV care with primary care
  - Shifting PLWH on suppressive HIV regimens to FQHC providers

- With each of these approaches, co-management is an option
  - Patients continue to be assigned to both a primary care provider and an HIV specialist
  - Patients with less complicated HIV are assigned only to a primary care providers, but providers have access to an HIV specialist for consultations

Share the Care

- Approaches used with the initiative
    - Implement team based care
    - Enhanced care coordination
    - Training for midlevel providers and/or clinical staff
    - Stakeholder engagement
    - Health information technology

Enhancing Patient Engagement

- Approaches within the initiative include:
  - Patient navigation/care coordination to ensure patients are receiving the services they need
  - Tracking down patients who have fallen out of care
  - Efforts to increase patients' capacity for self-managing aspects of their health

Cross-site Evaluation

- Conducted by the University of California San Francisco
- Consisted of multiple components
  - Organizational assessment
  - Qualitative interviews with demonstration project personnel, providers, and staff
  - Surveys with providers and staff
  - Cost assessment
  - Clinical outcomes data
- Material in this presentation will focus on the organizational assessment.

Organizational Assessment

- Conducted with each demonstration project every 6 months starting at baseline
  - Total of 5 assessments/project
  - July 2015 – February 2018
- Components
  - Web-based site survey to gather basic information about a project site
  - Building Blocks of Primary Care (BBPCA)
    - Completed in consultation with a member of UCSF evaluation team

Building Blocks of Primary Care Assessment *(version 12.28.12)*

Block 1: Engaged leadership

Components	Level D	Level C	Level B	Level A
1. Executive leaders	are focused on short-term business priorities.	visibly support and create an infrastructure for quality improvement, but do not commit resources.	allocate resources and actively reward quality improvement initiatives.	support continuous learning throughout the organization, review and act upon quality data, and have a long-term strategy and funding commitment to explore, implement and spread quality improvement initiatives.
Score	1 ☐ 2 ☐ 3 ☐	4 ☐ 5 ☐ 6 ☐	7 ☐ 8 ☐ 9 ☐	10 ☐ 11 ☐ 12 ☐
2. Clinical leaders	intermittently focus on improving quality.	have developed a vision for quality improvement, but no consistent process for getting there.	are committed to a quality improvement process, and sometimes engage teams in implementation and problem solving.	consistently champion and engage clinical teams in improving patient experience of care and clinical outcomes.
Score	1 ☐ 2 ☐ 3 ☐	4 ☐ 5 ☐ 6 ☐	7 ☐ 8 ☐ 9 ☐	10 ☐ 11 ☐ 12 ☐
3. The responsibility for conducting quality improvement activities	is not assigned by leadership to any specific group.	is assigned to a group without committed resources.	is assigned to an organized quality improvement group who receive dedicated resources.	is shared by all staff, from leadership to team members, and is made explicit through protected time to meet and specific resources to engage in QI.
Score	1 ☐ 2 ☐ 3 ☐	4 ☐ 5 ☐ 6 ☐	7 ☐ 8 ☐ 9 ☐	10 ☐ 11 ☐ 12 ☐

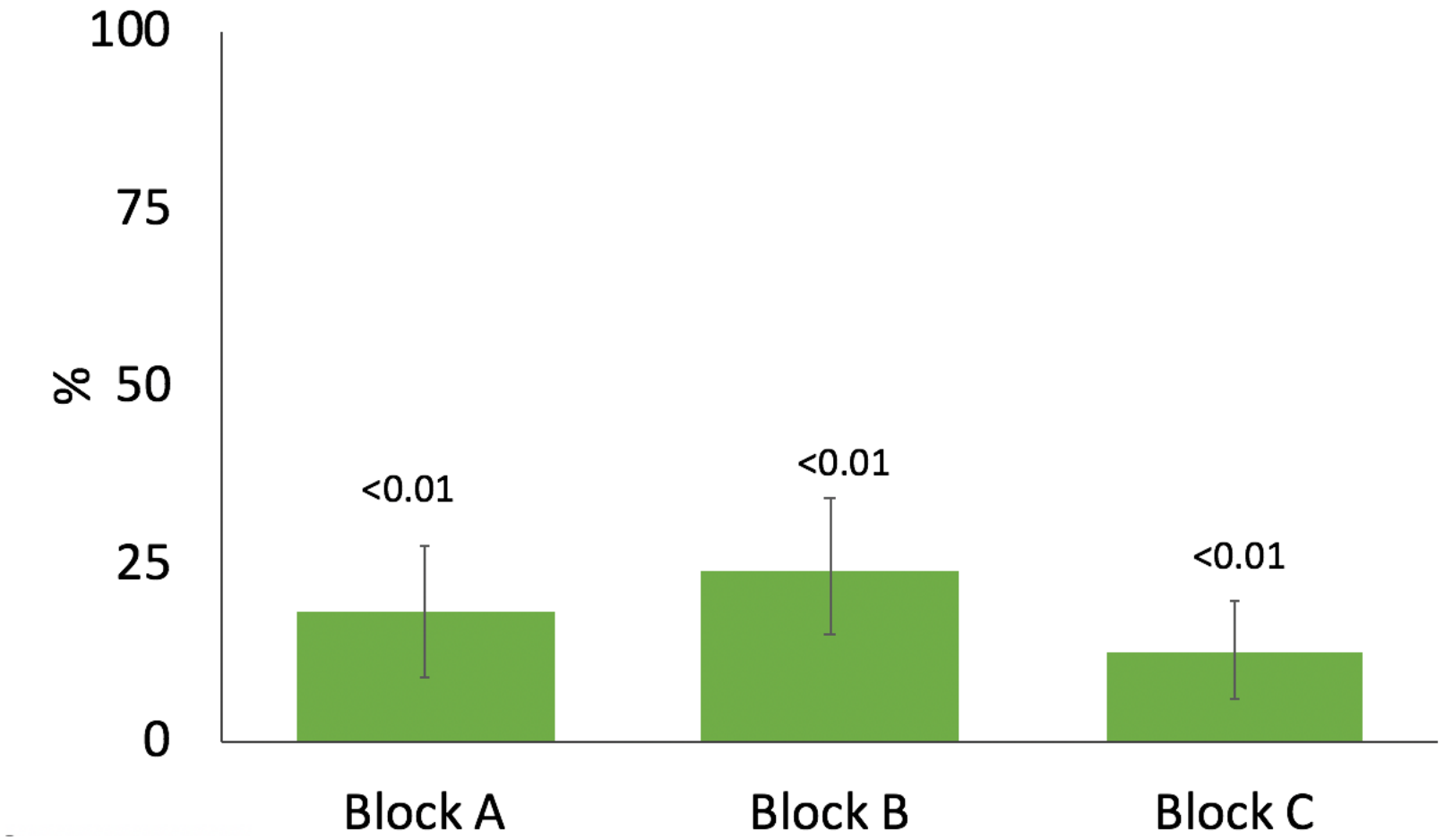
Example from the BBPCA

Organizational Assessment

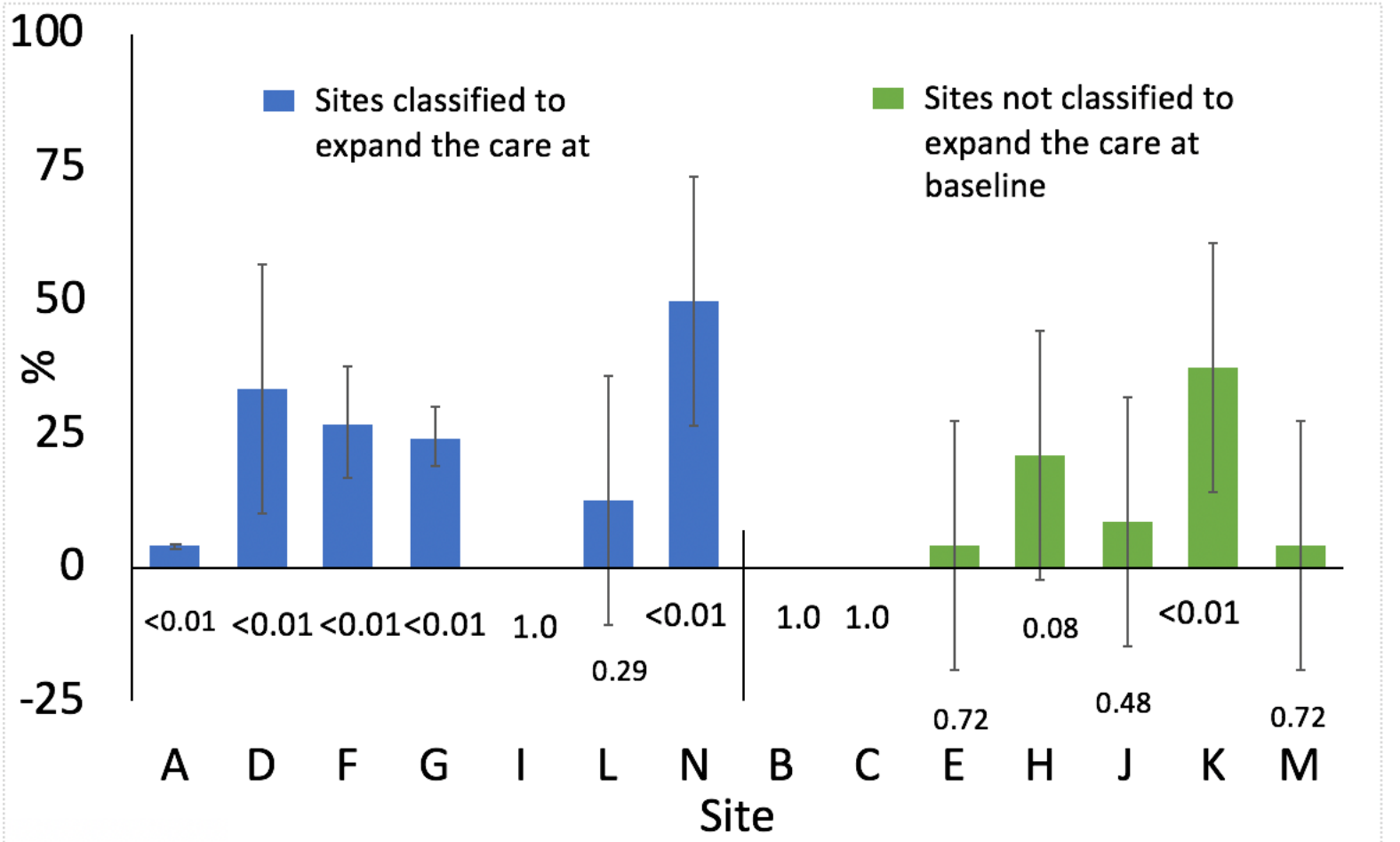
- The UCSF team created an addendum with 12 questions that specifically describe characteristics of care delivery specific to people living with HIV
- The 12 questions were organized into blocks, with multiple questions per block.
  - Block A: Characteristics related to expand the care
  - Block B: Characteristics related to share the care
  - Block C: Characteristics related to improving patient engagement
- Average scores were calculated for each block
- Percent change from Round 1 to Round 5 was assessed by modeling with repeated measures, clustered by demonstration project

Site Characteristics	Baseline Mean (SD)	Round 5 Mean (SD)	p-value
Number of clinics	2.1 (1.5)	1.9 (1.5)	0.05
Number of patients seen in the past 6 months for all conditions	3089 (2932)	3801 (3294)	0.25
Number of HIV-infected patients seen in the past 6 months	916 (1167)	1123 (1594)	0.09
Number of prescribing providers	18.5 (23.5)	19.8 (22.1)	0.31
Total prescribing provider FTE	7.7 (7.5)	7.1 (6.2)	0.61

