2018
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SPNS Workforce Capacity Building Initiative: NewYork-Presbyterian Outcomes

Mila C. González[1,2], MPH, Rebecca Schnall RN, MPH, PhD,[2] Susan Olender, MD, MS[1,2]

[1]NewYork-Presbyterian Hospital Columbia University Medical Center; [2]Columbia University School of Nursing

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)

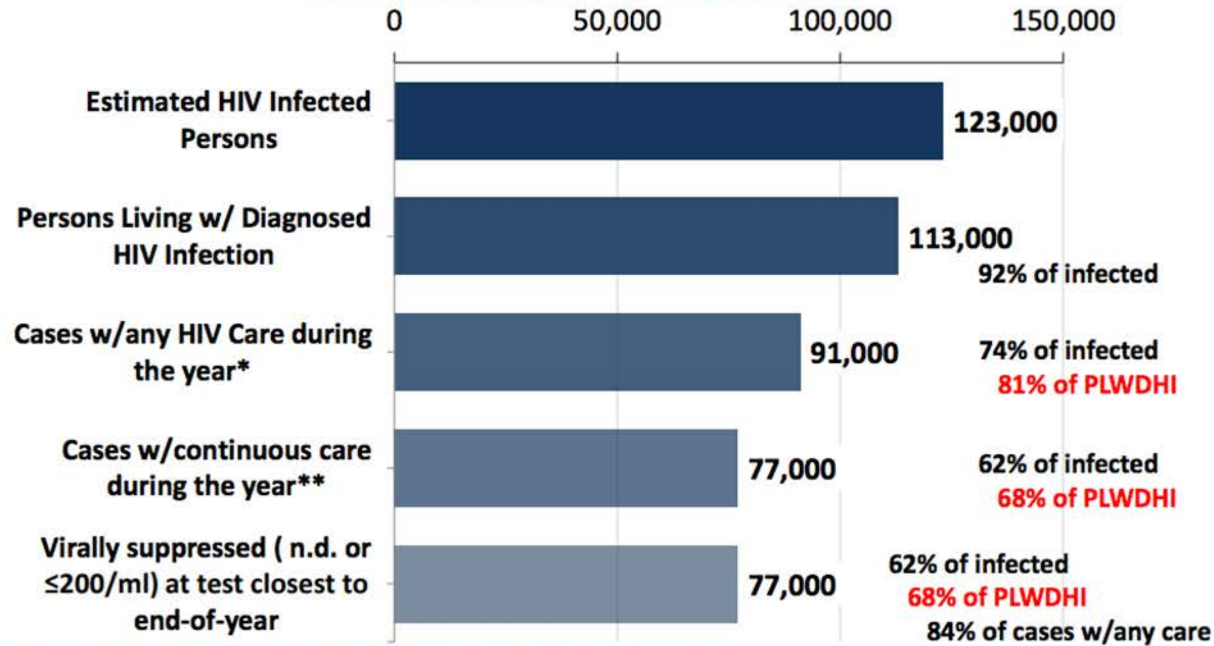
- **HIV Care & Treatment**
  - Serving Pediatric (including exposed infants and children), Adolescent, Young People, and Adults
  - Primary Care, Behavioral Health & Supportive Services
  - Hepatitis C Treatment for Co-infected Individuals
- **Sexual Health**
  - Serving individuals of all ages at risk 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

