NATIONAL **S**RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT



SPNS Workforce Capacity Building Initiative: NewYork-Presbyterian Outcomes

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Disclosures

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

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



Session Objectives

Describe the SPNS NYP Practice Transformation Model

- Reflect upon barriers and facilitators associated with implementation of a Practice Transformation Model in an urban academic HIV clinic
- Discuss the outcomes of NYP PTM's system-level changes



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

• HIV Care & Treatment

•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

Sexual Health

•Serving individuals of all ages at risk of HIV infection

•STI Testing (including HIV & Hepatitis C)

• PrEP, PEP, Primary Care, Mental Health & Supportive Services

•Linking to Hepatitis C Treatment

•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

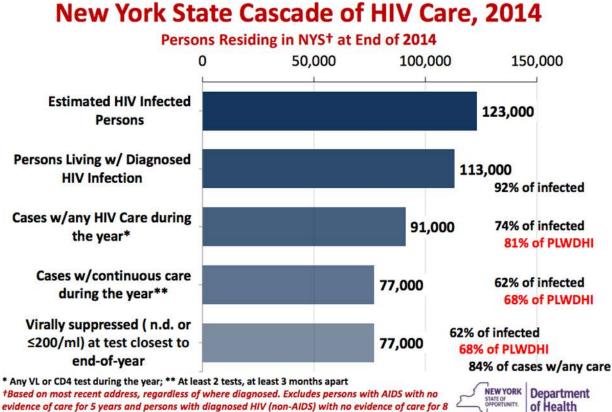


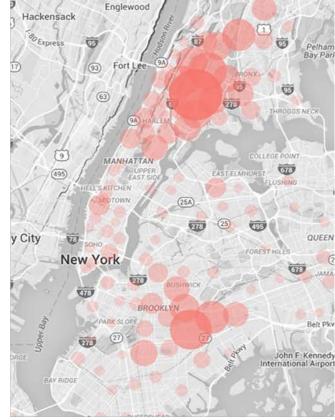


Figure 1. New York City Map.



Why Practice Transformation at **NYP-CHP?** Mt Vernon New P





Credit: Dan Feller, NYSDOH, 2015.



years.

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" to create system-level workforce capacity for HIV care
- 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 standards
- Improvements to Practice's capacity to care for people living with HIV, valuing efficiency and sustainability
- Optimization of resources in changing healthcare landscape
- Quality improvement efforts aimed at increasing the rates of linkage, engagement, retention in care, and viral load suppression



Patient Care Coordination Challenges

Care coordination

- Inefficiencies in identifying who to follow-up
- Separate programs for adherence, care coordination, nursing care, medical
- Untapped opportunities for efficiencies through HIT

Team communication

Complex communication patterns in clinic and across settings

Staff working at the top of their license

Nursing

Social work



Patient Access Challenges

Accessibility

Need for strengthening patient access to same-day walk-in care

Many providers are not on-site full time (fellows, researchers, etc.)

No-shows

High no-show rates resulting in lost capacity



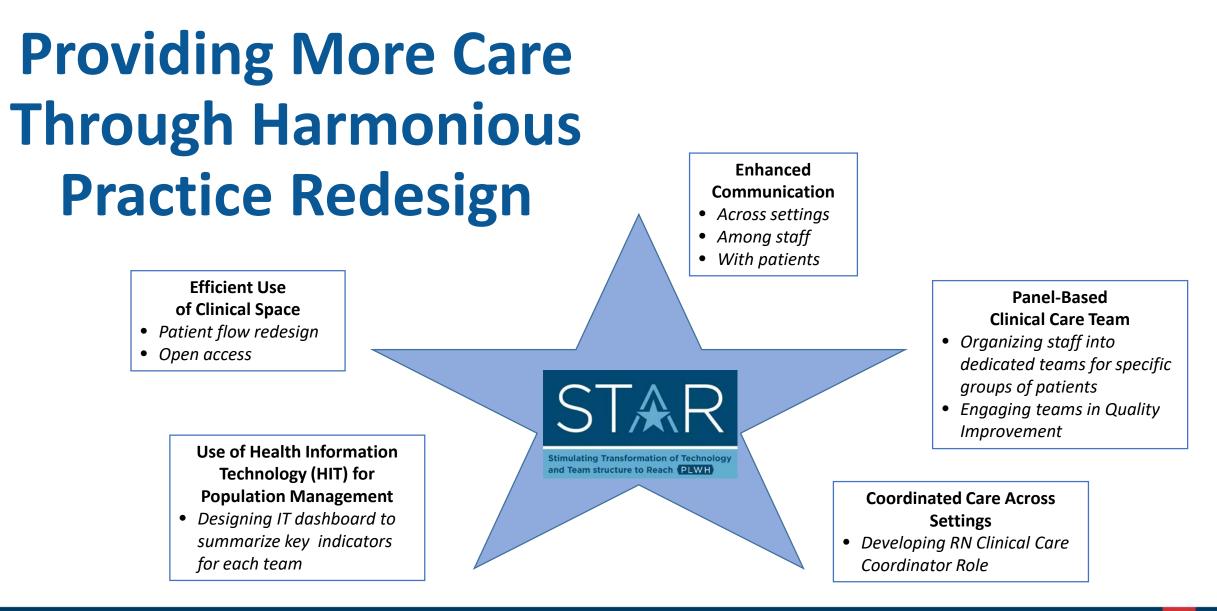
STaR's Practice Transformation Intervention Overview