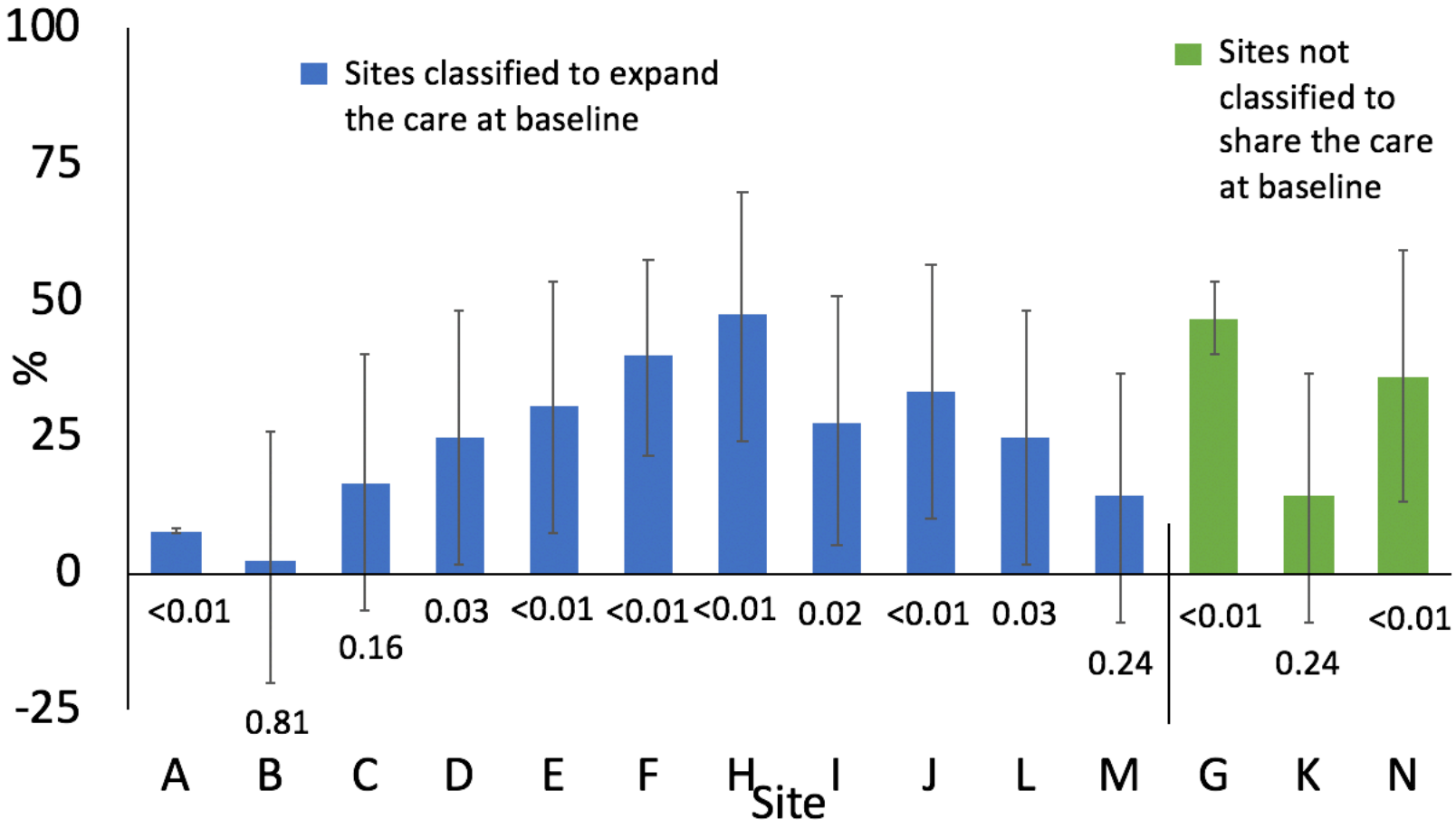
Demonstration Project Characteristics



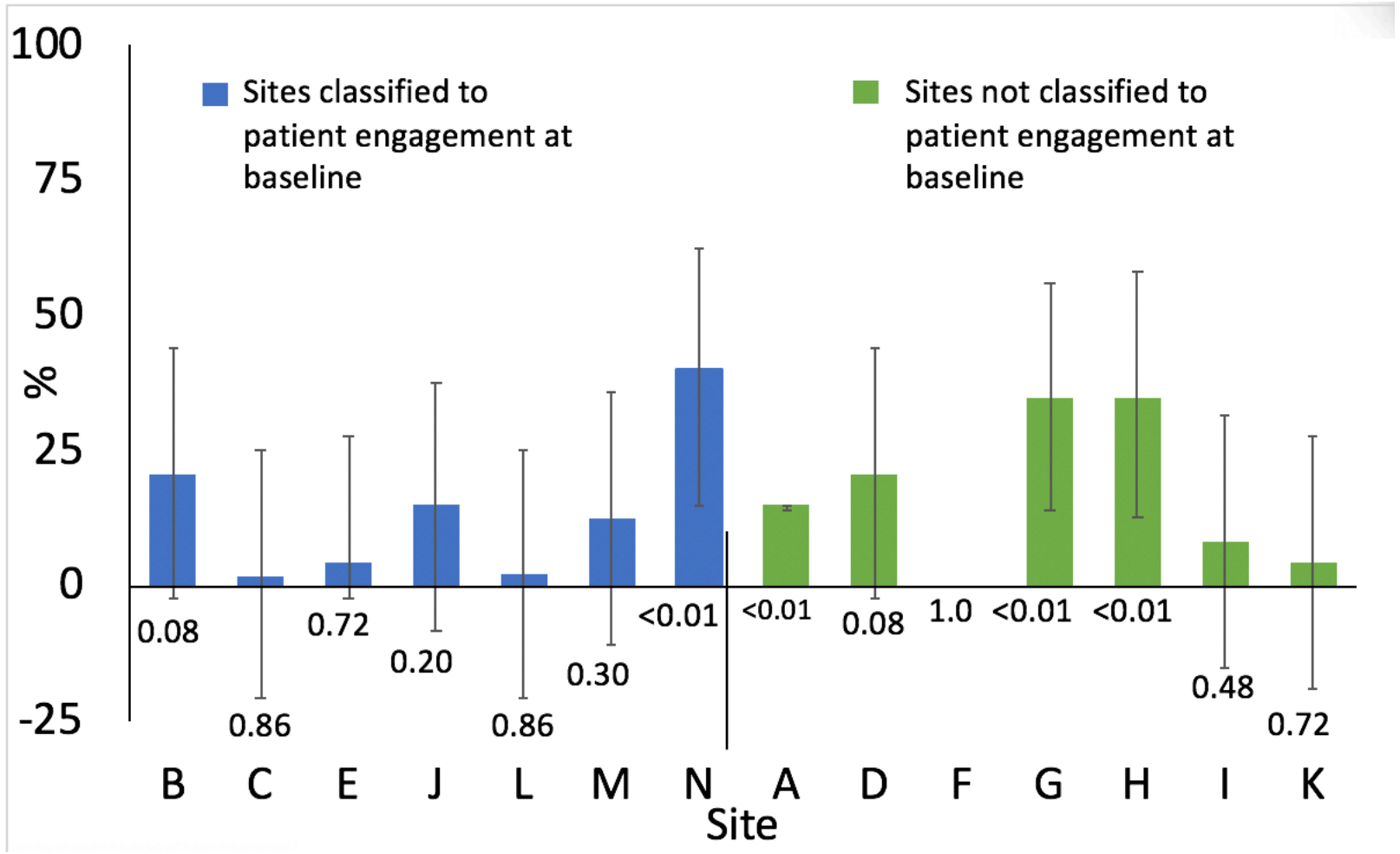
Overall Percent Change in BBPCA Addendum Blocks From Round 1 to Round 5



Percent Changes at Individual Projects in Scores on the Expand the Care Block



Percent Changes at Individual Projects in Scores on the Share the Care Block



Percent Changes at Individual Projects in Scores on the Improve Patient Engagement Block

Summary of Findings

- The largest and most common changes were seen in practices related to sharing the care
- There were also significant changes in expand the care practices at a number of sites
- There was less evidence for changes in practices related to improving patient engagement

Implications

- Implementing transformations to expand the care and share the care may be easier to achieve
- Strategies to improve patient engagement may be harder to implement
  - Are designed to work with some of the most challenging patients
  - Are likely to be more of a focus after making more foundational changes (e.g., expanding care or sharing care) that affect delivery of care for all patients
- Practice transformation is an inherently iterative process. Therefore, the components of the transformation may evolve over time.

Thank you!

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Access Community Health Network

December 12, 2018

Presented by Brian Bragg
VP, Behavioral Health & Community Integration, SPNS Project Director

ACCESS COMMUNITY HEALTH NETWORK
TRANSFORMING COMMUNITY HEALTH CARE

Disclosures

Brian Bragg

Grant/research support from: Health Resources and Services Administration (HRSA) Special Projects of National Significance (SPNS) (Grant number H97HA27420)

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HIMSS

ACCESS Background

ACCESS Background

- Federally-qualified health center
- **35 locations** across Cook and DuPage Counties
- **25+ year history** of serving underserved, hard-to-reach populations
- **183,000** individuals served annually
- NCQA Level 3 Patient-Centered Medical Home Certification at all 34 eligible sites

ACCESS HIV Background

- Nationally recognized integration model that incorporates outreach, education, linkage to care and treatment
- Universal HIV testing across the ACCESS Network (6/27/15)
- **5 HIV hub site** locations offering specialty care
- **20+ year** history as a Ryan White provider
  - (Parts A, C, and D)
- **900** (nearly) HIV positive individuals come to ACCESS for care
- **6** infectious disease (ID) specialists

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ACCESS HIV Service Line Challenges

Access to HIV care

- Services limited to five hub sites
- Limited clinic days with ID specialists at hub sites

ID specialist capacity

- 1.5 FTE ID specialist across all five sites
- HIV, Hepatitis C, and other ID patient needs

ACCESS HIV HUB Health Centers	Geographic Area Served	ID Specialist Hours/Mo.
ACCESS Evanston-Rogers Park Family Health Center	Chicago – North Side	25 hours/mo.
ACCESS Grand Boulevard Health and Specialty Center	Chicago – South Side	64 hours/mo.
ACCESS Madison Family Health Center	Chicago – West Side	6 hours/mo.
ACCESS Family Health Society	South Suburban Cook County	3 hours/mo.
ACCESS Martin T. Russo Family Health Center	DuPage County	4 hours/mo.

