2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

The Fight in Me, Honors the Fight in You: RI HIV CoEXIST

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Paul G. Loberti. MPH

Administrator for Medical Services, RI Executive Office of Health & Human Services

Amy Black, Ph.D

Senior Consultant, John Snow International

Tonya Glantz, Ph.D

Director, RI College Institute for Health Education

Kenya Young

HRSA Project Officer

Learning Objectives

- Identify effective, efficient and appropriate ways to utilize RW rebate revenues.
- Discuss, interact and hear presentations from community and state partners regarding RI HIV CoEXIST.
- Present and discuss our CoEXIST evaluation domains, best practices, innovative models and our road to creating evidence based practices.
- Facilitate an audience discussion pertaining to the project related to rebate spend, effective needs assessments/gaps analysis, resource allocation to meet needs/gaps, the CoEXIST model & next steps

What is RI HIV CoEXIST?

- **Founded in April 2017:** The Executive Office of Health and Human Services, Ryan White Program funded 12 agencies to expand the Ryan White system of care in Rhode Island

- **The initiative:** *Centers of Excellence Integrating HIV Care, Support and Treatment, Behavioral/Physical Health* (CoEXIST).

- **Designed to fill the consumer needs and system gaps:** Based off numerous needs assessments of the HIV system of care in RI

Goals

- Create Centers of Excellence both brick/mortar and mobile units that focuses upon the integration of physical and behavioral health, sexual health, **Intensive Case Management**, multi-disciplinary teams in the early intervention and treatment of HIV
- **To go beyond the HIV Continuum of Care to fully understand and engage** patients and create social and economic solutions to poly morbidities and conditions
- **Address and solve social determinants of health** such as overcoming barriers to SES, housing stability, transportation, education level, etc.
- Make available and utilize cutting edge, advanced technology to insure vulnerable client/patient efficacy and attainments of excellent health outcomes

RI COEXIST HIV

- The RI HIV Provision of Care & Special Populations Unit is in the Medicaid Division under the Executive Office of Health and Human Services: HIV Care and Treatment/Ryan White is in Medicaid – Prevention in DOH
- RI like may states had a difficult time expending rebate funds in a timely and efficient, effective manner
- Our procurement process allowed for delegated authority which allowed for a unique, equitable, efficient and expeditious method of needs based targeting
- The goal was to get the funds out quickly, but to target the right agencies to do the needed tasks to meet needs illustrated in extensive needs assessments, provider capability and capacity assessments and gaps analysis
- Agencies were solicited, reviewed, and selected within three months time
- General motto throughout was to create solutions to address social determinants, broaden the HIV care and treatment provider network in RI (e.g., public institutions of higher education, etc.), synergize partners ability to impact HIV Continuum of Care, create housing, develop and sustain Intensive Case Management with Multi disciplinary team approach (using students!), etc.

COEXIST and the Triple Aim Framework

- **"The Triple Aim"** is the foundation of health system transformation with a goal to successfully transition from a focus on health care to optimizing health for individuals and populations.
- **The Ryan White Program** founded CoEXIST to address the 3 dimensions of the Triple Aim:
  1. Enhance the patient experience (***Better Care***)
  2. Improved health outcomes ***(Heathier People)***
  3. Efficient spending ***(Better Spending)***

- **CoEXIST prioritizes HIV system of care needs and gaps** including an interdisciplinary/comprehensive patient-centered approach to patient care.

- **Key activities to impact the triple aim are:** integrated care/case management, increasing patient self-efficacy, attention to transitional moments in high risk patient care (e.g., housing, relationships, trauma), and early intervention

Evaluation Domains

- CoEXIST by design is based upon effective and best practices across several Ryan White service categories.
- The developer wanted to create a effective intervention by illustrating several evaluation domains across key areas of measurement.