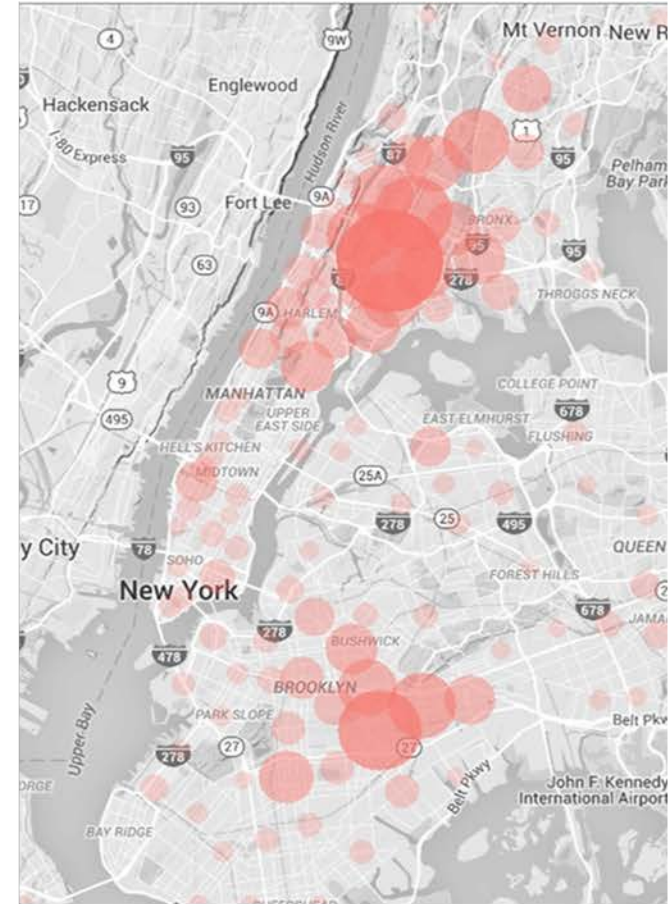
In 2017, **NYP served 2,966 clients living with HIV** from New York City's Upper Manhattan and the Bronx

Funding for Programs:

Figure 1. New York City Map.

Why Practice Transformation at NYP-CHP?





Credit: Dan Feller, NYSDOH, 2015.

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.)