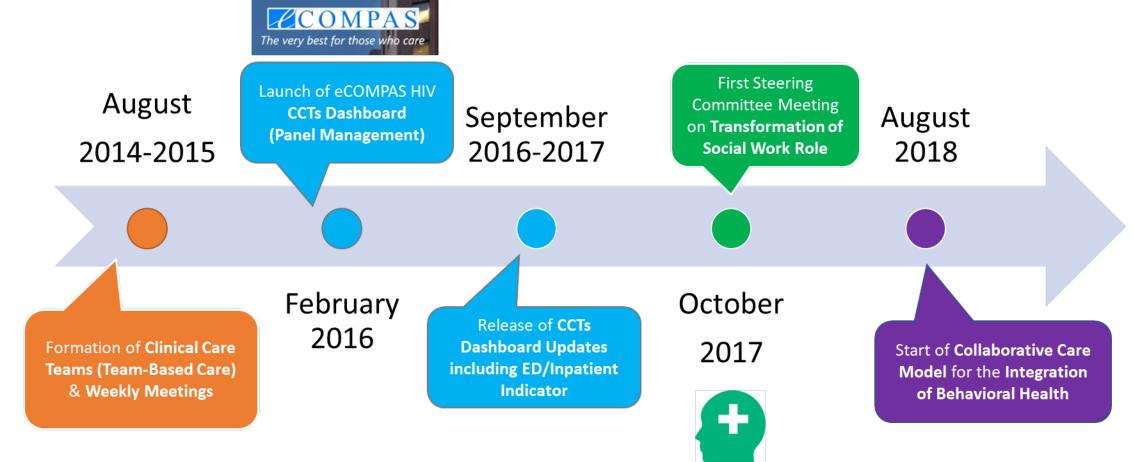


Stimulating Transformation of Technology and Team structure to Reach (PLWH)





STaR's Practice Transformation Timeline



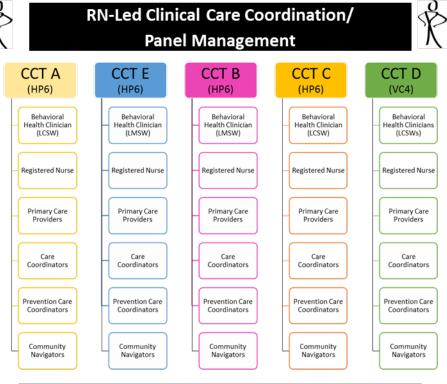
Imagine Credit: RDE Systems; Github.