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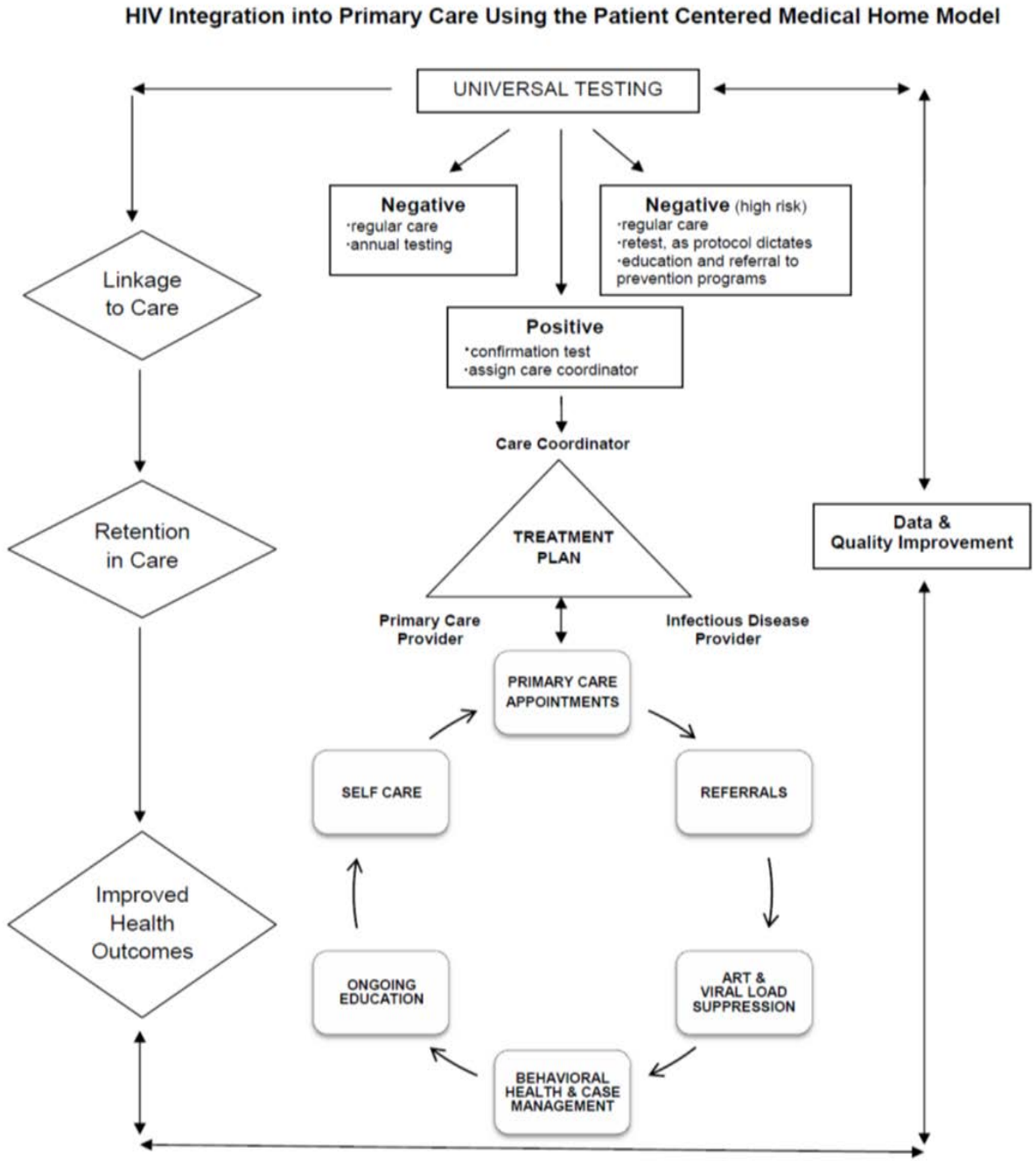
ACCESS HIV Service Line Challenges

Service Delivery in a Silo

- Patients referred to ID specialists – HIV-positive patients viewed as the ID specialists responsibility
- ID specialists feel responsible – viewed as *my* patients
- ID specialists hesitancy to trust the rest of the care team
  - Cultural competency and comfort discussing sensitive topics
  - Expanding care team
- Primary care provider (PCP) capacity at the health center level
- PCP hesitancy to care for patients with HIV – concerns about ability to provide appropriate care
- Patient hesitancy because of ongoing stigma in health care (e.g., dental visits, etc.)

Illustration of Overall PTM



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ACCESS Practice Transformation Model Overview

Model Goals

- Improve access and continuity of care
- Eliminate care silos
- Expand system capacity and workforce
- Utilize a team approach based on the patient centered medical home (PCMH) model
- Care team and program integration with Ryan White

Model Components

- Focus on the five HIV hub sites
- Partner with Midwest AIDS Training and Education Center (MATEC) for health center training
- Patient empanelment
  - PCP
  - ID specialist
  - Nurse care coordinator
- Nurse care coordinator integration (2)
- Champion PCPs

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Outcome – Primary Care Measures

HIV-Positive Patients Engaging in Primary Care

Measure	2015	2016	2017
Primary care visit	43.4%	52.2%	62%

- ID specialists who previously reported apprehension about expanding the care team are seeing the benefits.
- ID specialists report that it's the individual not the role that makes the difference.

- PCPs report seeing HIV+ patients primarily for sickness and referrals.
  - Looking to start addressing preventive care
- Primary care measures have remained steady during the model rollout.

HIV-Positive Patients Preventive Care Engagement

Measure	2015	2016	2017
Chlamydia/ Gonorrhea screening	54.3%	52%	54.2%
Hypertension controlled	80.5%	85.2%	83.2%
Diabetes controlled	67.9%	62.7%	67.5%

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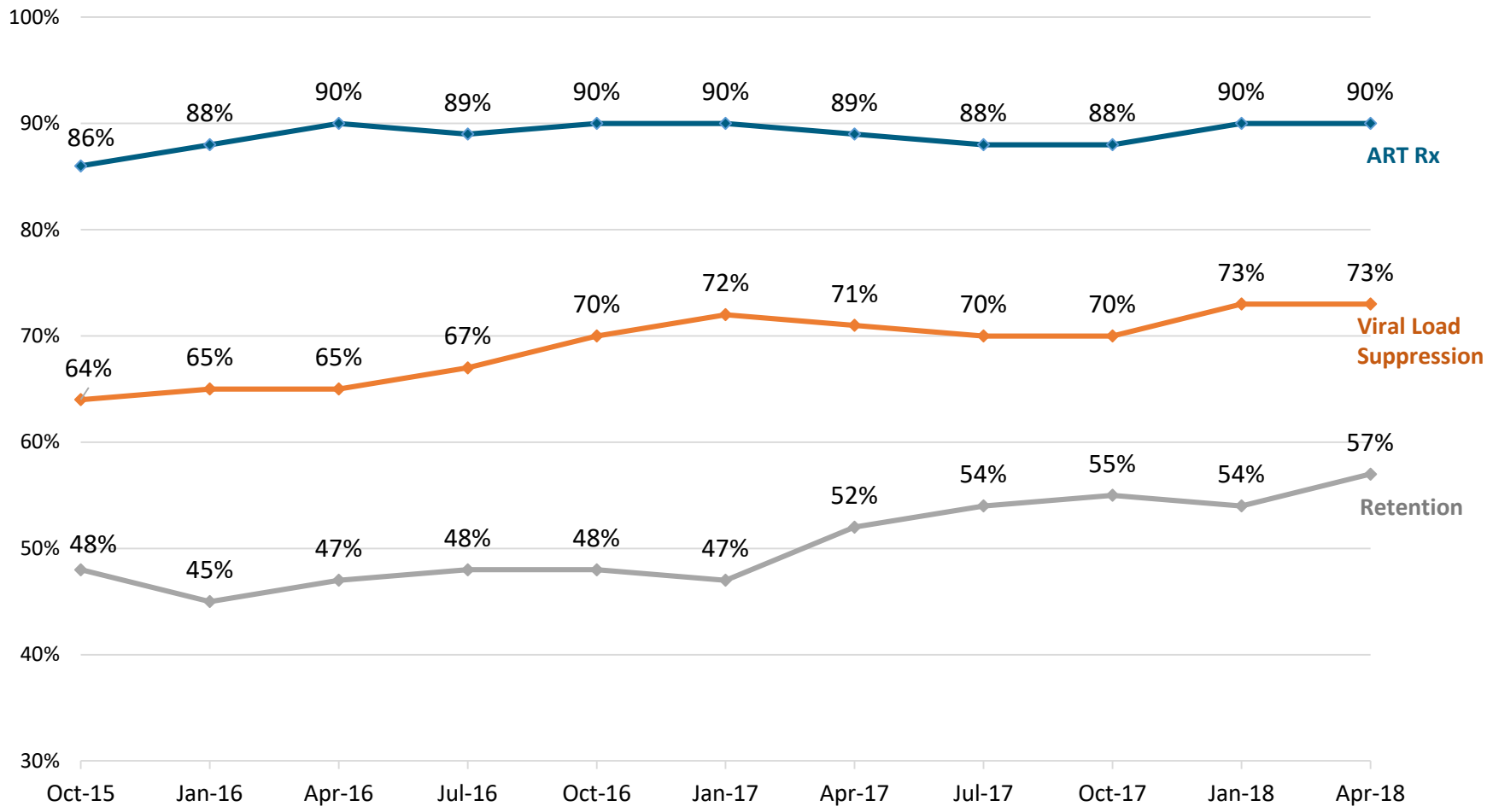
Outcome - HIV Quality Measures



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Model Challenges & Lessons Learned

Implementation

- **Unclear care team roles** and responsibilities lead to confusion among health center staff.
- **Health center staff turnover** does impact HIV care team and patients.
- **Communication** limitations existed due to contracted ID specialists.
- **Dynamic health care environment** can include multiple initiatives and cause confusion at the point of orientation.
- **Time constraints** of workgroup members affected our ability to orient health centers to the initiative.

Overall

- Change takes time.
- Training is critical.
- Leadership and stakeholder involvement should be present for planning **and** throughout the practice transformation.
- Create opportunities for examining current workflows, logistics and facility environment to understand differentiation within each health center site.
- Be open to readjusting the model based on changes in the system environment, feedback from patients and others.

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Next Steps

- Development and implementation of sustainable training
  - Collaborating with MATEC and ACCESS' Clinical Education team to develop a curriculum in ACCESS' learning management system.

- Create reports
  - Gather qualitative feedback – patient perspective
  - Optimize HIV registry – reporting workbench

Connect With Us

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Transforming HIV Care for Latinos

La Clinica del Pueblo

Catalina Sol, MPH, Project Director

Jesus Felizzola, MD, Principal Investigator

Disclosures

Catalina Sol, MPH, and Jesus Felizzola, MD

Grant/research support from: Health Resources and Services Administration (HRSA) Special Projects of National Significance (SPNS) (Grant number H97HA27428)

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Commercial Support was not received for this activity.

Background

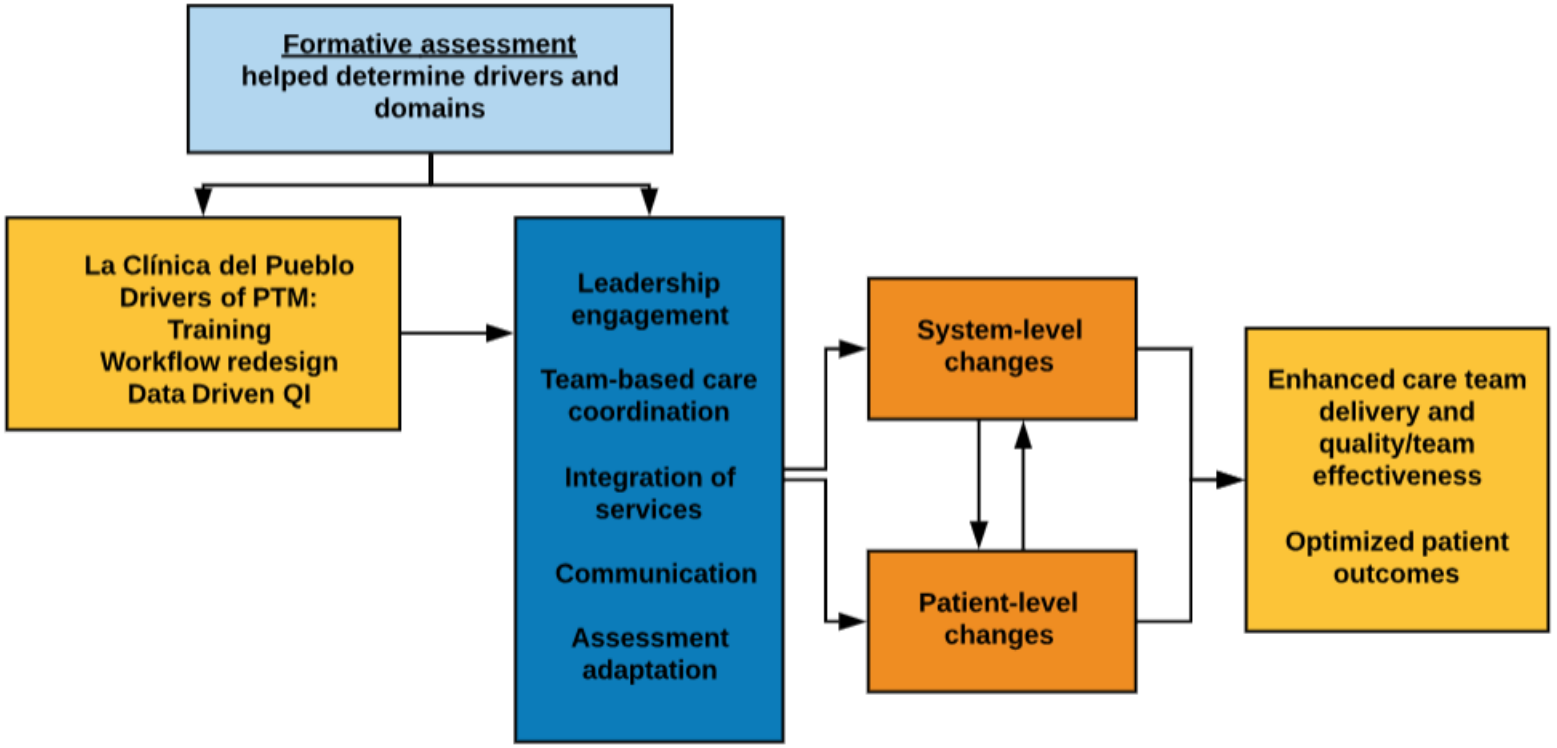
Founded in 1983 as volunteer-run, free clinic in response to Salvadorian migration to Washington DC area