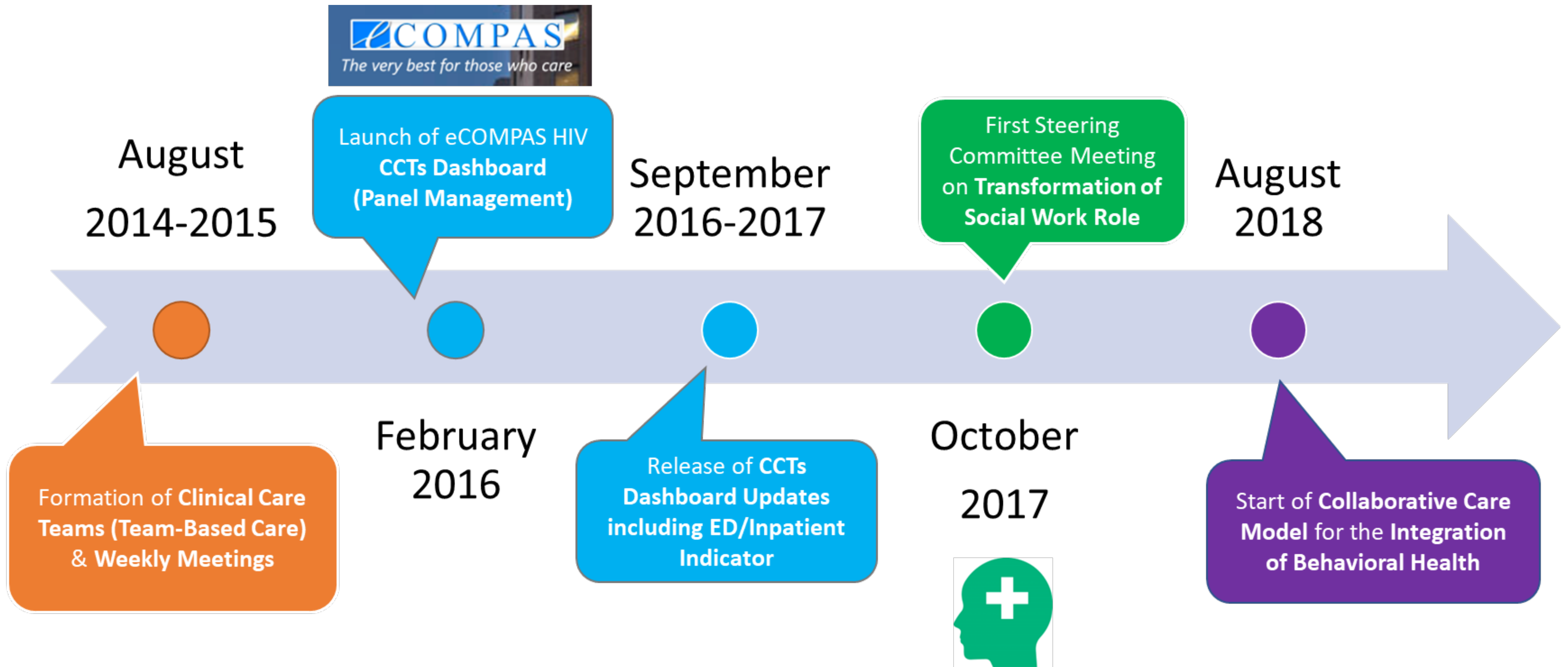
No-shows

- ❑ High no-show rates resulting in lost capacity

STaR's Practice Transformation Intervention Overview

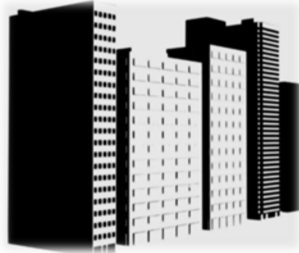
Providing More Care Through Harmonious Practice Redesign

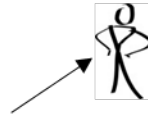
STaR's Practice Transformation Timeline

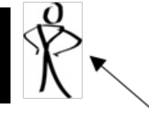


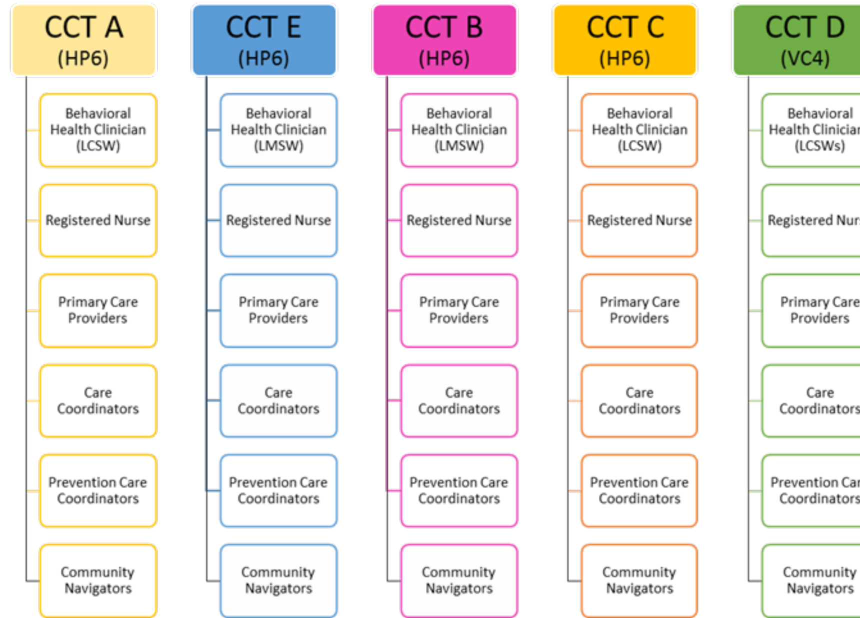
Imagine Credit: RDE Systems; Github.