Empanelment and Team-Based Care Coordination Strategy

RN Care Managers	
(STAR and DSRIP):	

- Provides CCT structure and training
- Supports Navigators, Community Health Workers and Peer Educators
- Crosses settings and program boundaries
- Work closely with CCT Prevention Coordinators to advance population strategies



Adherence Supervisor, Community Health Worker, Nutritionist, Psychiatrist, Patient Financial Advisors, Data, & Other Staff

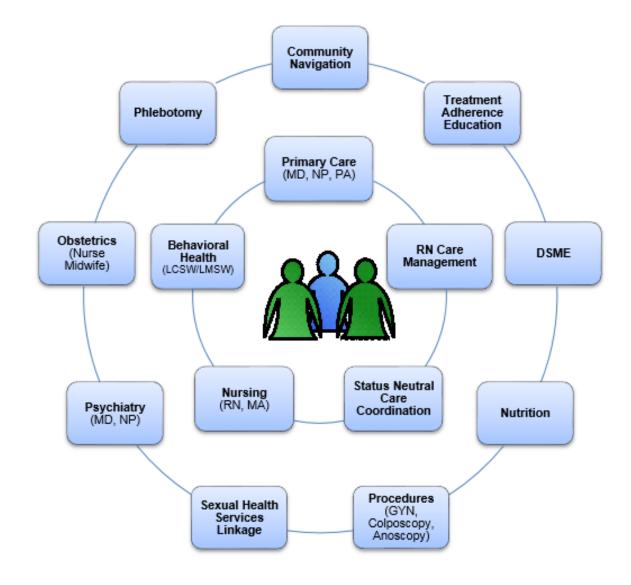


Care Enhancements:

- ✤ Better communication
- Social Worker co-lead Clinical Care Teams
- Medication adherence through Primary Care RN
- Integration of HIV Prevention and HCV
- Coordinated Services for People with Complex Co-Morbidities
- Integration of Behavioral Health



Team Based Care Coordination Model





Clinical Care Team Meetings

- RN Care Manager provided CCT structure and trainings
- Prioritized care coordination resources for patients by level of risk utilizing CCT dashboard
- Facilitated weekly case conferences





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.

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Clinic Flow Redesign and Expansion of Open Access











Barriers/Facilitators of PTM Implementation

- Frequent team-based communication through weekly clinical care team meetings
- Shared values on the importance and efficiency of conducting clinical care team meetings
- Overlapping responsibilities with the addition of new HIV care coordination roles to the clinic
- Alignment process of patient caseload between PCP and other team members was sometimes not compatible with programs or provider values
- Direct access to panel's quality indicators, including ED/hospitalization through panel-based dashboard
- Limitations of current HIT systems in differentiating patients based on HIV diagnosis status



Barriers/Facilitators of PTM Implementation

- Self-efficacy among non-PCP team members to execute care coordination tasks
- Limited nurse care manager scope of knowledge around implementation of intensity of care coordination based on risk-stratification
- Integration of HIT during care team meetings
- Development of program silos supported by fragmented HIT
- Limited participation of PCPs at the care team meetings due to part-time status
- Willingness from team members to be available in real-time
- Program alignment with regional goals for improvements in HIV care continuum including expansion of PrEP/PEP
- Complexity of integrating pay for performance initiatives and grant-funded activities within a team-based care structure