- Federally Qualified Health Center (FQHC) since 2007
- Ryan White provider since 1994, provide continuum of HIV prevention and care
- 4,000 patients in 2017, 8% PLWHA
- Majority of patients immigrants from Central America

Practice Transformation Model (PTM)

Main Goal: Develop, implement and evaluate a PTM that will enhance LCDP's organizational capacity to deliver HIV culturally appropriate and patient-centered care in the Washington, DC area

PTM Conceptual Model

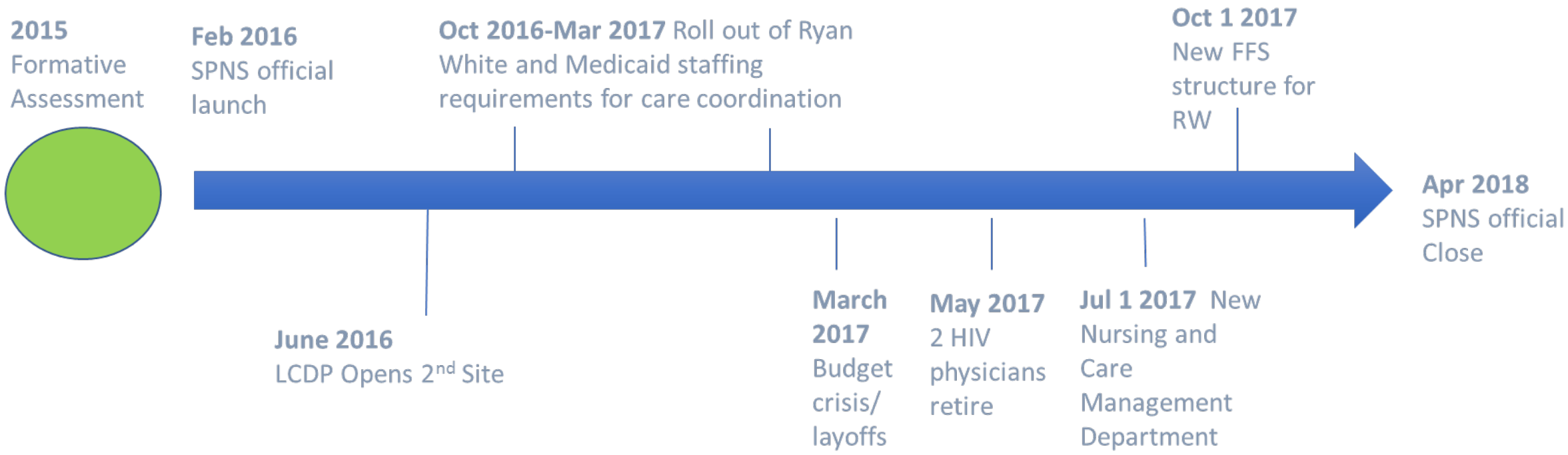


PTM Components

- **Workflow Redesign**
- **Training**
- **Data Driven Quality Improvement**

WHAT DID WE DO?

Context for PTM



Training Content

- PrEP Overview
- HIV/AIDS in the Latino Community
- HIV Evidence-based guidelines
- Team Communication
- LCDP LGBTQ Cultural Competency

Care Management and Care Coordination Part 1 and 2

HIV and Substance Use

HIV History and Science

Best Practices in Young MSM Health

Training Format

Starting Point

1.5 hours within monthly HIV case review

11- 12:30

Mostly external speakers

All care team members

Ending Point

3 hours every other month

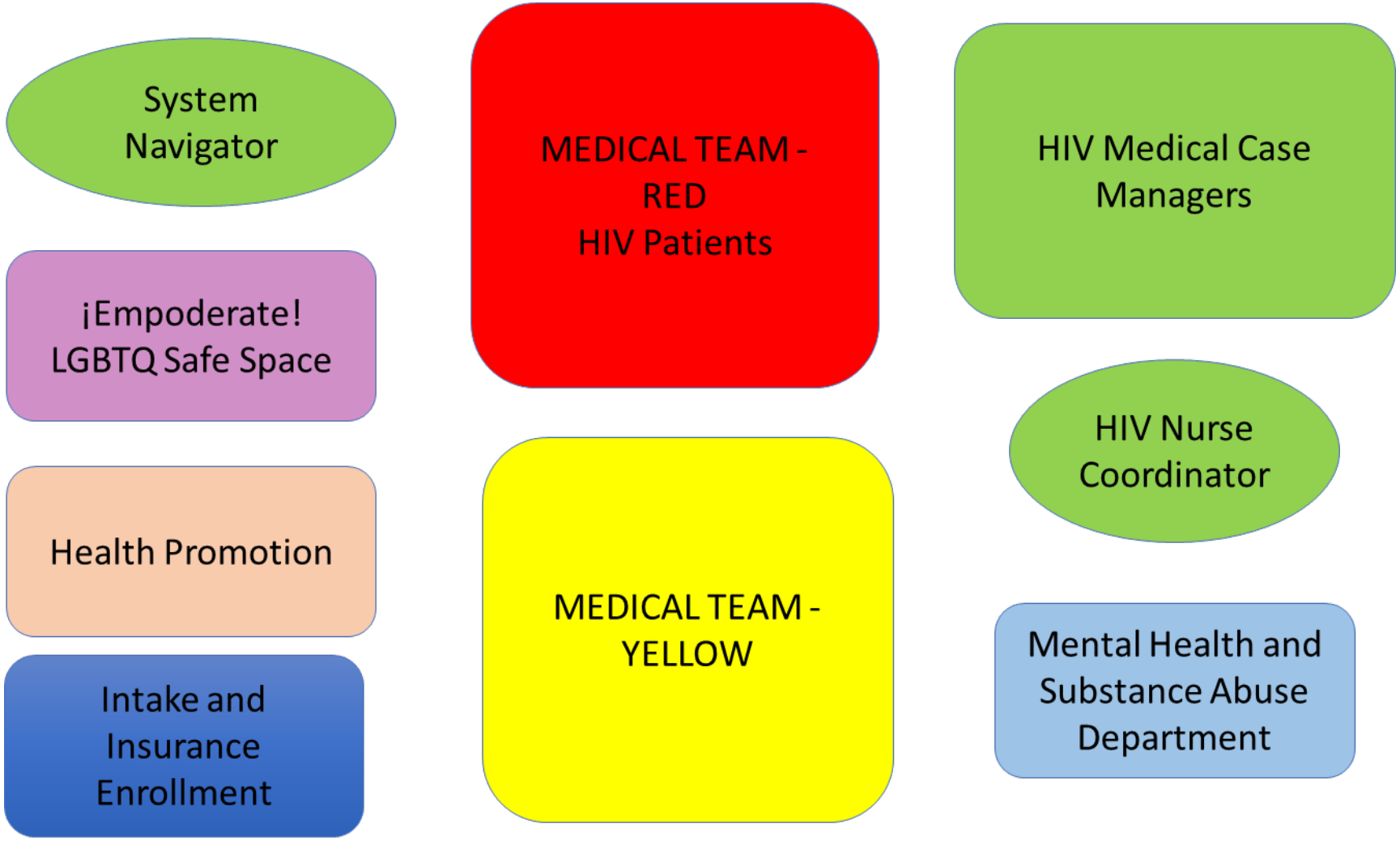
Block morning schedules

Mix of internal and external speakers

All care team members

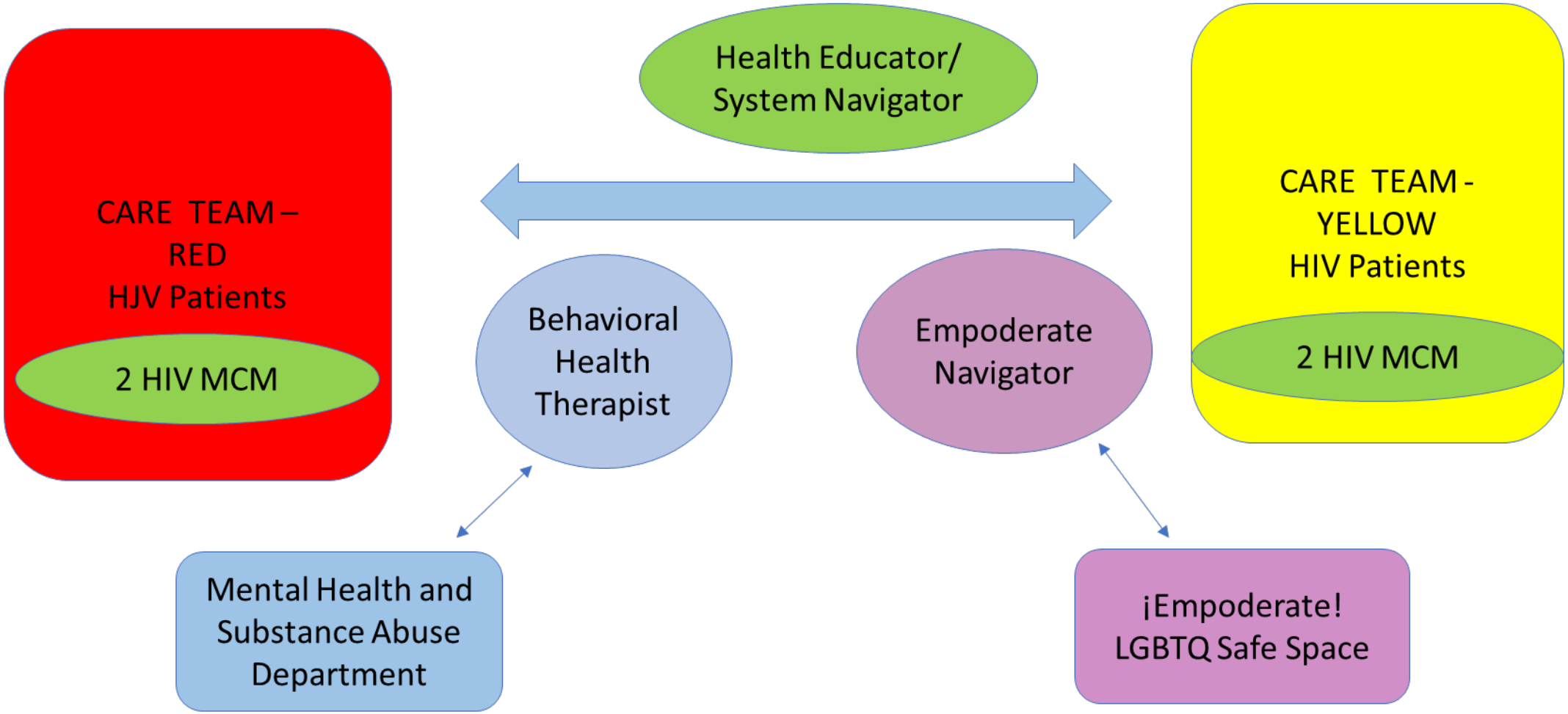
Workflow Redesign – Starting point

- Patients paneled to providers, but not care team
- Medical providers and medical staff organized in Red and Yellow teams, but teams did not include case managers, health educators, or staff from other departments and programs
- All HIV providers were in one team
- Most supportive services performed by Medical Case Managers, lay staff serving only HIV patients
- Role of HIV RN unclear, no other RNs in teams
- Important support and navigation services for LGBTQ not in EHR