Empanelment and Team-Based Care Coordination Strategy









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

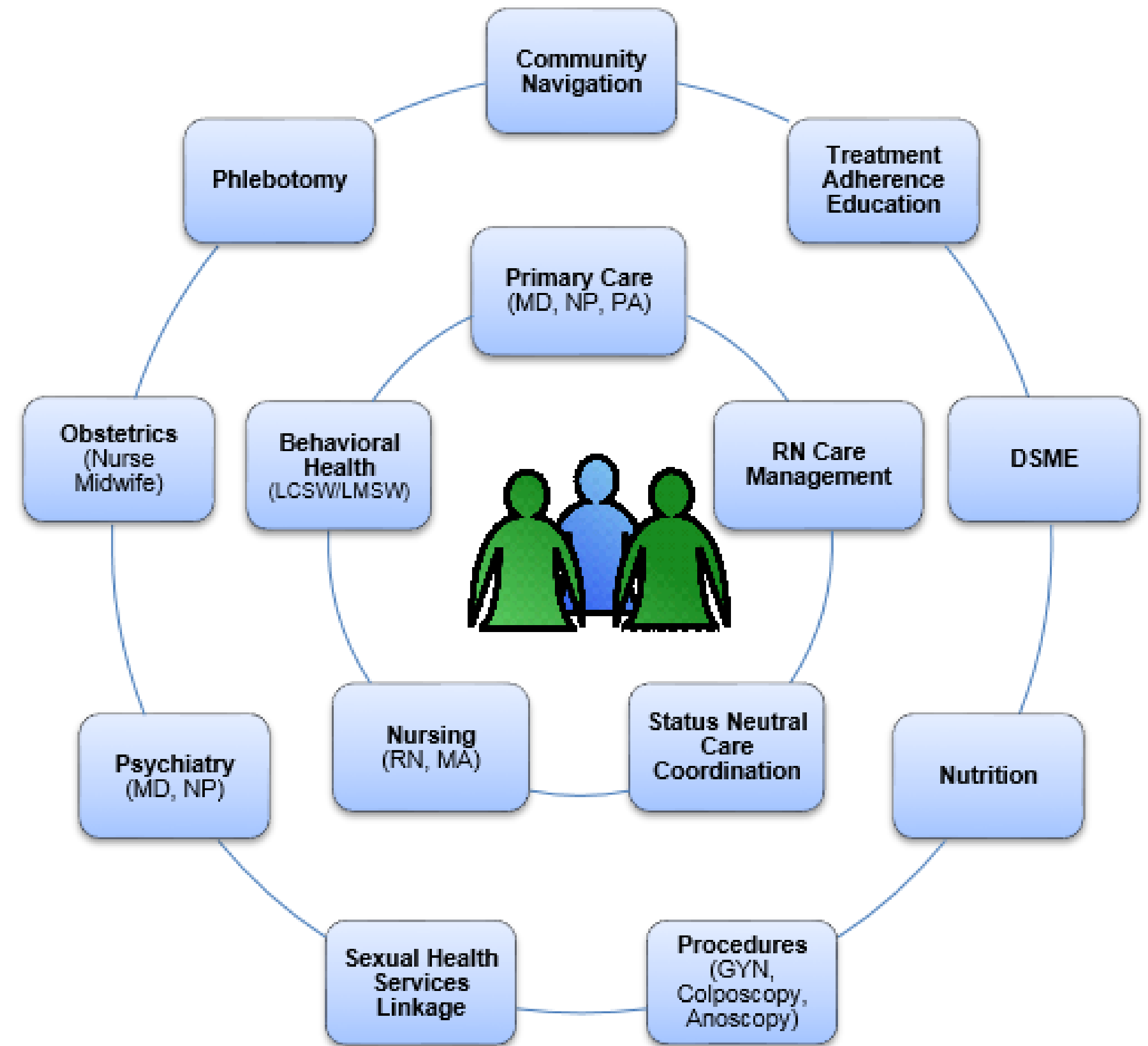
RN Care Managers (STAR and DSRIP):