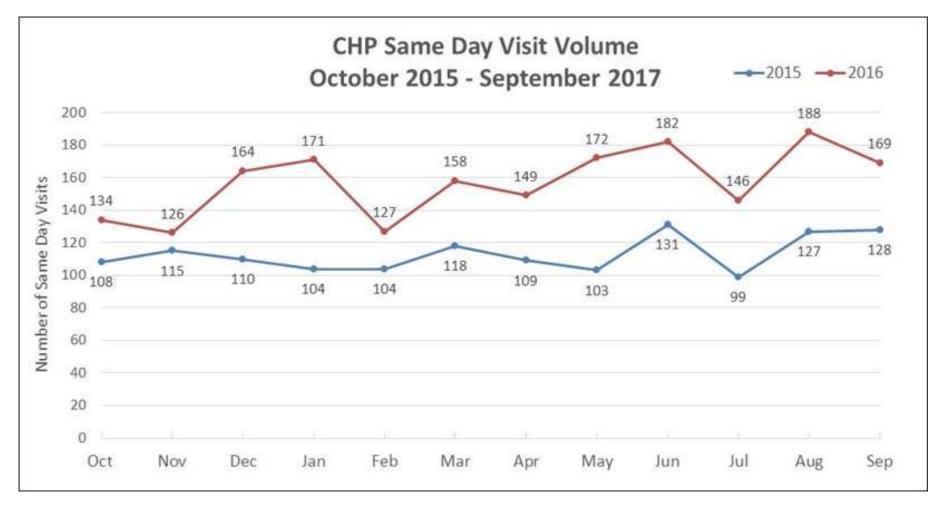
STaR's PTM Successes

Effectively expanded Practice's HIV care coordination model

- 1 care coordinator per patient panel (5) by leveraging existing resources, revising roles and responsibilities, and integrating in the STaR team-based care model
- Integration of RN Care Management role responsible for oversight of care transitions and panel management
- Sustained use of HIT-based panel management strategies to facilitate team meeting discussions and identify patients with complex care needs
- Clinic-wide adoption of weekly interdisciplinary care team meetings
- Redesign of patient flow allowed for expansion of same day services
 - Implementation of shared space via PCP swing spaces and team pods
- Routine application of QI methodology for introducing system-level changes and associated workflows
- Development and integration of "collaborative care model" to transform LCSW/LMSW as mental health providers and expand mental health services at our Practice



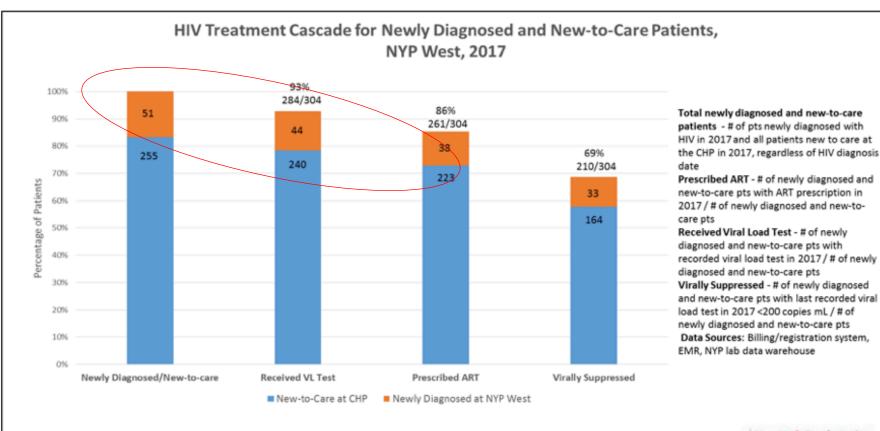
Same Day Care





Ongoing Challenges in Improving the HIV Care Continuum

Although VLS rates reached 85% in 2017, patient care coordination challenges remain especially as it relates to new and re-engaging patient populations.



- NewYork-Presbyterian



STaR PMT 2.0: Collaborative Care and Development of LCSW/LMSW as Behavioral Health Clinicians

Problem solving therapy (February-October 2018)

 Facilitated by University of Washington AIMS Center

CBT Overview and Tools for Practice (2 sessions in August 2018)

 Facilitated by Alberto D. Luna, Ph.D. Instructor in Clinical Psychology (in Psychiatry), Columbia University

DBT Boot camp (July-August 2018)

✓ Facilitated by Columbia University

Trauma Workshop (July 2018)

✓ Facilitated by Rosemary Masters, JD, LCSW

Reflective Functioning or 'mentalization' (March 2018)

Facilitated by Dr. Howard Steele, Professor & Chair for Clinical Psychology, The New School





Acknowledgements

- Audrey Perez, RN, *Nurse Care Manager, STaR Project*
- Sames Beltran, Data Coordinator, STaR Project
- Mila Gonzalez, MPH, STaR Project Director and Quality Manager
- Susan Olender, MD, STaR Principal Investigator and Quality Program Director
- Peter Gordon, MD, Medical Director
- Rebecca Schnall, PhD, RN, STaR Project Evaluator
- William Seiling, MPH
- Amber Gibbs, MPH
- Sesse Thomas, RDE Systems, HIT Consultant
- Anusha Dayananda, *RDE Systems, HIT Consultant*
- Comprehensive Health Program Team!







Funding Acknowledgement:

This NYP-Columbia STaR project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H97HA27430, a Special Projects of National Significance (SPNS) entitled "System-level Workforce Capacity Building for Integrating HIV Primary Care in Community Health Care Settings -Demonstration Sites" for 1,189,500 from 2014-2018. This information and these conclusions are those of the authors 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.





Question?