System Navigator
MEDICAL TEAM - RED HIV Patients
HIV Medical Case Managers
¡Empoderate! LGBTQ Safe Space
HIV Nurse Coordinator
Health Promotion
MEDICAL TEAM - YELLOW
Mental Health and Substance Abuse Department
Intake and Insurance Enrollment

Workflow redesign – Initial Model

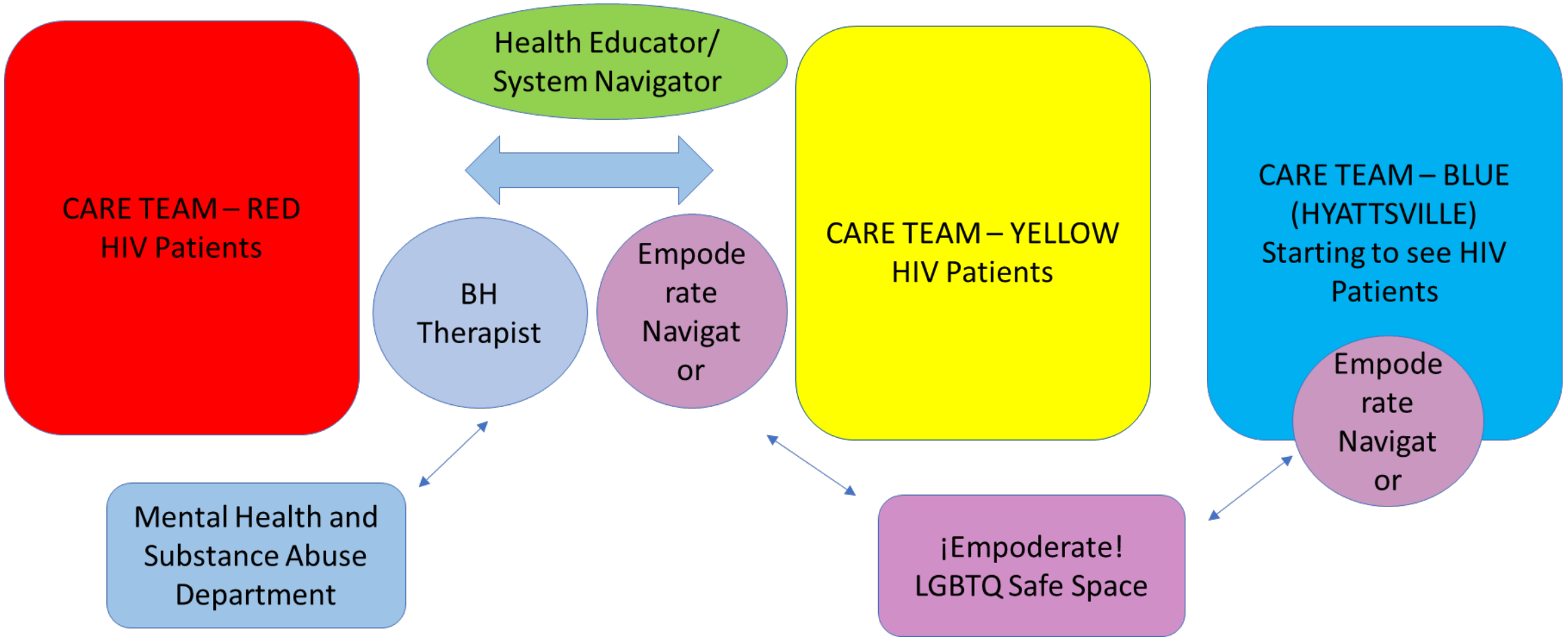
- Panel patients to a care team, not just a provider
- Reassigned medical providers within teams to include HIV providers in each team
- Recruited an RN for each team to support medically complex patients
- Integrated behavioral health therapist and specialized navigators within care teams
- Assigned medical case managers, health educators, insurance enrollment staff to work with patients of red or yellow teams


CARE TEAM – RED HJV Patients
2 HIV MCM
Health Educator/ System Navigator
Behavioral Health Therapist
Empoderate Navigator
CARE TEAM - YELLOW HIV Patients
2 HIV MCM
Mental Health and Substance Abuse Department
¡Empoderate! LGBTQ Safe Space

Workflow redesign – after system changes

- Addressed new licensure requirements for medical case managers (MCM) by redesigning care team;
  - Group of 3-4 Medical Providers, at least 1 empaneling HIV
  - Medical Assistants per provider
  - Medical Receptionist
  - Referral Coordinator
  - Intake/Insurance Enrollment
  - RN Care Manager
  - Care Coordinator
  - Health Educators
  - Behavioral Health Therapist – link to mental health and substance use services
  - Empoderate Navigator- link to Empoderate Centers

- Used this care team model as a template to initiate HIV services in new site


CARE TEAM – RED
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HIV Patients
¡Empoderate!
LGBTQ Safe Space
CARE TEAM – BLUE
(HYATTSVILLE)
Starting to see HIV
Patients
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Data-Driven Quality Improvement

Starting Point

- Monthly HIV Case Review share with care team training
- Included staff from Red and Yellow teams
- Focus on data review, program workflows, training and QI
- HIV Measures presented from external sources

End Point

- HIV Care Review every 2-3 months, separated from training
- Focus on data review, program workflows, training and QI
- Space for monitoring staff experience with PTM
- HIV measures integrated in population health platform

Lessons Learned

- Formative assessment key to development of PTM
- Need to align PTM with requirements of external environment
- Greater project impact through synchronizing SPNS goals and opportunities with larger institutional projects
- Leadership engagement critical to PTM
- Limitation of fee service model to carve out time for practice transformation – importance of demonstration

This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant H97HA27428; Title: La Clínica del Pueblo - Transforming Latino HIV Care; Grant Amount: $1,115,352.00; 0% financed with nongovernmental sources. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government."

THANK YOU!
QUESTIONS?

NATIONAL 2018 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Practice Transformation Approaches from the Special Projects of National Significance Workforce Capacity Building Initiative (Institute 101), 12261

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Associate Clinical Professor - Medicine/Infectious Diseases
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Disclosures

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Family Health Centers of San Diego (FHCSD)

- Private 501(c)3 Federally Qualified Health Center
- Operates 21 clinic sites throughout San Diego County
- HIV Services since 1990's; largest provider of HIV services in SD County
- Serves approximately 1,300 persons living with HIV per year
- Patient population racially/ethnically diverse, un/underinsured, low income
- Provides HIV Pre-Exposure Prophylaxis (PrEP), transgender hormones, and focused LGBTQ services (at certain clinics), medication-assisted treatment (Suboxone), integrated mental health, healthcare for the homeless grantee

Challenges and Transformation Goal

Goal:

Expand the capacity of FHCSD to provide specialty HIV care through system-level structural changes over a period of 4 program years (2014/15 through 2017/18)

Challenges:

- HIV care and supportive services/case mgmt located at one central clinical site
- HIV care siloed (not integrated into primary care), patients traveled to central clinic
- Three full-time HIV Medical Specialists were leaving FHCSD
- FHCSD needed more trained HIV specialists to care for the approximately 1,300 existing and any new HIV patients

Practice Transformation Model

Aim: Expand HIV medical care and supportive services to additional clinic sites through:

- Training existing primary care providers and family medicine residents to provide HIV specialty medical care

MD, DO, NP, PA FM Residents

- Training support staff at the additional clinical sites to provide HIV supportive services and culturally-sensitive care to persons living with HIV (sensitive to the needs of LGBTQ and other stigmatized groups)

Case Mgrs, Care Coordinators Lab Staff Front Desk Staff

MA, RN, LVN Insurance Application Assistors

Training Model – Clinical Support Staff 1

Curriculum: 2-hour sessions both in person and online, approximately once per month for a period of six months; Curriculum developed by the Program Manager

Topics:

- HIV 101
- Hepatitis C 101
- Cultural Competency/Sensitivity
- HIV Pre-Exposure Prophylaxis (PrEP)
- HIV Resources and Referrals (drug assistance, Ryan White, etc.)
- Trauma Informed Excellence (Coldspring Center - a training center)

Instructors:

- Pacific AIDS Education and Training Center (AETC) for HIV/HCV 101, Cultural Competency
- Coldspring Center (a training center) for trauma informed care
- Existing Family Health Centers of San Diego staff champions from the first clinic site

Training Model – Clinical Support Staff 2

Recruitment: The Program Manager obtained buy-in from clinical managers (with effort) who then approved support staff attendance at the training sessions

Timing: Sessions were offered outside of clinic hours to accommodate staff work schedules

Attrition: Sessions were offered on a rotating basis and staff were invited to attend any missed sessions in the future; refresher sessions were also offered during the last year

Financing: Support staff were reimbursed for their training time by the grant

Coordination: The training site for support staff and medical providers were coordinated

- Support staff were trained in new clinical sites during the same time during a period of about six months
- Support staff were trained at sites where newly trained medical providers would provide care

Training Model – Medical Providers 1

Curriculum:

- Multi-modal and longitudinal training program culminating in American Academy of HIV Medicine (AAHIVM) specialty certification
  - 24 months for family medicine residents
  - 6 months for existing primary care medical providers
- Developed by existing HIV Specialist Physician (Physician Champion)

Training Model – Medical Providers 2

Curriculum Features:

- Immersive clinical preceptorship: rotations of two ½ days per month progressing to preceptoring then empanelment (assigned own patients)
- Independent study
  - HIV Webstudy/Question Bank (AIDS Education Training Center, or AETC)
  - Telehealth recorded sessions (Northwest AETC)
  - Hepatitis C Curriculum (University of Washington)
  - HIV Online Curriculum (University of Washington)
- Telehealth (Pacific AETC HIV Learning Network) and weekly huddle (FHCSD)
- Ongoing Specialty consultation (via text, telephone, electronic)

Training Model – Medical Providers 3

Instructors: Physician Champion; self-study; other providers during huddles

Recruitment: Competitive Application process among existing PCP's and residents

Timing: Precepting integrated into schedule, telehealth sessions held over lunch hour, consultation ongoing; independent study outside of clinical hours

Attrition: Medical staff who were trained signed a 2-year commitment to remain at the agency after the training was completed

Financing:

- Grant paid for per-diem providers for the clinic hours missed while existing medical providers were trained
- Physician Champion received salary support for admin time
- Curricula became a part of the existing family medical residency program which pays for Physician Campion residency education

Implementation Challenges

1. **Clinic directors (middle management) were skeptical, uninformed, and reluctant**

   Extra care to explain rationale, importance of decentralizing HIV care. Needed to back-fill training time for medical providers with per-diem providers, conduct clinical support staff trainings outside of work hours

2. **Two trained medical providers found better opportunities**

   Required future trainees to sign contract addendum with two-year commitment as condition to receive training

3. **Expansion clinics and providers not always aligned**

   Coordinated training of staff and providers; quickly adapted trainings to sites where providers were placed