- 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

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

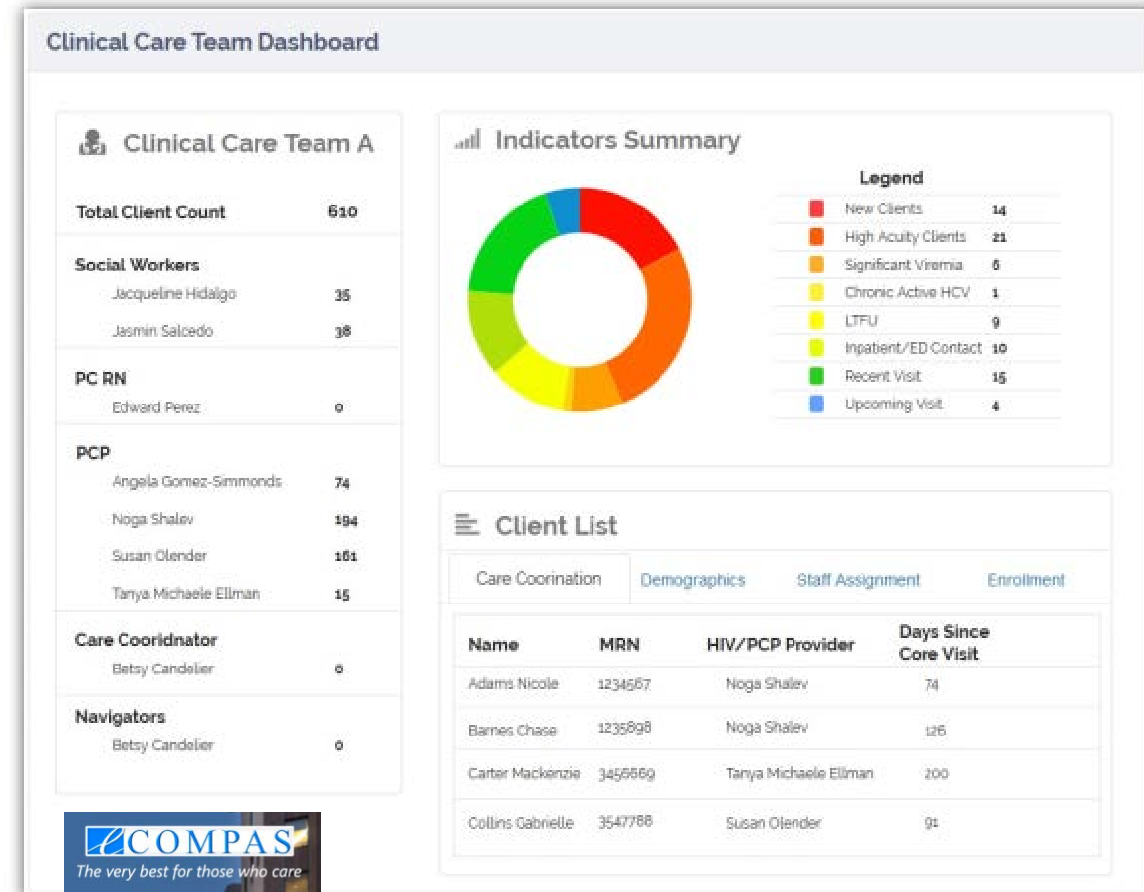


Clinical Care Team Meetings

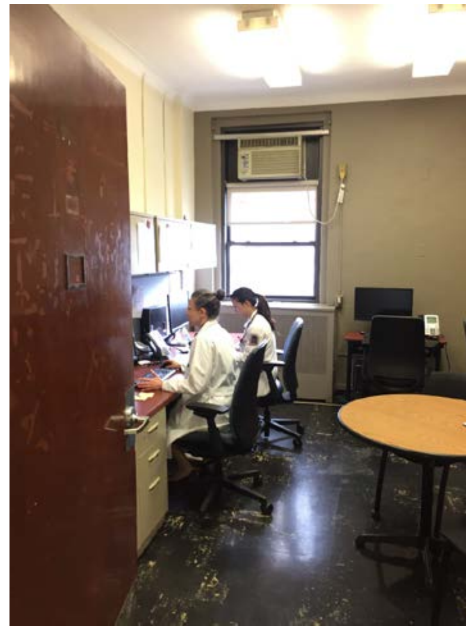
- RN Care Manager provided CCT structure and trainings
- Prioritized care coordination resources for patients by level of risk utilizing CCT dashboard
- Facilitated weekly case conferences

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.