CoEXIST Domains, continued

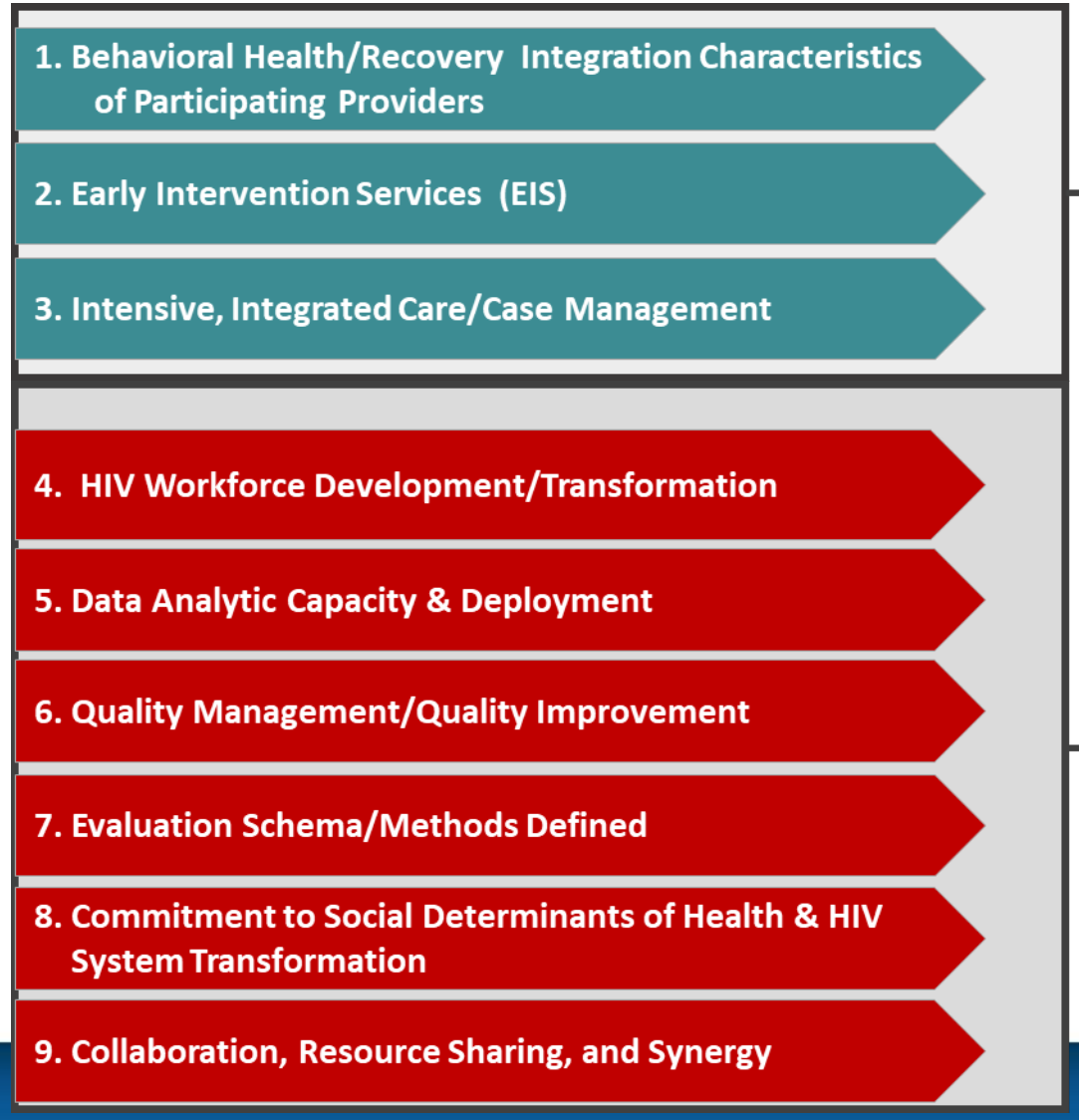
CoEXIST System Categories (*Represent either: HRSA Requirements, Specific grant related focus areas or **BOTH** HRSA Requirements and Specific Grant Focus Areas)*

- **HIV Workforce Development/Transformation**
- **Data Analytic Capacity & Deployment**
- **Quality Management/Quality Improvement**
- **Evaluation Schema/Methods Defined**
- **Commitment to Social Determinants of Health & HIV System Transformation**
- **Collaboration, Resource Sharing, and Synergy**

Sample activities under these domains include: Training program of students at universities; increased housing for PLWH; enhanced data surveillance systems; collaboration between agencies to conduct social media outreach, counseling and testing of high risk unawares

CoEXIST Domains

Inherent evaluation and quality components are in each agency agreement



HRSA Service Categories

- *Represent Official HRSA Service Categories*
- https://hab.hrsa.gov/sites/default/files/hab/Global/service_category_pcn_16-02_final.pdf

CoEXIST System Categories

- *Represent either:*
  - *HRSA Requirements*
  - *Specific grant related focus areas*
  - ***BOTH** HRSA Requirements and Specific Grant Focus Areas*

How We Will Measure Success

Behavioral Health/Recovery Integration Characteristics of Participating Providers

- Defining BH integration at agency with HIV/BH providers/PCP. Three levels of integration:

1. BH into HIV care
2. Integrating PCP into BH
3. Integrating BH into PCP

Early Intervention Services

- Measure four components of EIS

1. Outreach
2. Testing
3. Health education/risk reduction
4. Referral and link to care

"EIS is focused and not a one and done program. It is targeted, requires a client relationship, and has the ability to change the way we identify unawares."