Key Outcomes – Training

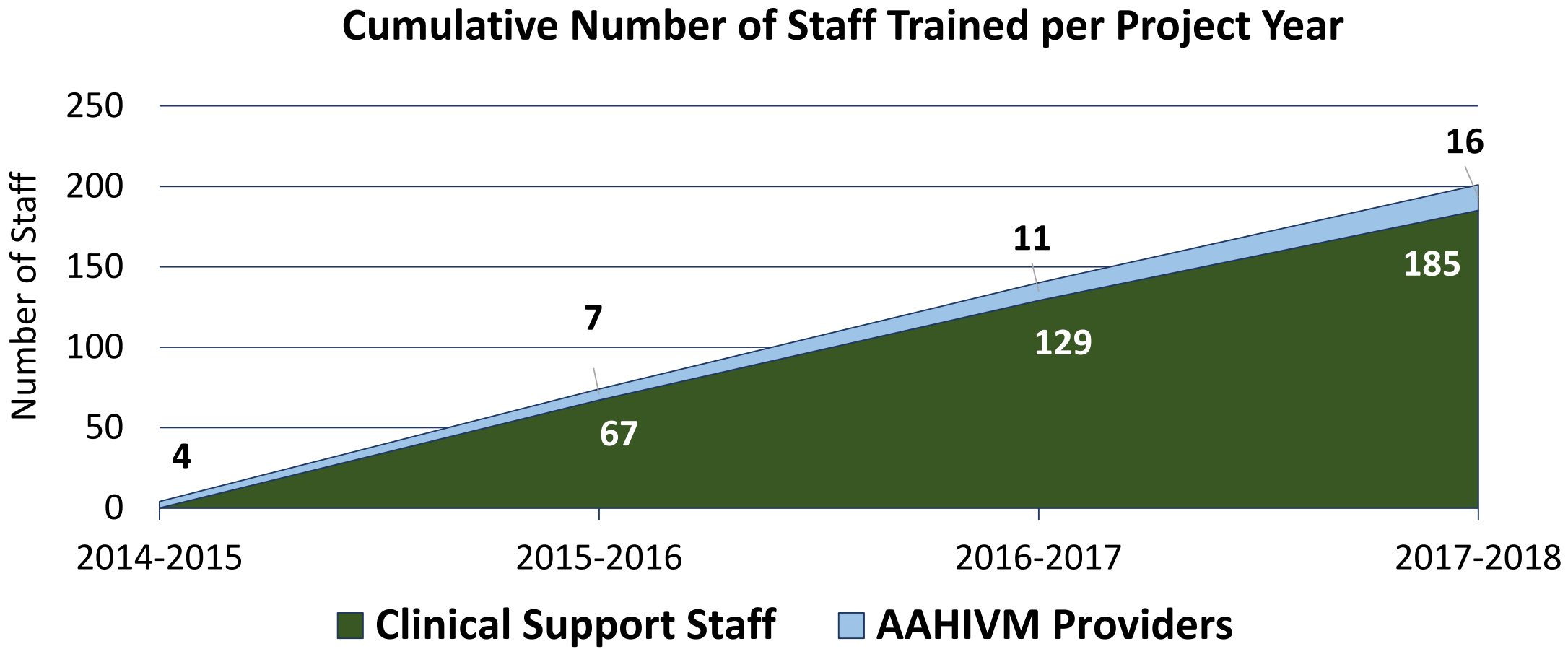
Medical Providers

- **16** medical providers were trained to provide HIV specialty care
  - 9 were AAHIVM-certified (2 of whom left the organization)
  - 4 were in queue to take exam (fall 2018)
  - 2 began training in July 2018
  - 1 decided to provide PrEP but not HIV medical care
- Of these trained HIV medical providers, 8 were Family Medicine Residents
  - Of the 4 who graduated, 100% were retained at FHCSD after residency
- 100% of the trained providers showed growth in self-efficacy and knowledge

Clinical Support Staff

- **185** clinical support staff of various types were trained
- 60% attended sessions for at least 3 of the 6 topics

Key Outcomes - Training

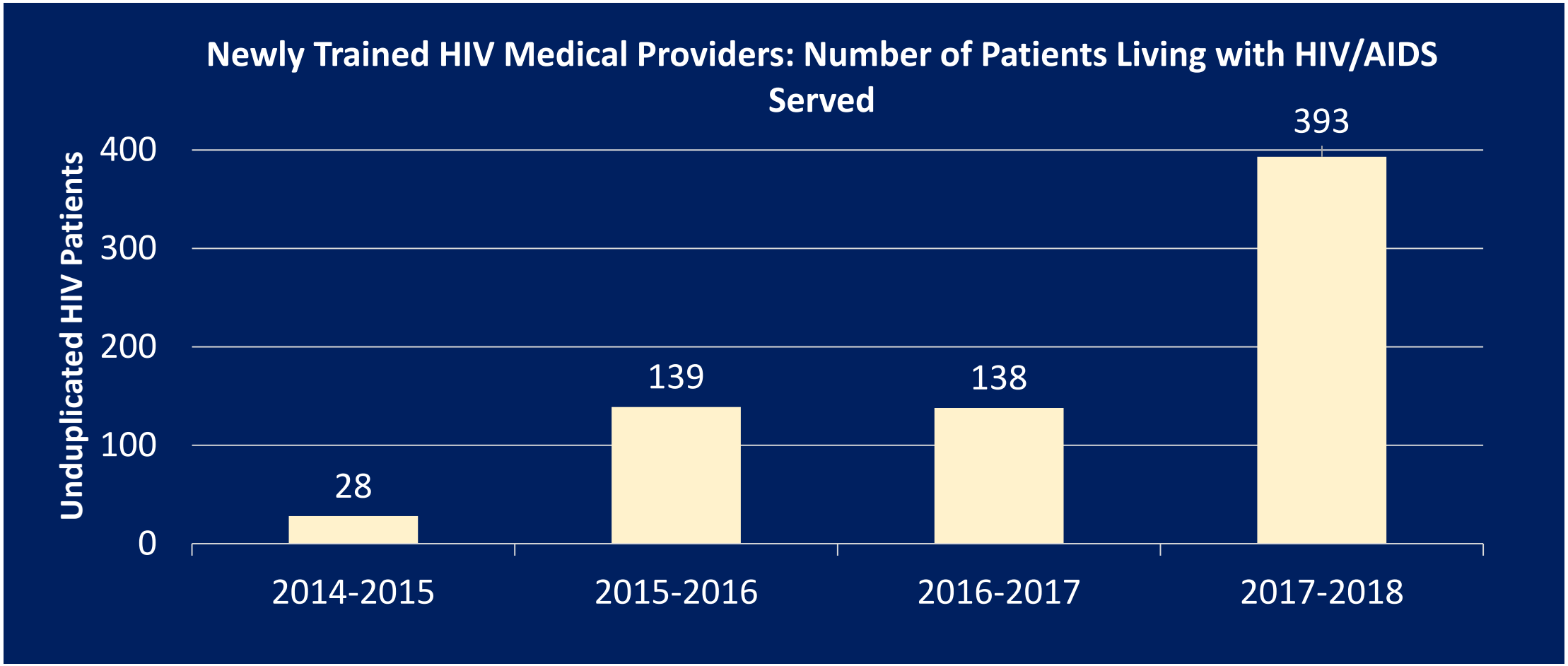


Key Outcomes

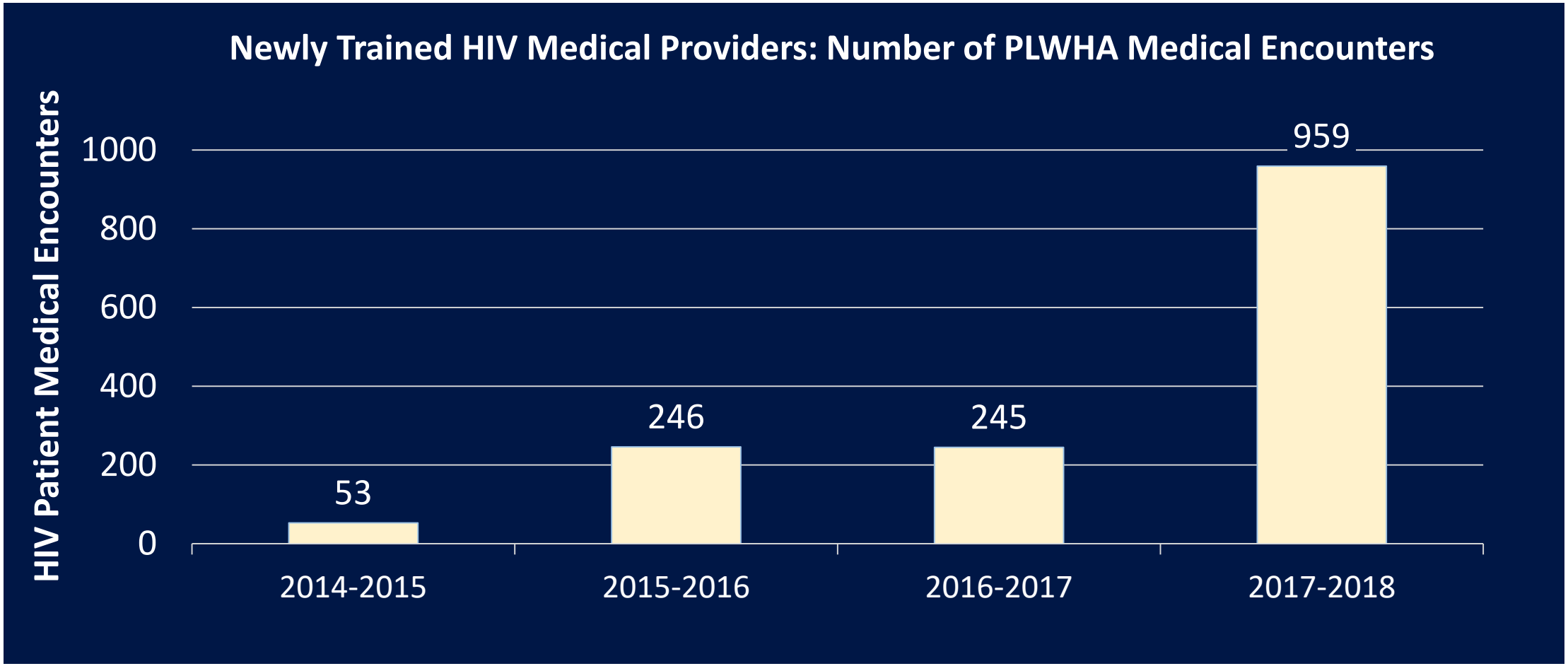
Significant Expansion:

- ★**6**★ FHCSD clinics began providing HIV medical care and supportive services [total of 7 clinic sites]
  - 4 by July 2018 and 2 after July 2018
- There was a significant increase in persons living with HIV served by the newly trained medical providers
  - The number of patients increased from **28** in the first program year to **393** by the fourth program year
  - HIV patient encounters with the newly trained physicians increased from **67** in the first program year to **959** in the fourth program year

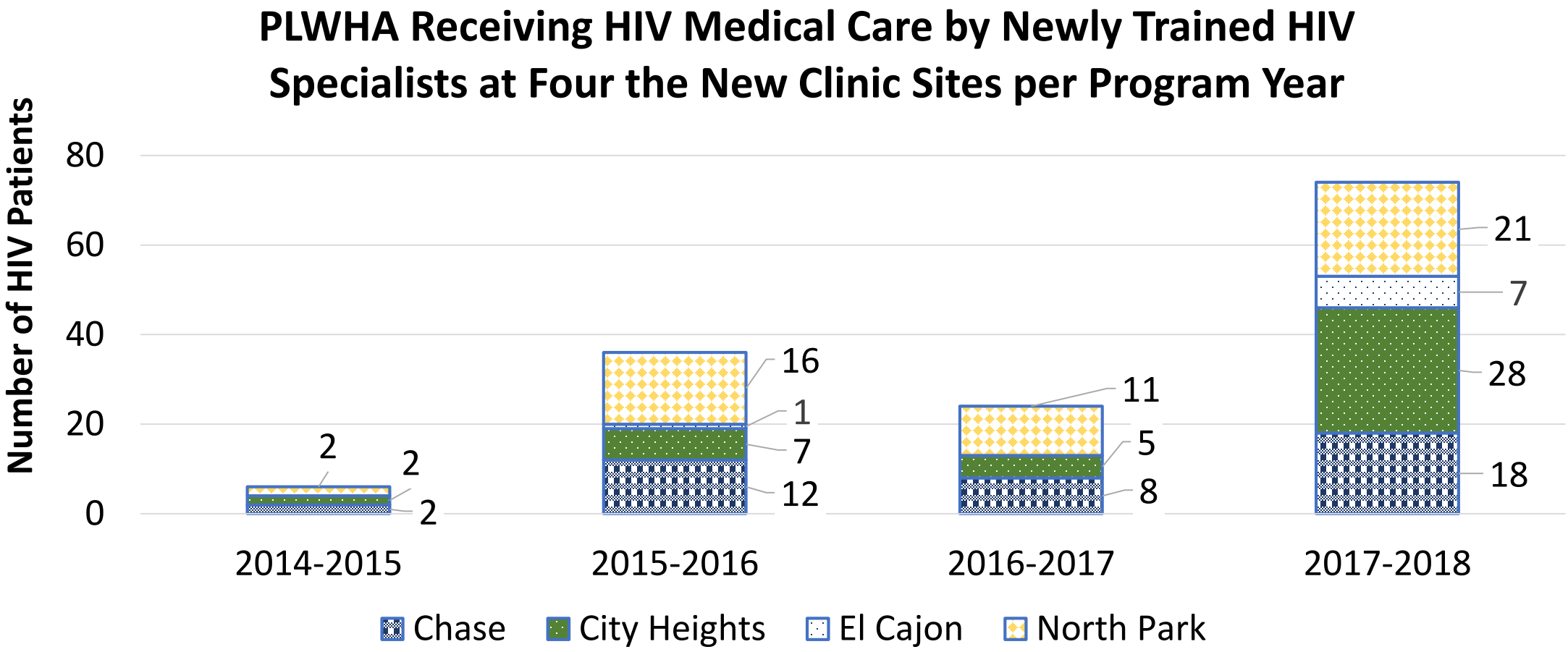
Key Outcomes – Patients



Key Outcomes – Encounters



Key Outcomes – Clinic Growth



Summary: Sustainability and Integration

By the end of 2018:

- 11 practicing PCP's providing HIV specialty care with a 2 year commitment in place
- HIV care provided at six FHCSD sites by AAHIVM certified HIV specialists
- 'HIV Track' (2 residents/yr) integrated into the Family Medicine Residency Program
- Physician Champion (faculty trainer) still present and available for ongoing mentoring/maintenance of 'teaching/learning culture'
- For medical providers: University of Washington online curriculum and the PAETC HIV learning network are enduring resources
- For support staff: 185 staff trained; newly hired staff will be trained by existing staff champions; clinic directors will allow time to complete online training

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2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

A Comprehensive Practice Transformation Model (PTM) to Enhance Capacity and Improve Quality of Care in PLWHA in Miami-Dade County

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UHealth UNIVERSITY OF MIAMI HEALTH SYSTEM | UNIVERSITY OF MIAMI MILLER SCHOOL of MEDICINE | Jackson HEALTH SYSTEM | PUBLIC HEALTH TRUST

Disclosures

Alan E. Rodriguez, MD

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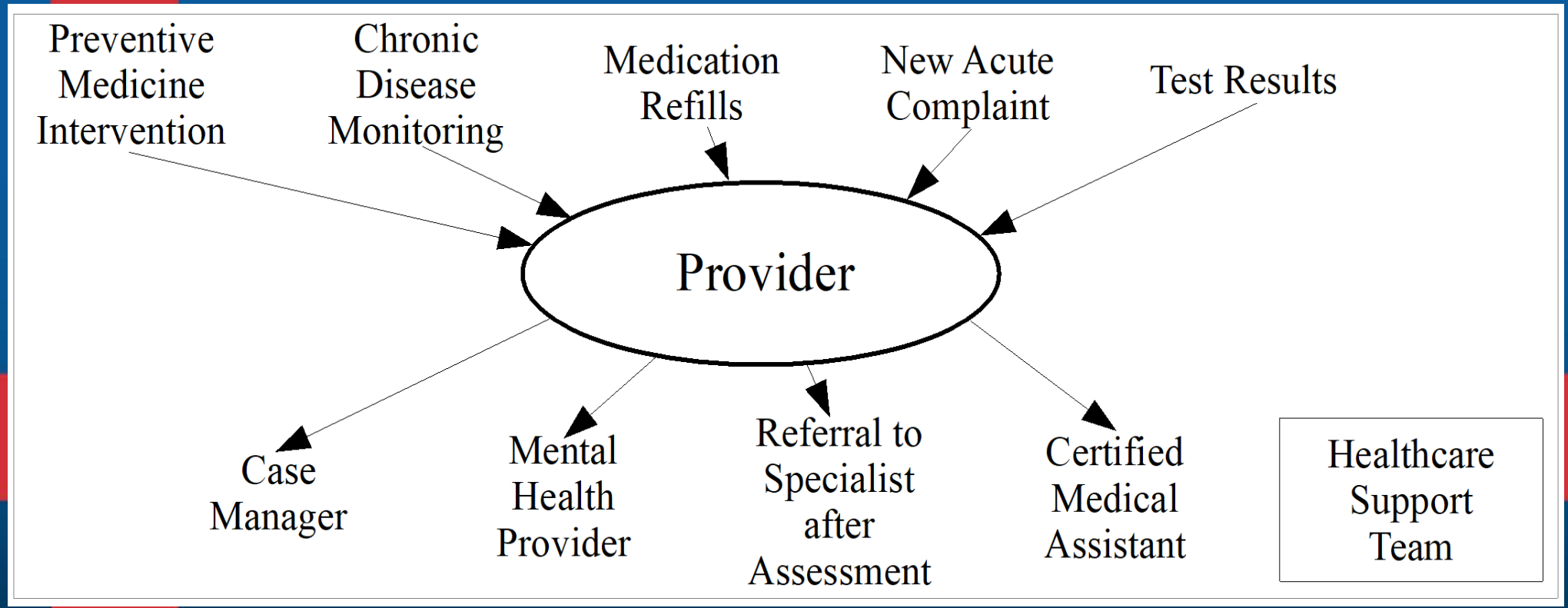
PTM Setting: Miami/Jackson Memorial Medical Center (UM/JMMC)

- Largest single-site HIV clinic in Florida
- Serves approximately 3200 individual patients annually
  ~23% of the estimated 14,000 adult HIV cases in Miami-Dade
- Majority of patients are from a racial/ethnic minority group
  57.9% Black; 36.4% Hispanic
- Women account for 37.6% of this population
- ~75% of patients are over 40 years old, and 51.7% are over age 50.
- Staffed by University of Miami faculty along with members of an interdisciplinary treatment team from both JMMC and UM

Medical Provision of Care Prior to the PTM Followed Traditional Method of Care

- Provider-driven medical care
- Served as the main resource of all patient information
- Delegated to the care support team as needed



Pre-PTM Data

Patient Attendance

53.6% kept

18.6% no show

27.8% cancelled + rescheduled

***Large variance between providers**

Virological Suppression (<20 copies/mL)

78.5% suppression rates among established, retained (≥3 visits/year) patients

-Across all patients, including inconsistent attenders, only 48.3% were suppressed

Clinic Utilization

93.0% utilized overall

-Range between providers: 75.0% - 97.5%

Gap Analysis

Points	Y/N/P	Standard/Element	Must-Pass (M)
10		PMCH 1: Patient Centered Access	
4.5	P	Element A Patient-Centered Appoints *(CF-A1)CF-Partial*	**M**
3.5	P	Element B 24/7 Access to Clinical Advice *(CF-B2)-Partial*	
2	N	Element C Electronic Access	
12		**PCMH 2: Team Based Care**	
3	P	Element A Continuity	
2.5	Y	Element B Medical Home Responsibilities	
2.5	Y	Element C Culturally and Linguistically Appropriate Services (CLAS)	
4	N	Element D The Practice Team *(CF-D3)-Partial*	**M**
20		**PCMH 3: Population Health Management**	
3	Y	Element A Patient Information	
4	Y	Element B Clinical Data	
4	P	Element C Comprehensive Health Assessment	
5	N	Element D Use Data for Population Management	**M**
4	Y	Element E Implement Evidence-Based Decision Support *(CF-E1)-Yes*	
20		**PCMH 4: Care Management and Support**	
4	Y	Element A Identify Patients for Care Management *(CF-A6)-No*	
4	N	Element B Care Planning and Self-Care Support	**M**
4	Y	Element C Medication Management *(CF-C1)-Yes*	
3	Y	Element D Use Electronic Prescribing	
5	N	Element E Support Self-Care and Shared Decision Making	
18		**PCMH 5: Care Coordination and Care Transitions**	
6	N	Element A Test Tracking and Follow-up *(CF-A1 & A2)-No*	
6	N	Element B Referral Tracking and Follow-up *(CF-B8)-No*	**M**
6	N	Element C Coordinate Care Transitions	
20		**PCMH 6: Performance Measurement and Quality Improvement**	
3	Y	Element A Measure Clinical Quality Performance	
3	N	Element B Measure Resource Use and Care Coordination	
4	P	Element C Measure Patient/Family Experience	
4	P	Element D Implement Continuous Quality Improvement	**M**
3	Y	Element E Demonstrate Continuous Quality Improvement	
3	N	Element F Report Performance	
NS	Y	Element G Use Certified EHR Technology	

Y=Yes (>75% Points); P=Partial (25%-75% Points) N=No (<25% Points or CF=No or M <50% Points)

CF = Critical Factor M = Must-Pass (> 50% Points)

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Multiple areas were identified as points of improvement:

- **Provider-centered care**
- **Appointments by clinic availability only**
- **Problem-focused patient identification**
- **Inconsistent/ de-centralized referral tracking**

UM/JMMC Practice Transformation Model

- A Practice Transformation Model (PTM) was incorporated into the existing UM/JMMC Adult HIV Outpatient Clinic infrastructure
- Using detailed workflows of clinic processes, the PTM involved the addition of two Medical Assistants (MA) and a Patient Navigator (PN):
  - Medical Assistants assisted providers with all aspects of a clinic visit and provide continued patient care & engagement outside of the clinic
  - Patient Navigator assisted patients with all aspects of continuous engagement in clinical care