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

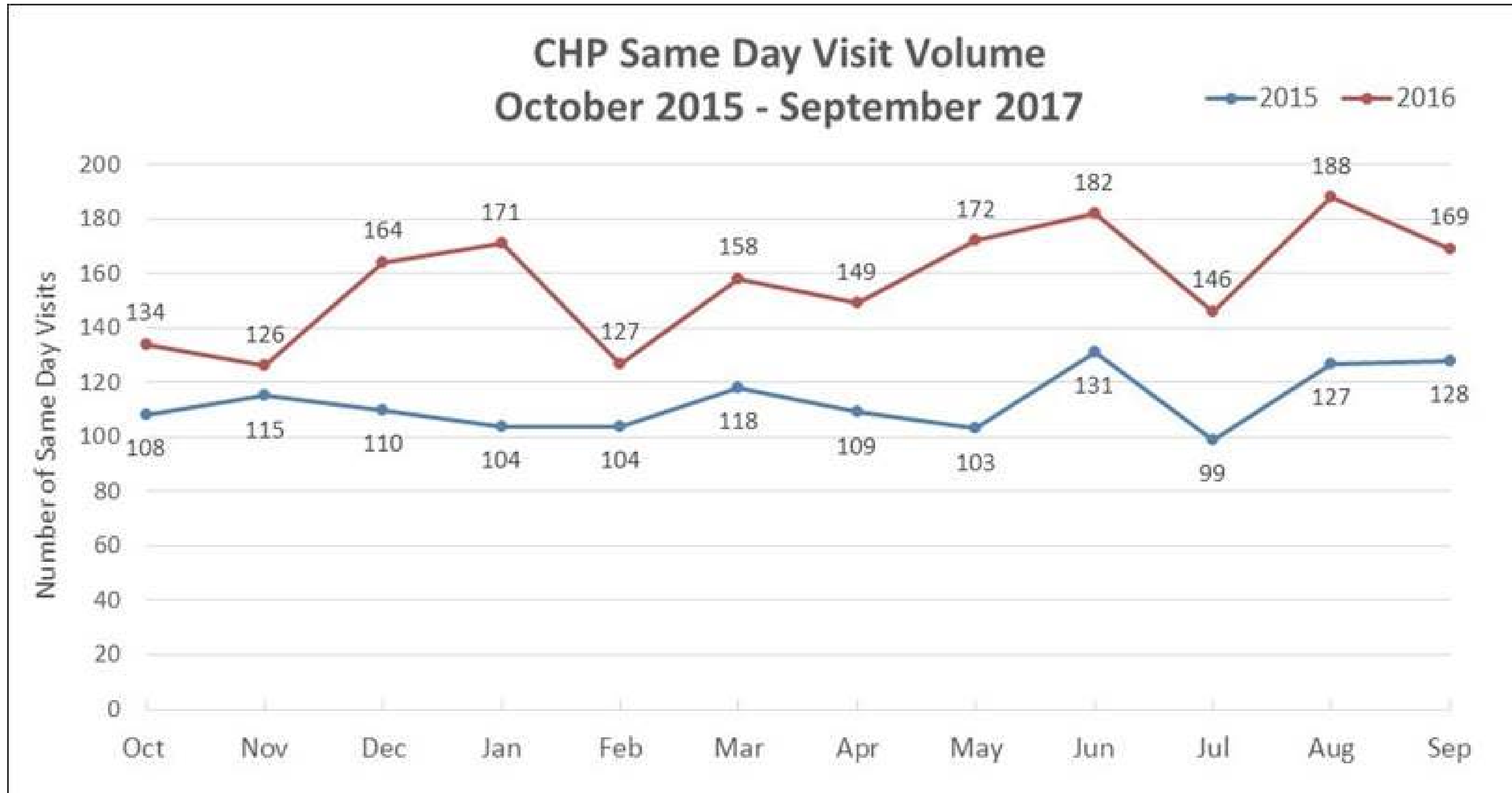
Barriers/Facilitators of PTM Implementation