Key HIGHLIGHTS by Agency and Area

- **Housing**
  - ACOS: 52 clients placed in housing during first 10 months of CoEXIST. 60 Slots allotted for a 200 person waiting list
  - CCA: Walk-in center, integrated team addressing housing stability along with social needs of clients; transportation and food instability; and substance use and mental health needs
  - APRI: Housing advocate for PLWH – transitional and long-term
  - BHDDH: Integrating substance use treatment for PLWH; residential care (8 beds)
- **EIS**
  - Clinica Esperanza: reached all testing goals with identification of 1 positive unaware.
  - APRI, RIPHI and Miriam Hospital; Social media outreach and education with high risk negatives; Promote HIV testing and linkage to care
  - DOH: Targeted testing strategy; Of the 164 "lost-to-care" eligible PLWHA patients referred by health care providers, the return-to-care field services team was successful in relinking 110 (67%) them to care
  - URI: Launching EIS mobile clinic in South County; creation of multiple behavior change modules
  - CCA/Agape: Monthly health education risk reduction activities on site and in the community; regular on-site testing
  - RIC: Student certification for testing and education on campus
  - BHDDH: Testing at residential centers
  - DOC: Testing at intake

Measurement

Intensive, Integrated Care/Case Management

- Systematic Processes to Identify Patients for Care Management, and connection to Interdisciplinary Teams with Specialized Expertise

HIV Workforce Development/Transformation

- Curriculum, certifications measured. Student, provider teams participation and satisfaction

Data Analytic Capacity & Deployment

Core data infrastructure expansion. Provider and Intensive care/case manager level of access to information

Key HIGHLIGHTS by Agency and Area

- **Intensive Case Management**
  - RIC: Coordination and training for student members of I-Teams
  - URI: training interdisciplinary student and professional teams
  - CCA/Agape: Intensive case management; integrated care for residents
  - ACOS: , integrated team addressing housing stability along with social needs of clients; transportation and food instability; and substance use and mental health need
  - BHDDH: Peer recovery specialists, certification; I-teams at residential centers

- **Workforce Development**

  - RIC: Established training program for intensive case management teams; approximately 50 students trained; Students feed into key CoEXIST agencies
  - URI: Development of modules to train at least 50 students and professionals a year

Key HIGHLIGHTS by Agency and Area

- **Dental Care**
  - **Thundermist**: Providing expanded dental services to PLWH; Referrals from other agencies; Established dental clinic
- **Data Systems & Evaluation**
  - **BHDDH:** Enhanced data tracking for HIV, SU and MH case management
  - **DOH:** Enhanced surveillance system; tracking towards 90-90-90 goals; ID of those PLWH out of care/return-to-care process
  - **Miriam and RIPHI:** Tracking clients to suppression; if social media outreach was effective
  - **URI:** Data analyses and evaluation guidance for COEXIST
  - **EOHHS:** Developed evaluation domains; established relationship with APCD; enhanced Ryan White data systems

Measurement: Other CoEXIST Priorities

Commitment to Social Determinants of Health & HIV System Transformation

- System Transformation and System Healthcare Workforce

* Reported housing stability of clients, access to transportation, and food security

** Housing is a HRSA service category*

Collaboration, Resource Sharing, and Synergy

- Documented collaboration (e.g., MOUs) and resource sharing among agencies. A clear leadership and governance structure of CoEXIST, including documented partnership meetings

Key Agency Efforts Across Domains

- **Behavioral Health Integration:**
  - Launch of a mobile van, “traveling” clinic to meet the behavioral health needs of PLWH, as well as conduct EIS with high risk unawares
  - **Intensive Case Management Teams:**
    - Building the HIV workforce through training as well as providing holistic, integrated care to clients
    - Includes **Housing**, and addressing **social determinants**
    - **Increased housing options,** few on waiting list
- **Early Intervention Services**
  - Target outreach and testing among latino/a and immigrant community in Providence. Identification of 1 positive unaware. Connecting to care
  - Social media outreach and testing of high risk unaware, MSMs. Identified 6 people who tested positive, linked them to care, and tracked their engagement in care and strengthened the referral process between ASOs

Synergy and Building Connections

- Increased Training opportunities for funded agencies.
- Ongoing “Brown Bag” sessions to discuss best practices in case management, issues/concerns around behavioral health
- Forming a “workgroup” around Behavioral health – mental health and substance use
- Ongoing “conferences” among partners to share successes, discuss and solve issues, identify trends among high risk population or those living with HIV
- Increased referrals and collaboration among agencies

Challenges: Summarized

- **Housing**
  - Meeting the needs of the most vulnerable clients in a culturally and linguistically appropriate way; managing transitional housing and co-occurring mental health needs and the burden of stigma (mental health, addiction, and HIV); accessing housing for clients
- **Early Intervention Services (EIS)**
  - Communication across sites, including referrals; unified/coordinated testing strategies
- **Intensive Case Management**
  - Getting teams up and running. Client hesitation to participate in the intensive case management program; client disinterest in medical care
- **Workforce Development**
  - Finding the right match for sites
  - Need to determine roles for multidisciplinary students at sites
- **Data analysis and Evaluation**
  - Measurement alignment
  - Coordinated and systematic data sharing – and addressing data privacy concerns

Opportunities for Growth

- **Increased Cross Agency Communication**
  - Meetings and trainings with all COEXIST partner sites: monthly to quarterly; modality could vary
  - CoEXIST newsletter & regular updates
  - Agency presentations at CPPG
  - Resource guide
- **Increased Integration & Coordination of Care**
  - Case conferences
  - Shared resources, activities, increased referrals
  - More integration of BH/SU (i.e., more providers/shared services)
- **Expansion of Services**
  - New sites for I-teams
  - Expanded dental services
  - Incorporation of LGBT health/sexual health
- **More Innovative & Formal Data Analysis**
  - Data/Evaluation committee
  - Formal data sharing agreements
  - Data Systems and Interoperability
- **HIV Training & Certification**
  - Other identified training needs
  - HIV case management and HIV BH peer to peer
  - Specialized HIV CHW