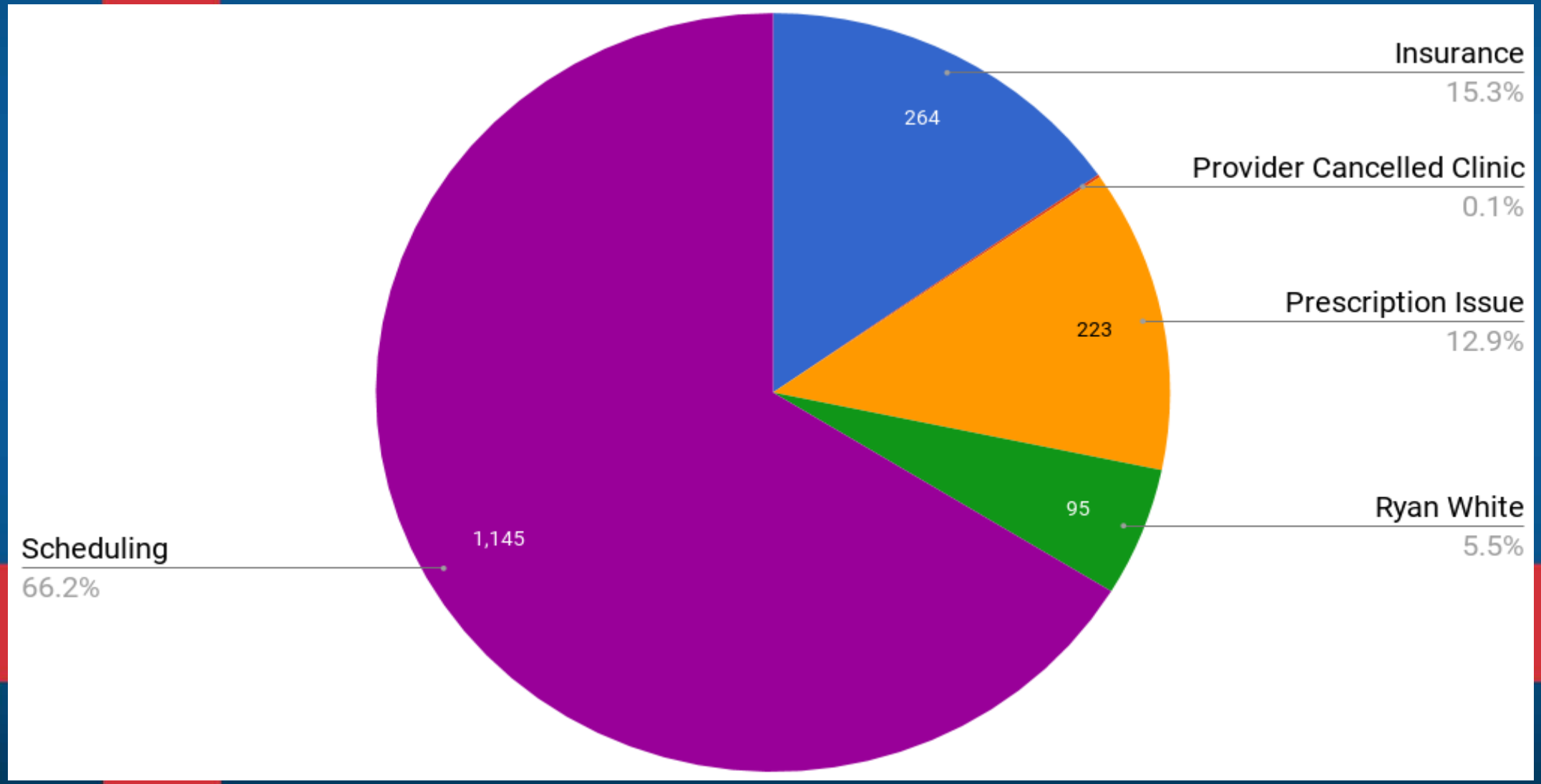
Role Overview – Patient Navigator

- Improved linkages by increasing the number and frequency of contact to agencies that provide HIV testing and refer patients to the clinic
- Provided outstanding customer service to enhance the patient-centered interaction
- Knowing and utilizing all HIV care resources available for patients
- Understanding each step involved for patients to successfully access the clinic, from appointment creation, meet with case management, insurance and financial clearance, blood draws for labs, meet with a provider, and check out with the subsequent appointment already scheduled
- Planning future patient interactions through centralized scheduling and coordinating with Patient Access Representatives
- Referring in and out of UM/JMMC to fulfill different insurance payer requirements

Role Overview – Medical Assistants

- Connected patients to available HIV care resources both at UM/JMMC and in the community
- Mastered the process involved in accessing all clinic services to improve patient access to the clinic
- Proactively planned upcoming appointments via centralized scheduling and Patient Access Representatives
- Referred in and out of UM/JMMC to accommodate different insurance payer requirements
- Navigated and documented patient contact in the EMR in order to maintain current contact details
- Assisted with medication refills

Post PTM Integration: Reason for PN Contact



Post PTM Integration

Increased Capacity

Pre-PTM: 6324 patient encounters in 2015

Post-PTM: 7949 patient encounters in 2016

More Kept Appointment Outcomes

Pre-PTM: 64.0% kept appointments

Post-PTM: 76.8% kept appointments

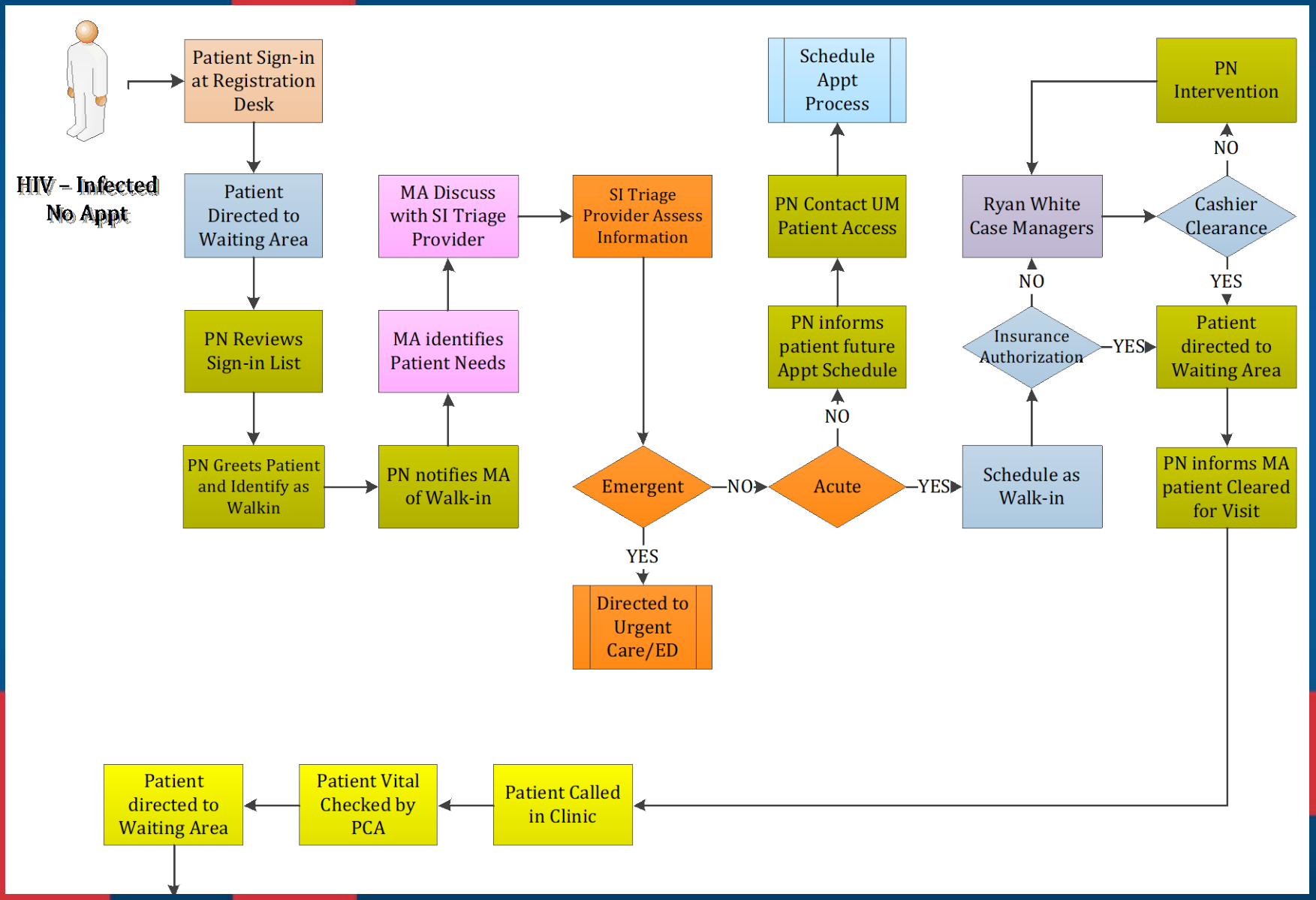
Improved Virological Suppression Rates (<20 copies/mL)

Across all patients:

Pre-PTM: 48.3%

Post-PTM: 70.6%

Rapid Response Initiative



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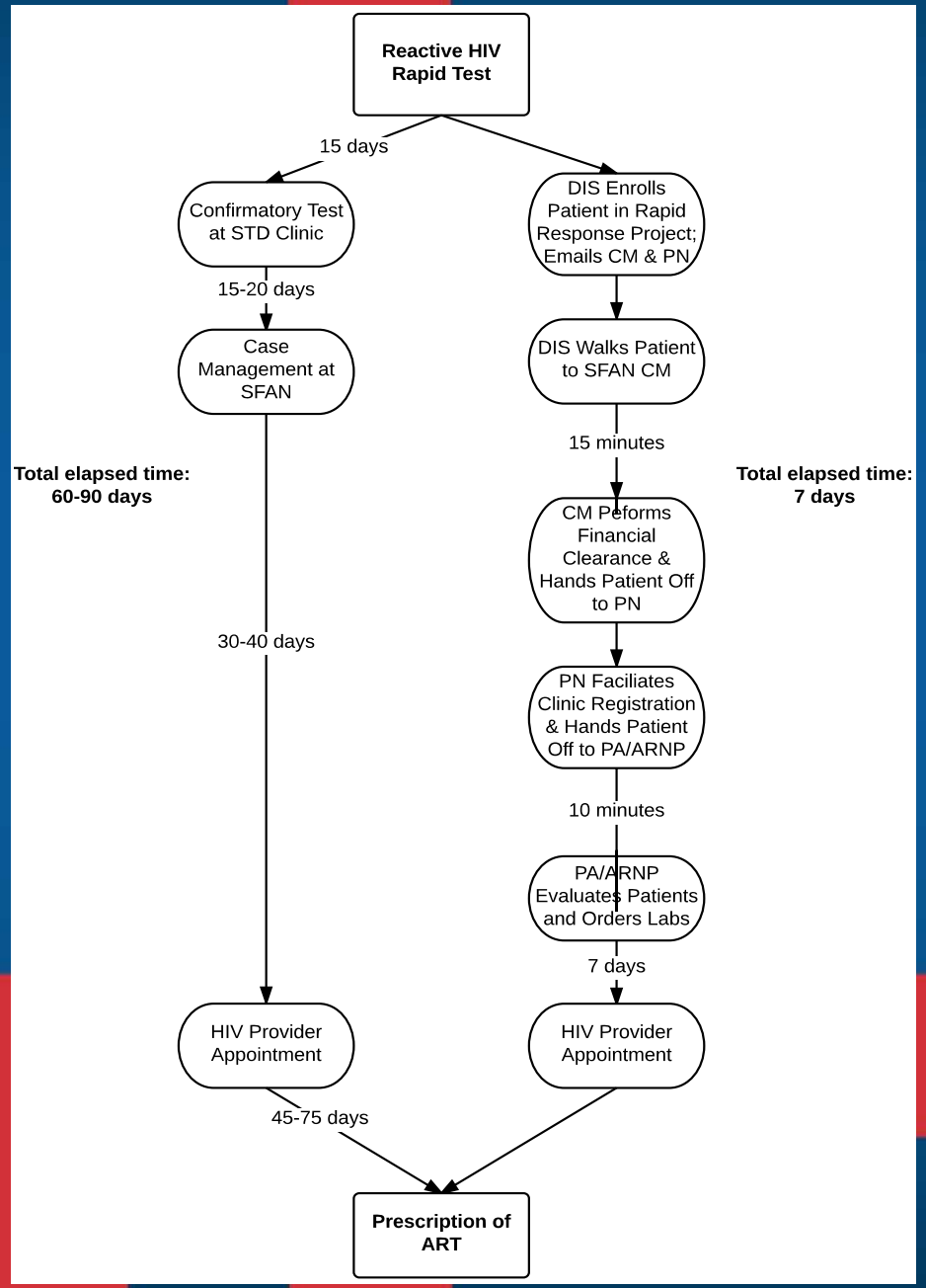
Facilitated by adapting existing walk-in workflow

Rapid Response Initiative



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A Rapid Response initiative was launched in collaboration with the Florida Department of Health in Miami-Dade County.

The program offered newly diagnosed patients a same-day appointment with a HIV provider along with an ART prescription to achieve immediate linkage to care.

Rapid Response Initiative

Compared to new patients entering care via the traditional route:

More First Appointments Kept

Traditional: 48.5%

Rapid Response: 100%

Higher Suppression Rates by 3rd Lab Visit

Traditional: 43.4%

Rapid Response: 70.0% ($X^2(1)=6.52$, $p = 0.011$)

Higher Mean CD4 Count at 3rd Lab Visit

Traditional: 327.77 + 242.5 cells/mm3

Rapid Response: 597.78 ± 322.5 cells/mm3 ($t(90)=4.59$, $p < 0.001$)

Conclusions & Lessons Learned

- The PTM, based on a Share the Care model, demonstrated that a PCMH can be integrated into a large existing HIV outpatient clinic.
- Stakeholder buy-in was integral to its success
- Workflows helped with buy-in, training new staff, and adopting new procedures such as the rapid response initiative
- Aside from administrative & management hurdles, incorporation of additional staff to offload non medical-related tasks improved patient outcomes

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