- 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

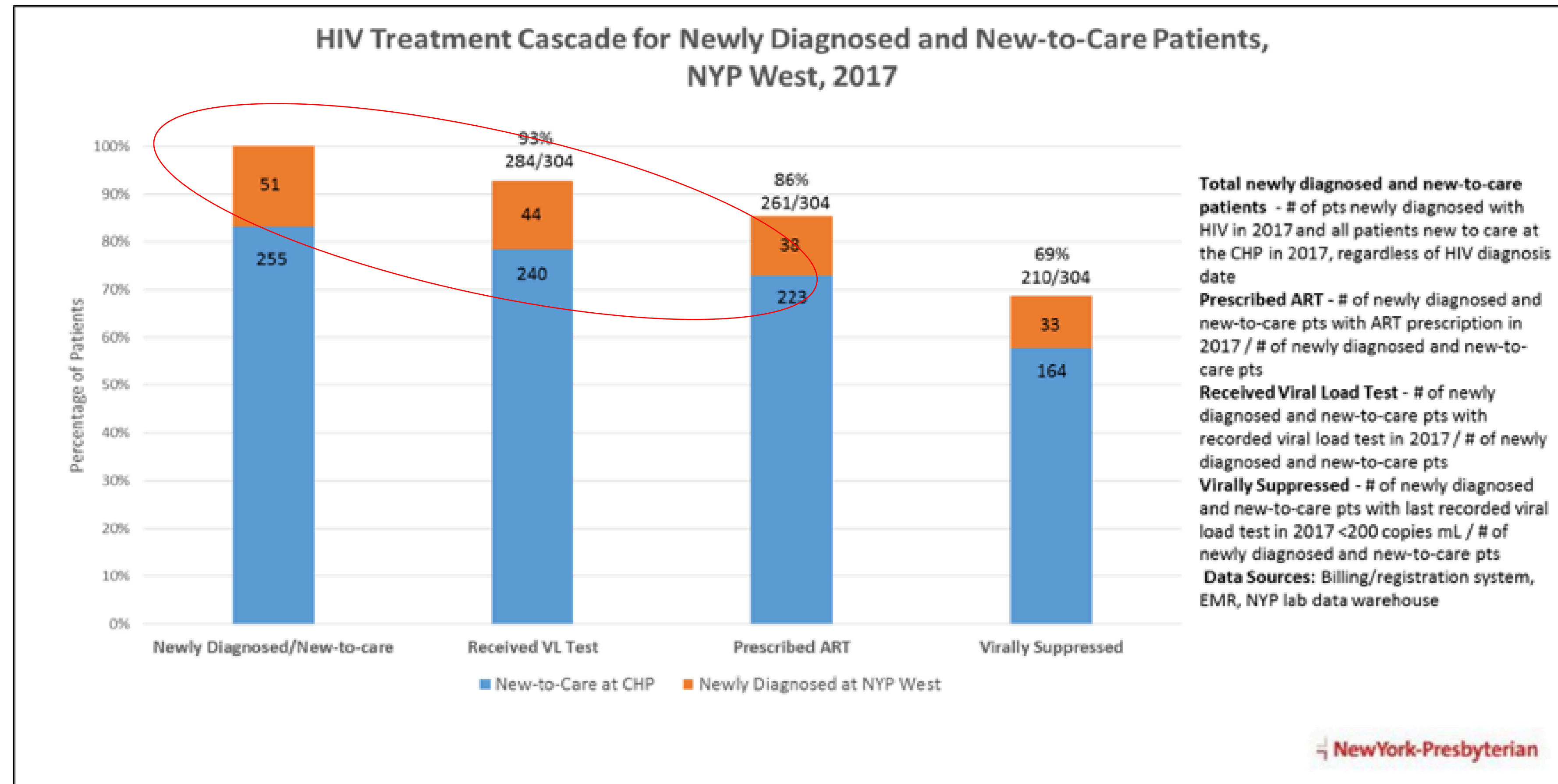
- Effectively expanded Practice's HIV care coordination model
  - 1 care coordinator per patient panel (5) by leveraging existing resources, revising roles and responsibilities, and integrating in the STaR team-based care model
  - Integration of RN Care Management role responsible for oversight of care 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.



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

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Question?