Framing Evidence-Based Practices

CoEXIST Evaluation Goals/Domains

CoEXIST Goals/Domains

Inherent evaluation components per each agency agreement

1. Behavioral Health/Recovery Integration Characteristics of Participating Providers
2. Early Intervention Services (EIS)
3. Intensive, Integrated Care/Case Management
4. HIV Workforce Development/Transformation
5. Data Analytic Capacity & Deployment
6. Quality Management/Quality Improvement
7. Evaluation Schema/Methods Defined
8. Commitment to Social Determinants of Health & HIV System Transformation
9. Collaboration, Resource Sharing, and Synergy

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CoEXIST System Categories

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Example: Strategy Map
Housing (Social Determinants)

- Definition
  - Commitment to social determinants of health and HIV system of care transformation
  - Context/foundation of all other domains; key CoEXIST evaluation domains
- Potential Metrics
  - Number of beds filled
  - Number of PLWHA stably housed
  - Measure/define: transitional points along housing spectrum
  - Measure/define: Sustainable stable housing
- Successes
  - Approximately 52 beds filled
  - Housing advocate for PLWH – transitional and long-term
    - Initiatives addressing housing stability, social needs
      - transportation
      - food instability
  - Addressing substance use and mental health needs
  - Walk- in center for basic needs
  - Building a network of providers
- Challenges
  - Meeting the needs of the most vulnerable clients in a culturally, linguistically appropriate way
  - Managing transitional housing and co-occurring mental health needs and the burden of stigma (mental health, addiction, HIV)
  - Accessing housing for clients (based on eligibility, etc.)
- Opportunities
  - Engaging clients in their care;
    - more social supports/group activities & workshops addressing social determinants (employment; food stability)
  - Ensuring long-term care facilities are equipped to address aging LGBT and PLWH

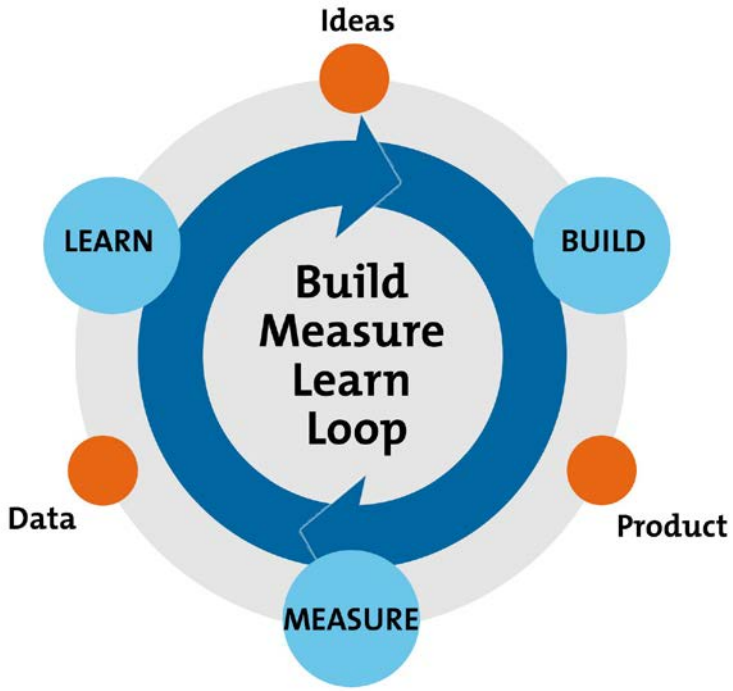
Opportunities for Growth

Findings from agency meetings

Training & Development

Identified Training Needs

- **HIV Counseling and Testing Certification**
  - Building HIV testing capacity and access across the state.
- **Data Collection, Evaluation-Sharing Across COEXIST Sites**
  - CareWare, assessment tools, Acuity scale, evaluation tools
    - Develop “coaching” calls/webinars on data and evaluation topics
- **Cultural Mediation-Responsiveness**
  - Culture related trainings to assist in serving multi-cultural clients including LGBTQ; communities of color; aging (over 50); and adolescents/young adults.



Top Requested Training Topics Areas: A Sample from CoEXIST Providers

- Data Collection & Evaluation
  - Sharing across sites
- Cultural Mediation & Responsiveness
- Behavioral Health Integration
- Administration & Management
  - Connected to #1
- Community-Clinical Linkages
- Integrating Public Health Theories into Clinical and Community Settings

Rhode Island College CoEXIST Categories and Performance Measures

RIC RYAN WHITE SERVICE CATEGORIES/HRSA FOCUS AREAS

- ICM Team
- Early Intervention Services
- Workforce Development

PERFORMANCE MEASURES

- Client Satisfaction
- ICM Team Contacts with Clients
- Evaluation of Training/Conferences
- Pre/Post-Test of Students Attitudes toward HIV/AIDS
- Peer Education (number of events held)
- Agency Satisfaction with Student Support

RIC HIV Workforce Development Transformation

Key Accomplishments

- Created critical partnerships in support of HIV workforce development/transformation (4.1 - Interdisciplinary professional ed teams and approaches measured; 4.3 - Student/provider participation quantified)
- Engagement of seven of RIC's academic departments in RIC-COEXIST
- Established academic and practicum relationships between RIC & HIV Care Continuum Organizations

Early Feedback CoEXIST - Ryan White Goes to College – Rhode Island College

- “Students bring a fresher platform, it’s a mutual relationship, so they get that information from us and they can help us spice things up”
- “We help empower them for their future and helping empower them we can give them information that they don’t know for our community.”
- “Its good for them to know how to treat patients and how to deal with the community and how to treat people and to know that sometimes doctors don’t know how to treat you”

- ***Data from RI College Assessment of students involved in Intensive Case Management Teams***

RI COEXIST HIV

RI Public Health Institute GY 1 Updates

SIGNIFICANT ACCOMPLISHMENTS

- Developed & implemented a digital data capture system to collect clinical, demographic, and behavioral data to identify gaps in linkage and retention in care

- Identified people who tested positive, linked them to care, and tracked their engagement in care and strengthened the referral process between APRI/FSRI and TMH

- Began monthly HIV testing, safer sex supply distribution, and sexual health education at Youth Pride, Inc. in Providence

RIPHI GY1 Continued

Data Accomplishments

Screened 709 MSM between August 1, 2017 and May 1, 2018

- Thru EIS Six individuals tested positive for HIV (0.85%)
  - Five were successfully linked to care; one sought care out of state
  - One achieved viral suppression in 49 days
- 40% of clients reported meeting their partners online

"EIS isn't your grandmother's HIV testing program. It is rich in creating targeted approaches to clients who are at unusually high risk for HIV, and via confidential testing, assures referrals linkages are made quickly."

RIPHI GY 1 Updates Continued

Significant Accomplishments (continued)

- Via EIS Outreached and engaged high-risk people and counseled them on health risk-reduction strategies via social media sites: Established a link between a virtual site and brick and mortar EIS
- Helped clients find stable housing or stay in stable housing
- Established new partnerships with 211/United Way to strengthen the housing referral process for PLWHA; maintained partnership with the 90-90-90 Housing Committee
- Identified messaging strategies to reach men who meet their partners online

University of RI Partnership

INTEGRATING NEW RESOURCES INTO THE RHODE ISLAND RYAN WHITE PROGRAM

- FACULTY EXPERTISE
- STUDENT INTENSIVE CASE MANAGEMENT TEAMS/MULTIDISCIPLINARY
- AN INTEGRATED MOBILE HEALTH UNIT
- PROCHASKA'S STAGES OF CHANGE WAS BORN HERE AND WE HAVE INVESTED IN A TRANS-THEORETICAL MODEL OF CHANGE FOR HIV

Overall URI Scope of Work

Project #1 – Co-EXIST, EIS and Intensive Case Management teams

- **Goal #1:** Creation of interdisciplinary teams (Nursing, Pharmacy, Psychology, Nutrition, PT, others) to engage within COEXIST South County network
- **Goal #2:** Enhance the identification of unawares in the COEXIST network

Project #2 – Behavioral interventions for lifestyle management of PLWH

- **Goal #1:** Develop and deliver trainings to supplement the ability of the teams and existing professional staff to deliver behavioral interventions
- **Goal #2:** Pilot the use of the integrated treatment suite among people living with HIV
- **Goal #3:** Expansion of the Integrated Treatment suite

Project #3 – Evaluation & analytics

- **Goal #1:** Complete a resource allocation program evaluation to help determine optimal use of resources available for HIV care and treatment in the Ryan White Program.
- **Goal #2:** Complete an analysis of the super-utilizers in the Ryan White population. The analyses would focus on identification of super utilizers, their economic impacts, and quality of their care.
- **Goal #3:** Provide evaluation services to the proposed projects connected with URIs implementation of the COEXIST models

URI – CoEXIST HIV Integrated Health Mobile Unit

What is it?

Functionally, a mobile health unit

- 2 multi-purpose exam/counseling rooms
- Intake/screening area with phlebotomy chair
- Medical refrigerator & freezer, centrifuge

URI is a new partner in the Ryan White system of care

- Potential for multi-faceted role
- Requires strategic identification of gaps and how can use our resources to fill them
  - Multi-disciplinary Faculty
  - Student teams
  - Mobile unit
  - Behavior change expertise

What will it do?

EIS activities

- Outreach and Health Ed/Risk Reduction
- Targeted testing (focused in South County)
- Access and Linkage to Care
- Referral Services

Intensive, integrated case management assistance

- Clinical, physical health capacity (nursing, pharmacy)
- Behavioral Health capacity (psychology)

Behavior change applications to assist in holistic health

- Expert system interventions targeting multiple behaviors

Focal Areas of Mobile Unit

Behavioral Intervention System

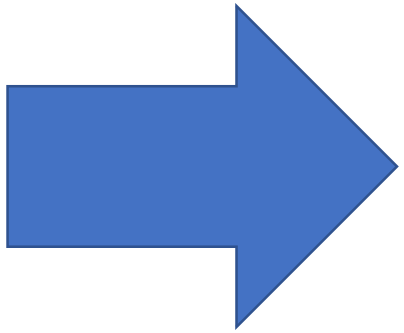
pro-change® BEHAVIOR SYSTEMS, INC.

Existing Ryan White/HIV System of Care

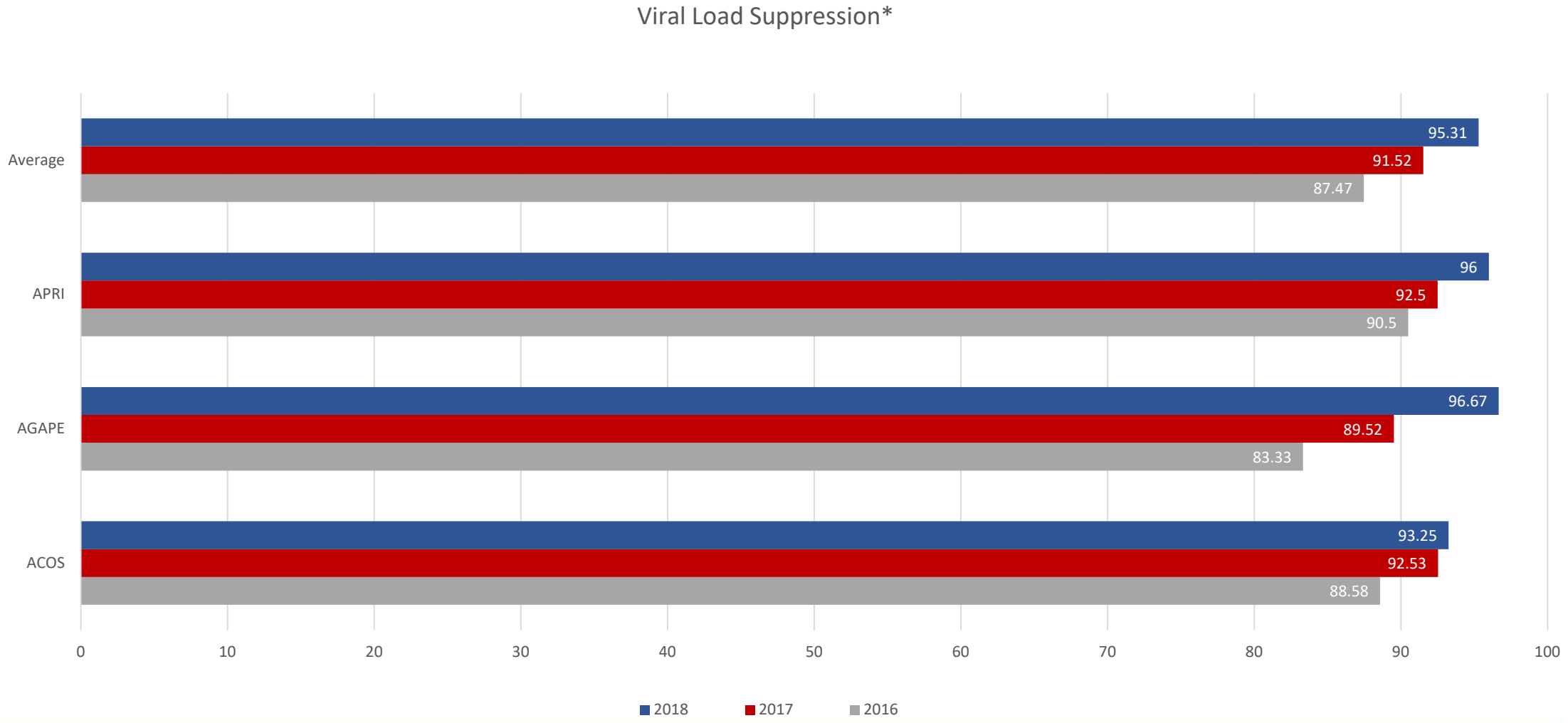
EIS Activities

Intensive Case Management

CoEXIST Quality Management Domain



Viral Load Suppression



Viral Suppression Slide Footnotes

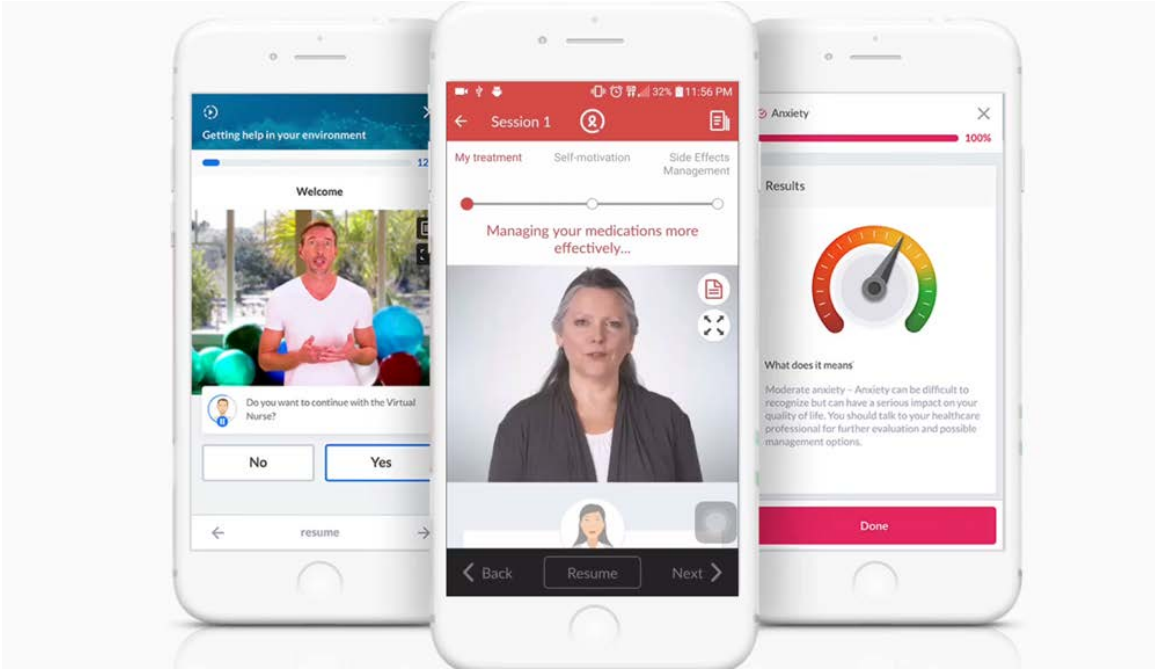
- The number of clients with a HIV Viral Load less than 200 copies/mL at the last HIV viral load test within the last 12 months.
- Numerator is defined as, the number of clients in the denominator with a HIV viral load less than 200 copies/mL at last HIV viral load test within the last 12 months.
- Denominator is defined as, all Ryan White Part B non-medical case management clients, regardless of age, with a diagnosis of HIV.

Why is Viral Suppression at 97% with RI RW Part B Providers???

- We're a small state that's manageable, compact geographically
- The QMC is involved, dedicated and committed to the HIV Continuum of Care Plus Model
- A Village Approach Towards Victory: Includes, Public Higher Education, RI Public Health Institute, State Agency Partners (BHDDH, DOH, DOC), ACOs, SIMs, mHealth app, etc
- Clear and effective capacity building that allows one on one approach
- We believe in a two way street whereby we all can learn from each other
- Agency integration of services whereby RW Service Category co-location is inherent
- New mApp
- CoEXIST

TAVIE/Virtual Coach Approach:

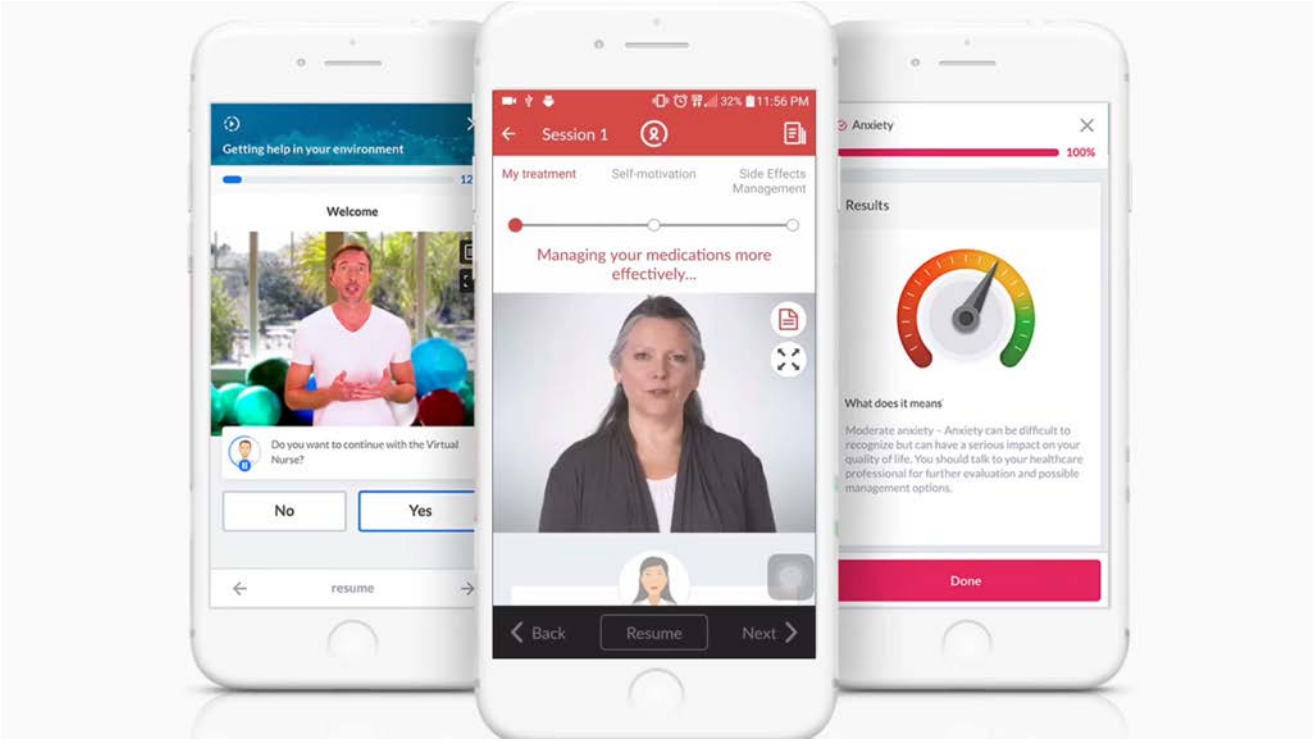
- Provide clients with a constant “companion”
- An application on a smart phone that links into other OHHS programs
- Application is always available to the client. Link is always available to the case manager.
- Intervention is clinically validated for an HIV+ population



Approach:

The First Clinically Validated Virtual Nurse Interactive Coach, TAVIE.

- Customized PRO collection
- Tailored virtual coach for each user
- Treatment reminders
- Symptom tracking



Platform Evolution

1. Validated Platform

Developed and validated at University of MTL Medical Center

2. Initial Adaptation

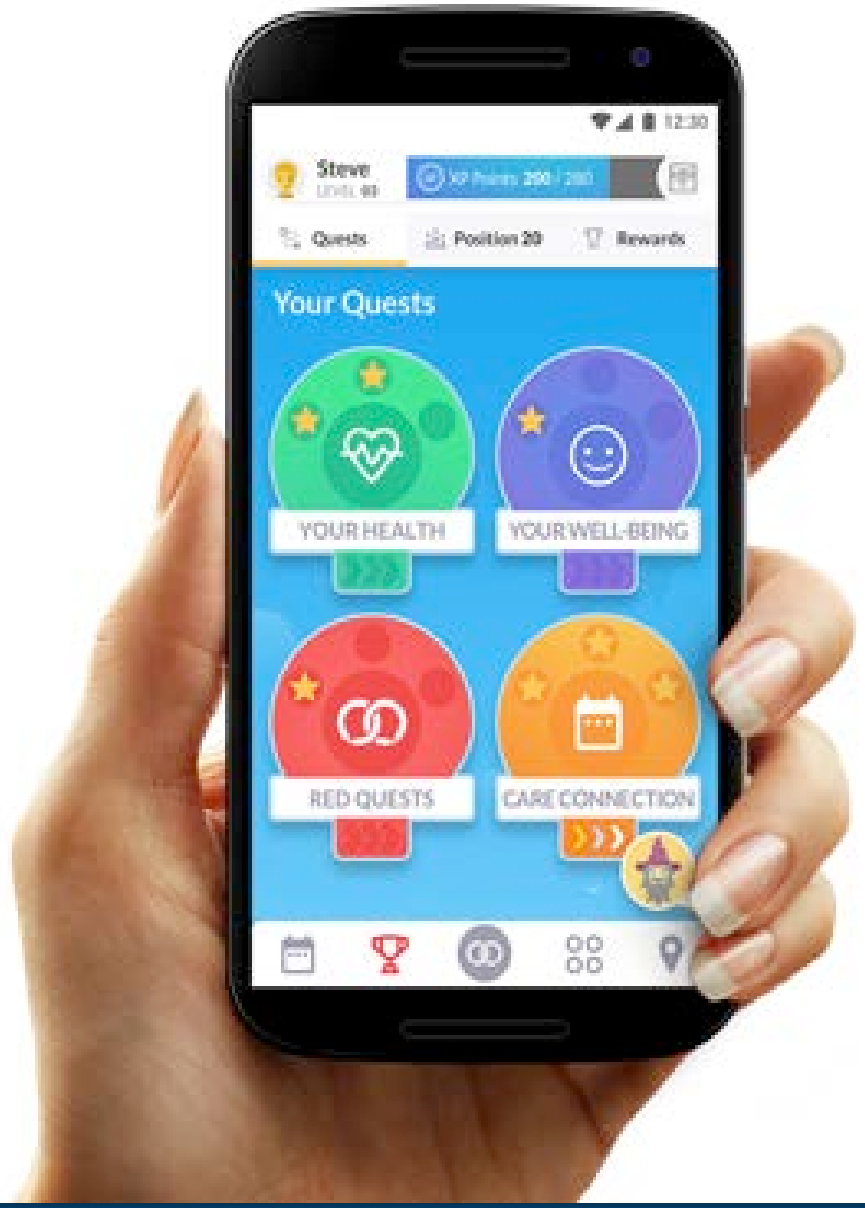
Adapted the content and trackers for U.S. vulnerable population

3. Second Release

Based on input and need to address SODH, increase engagement and delight

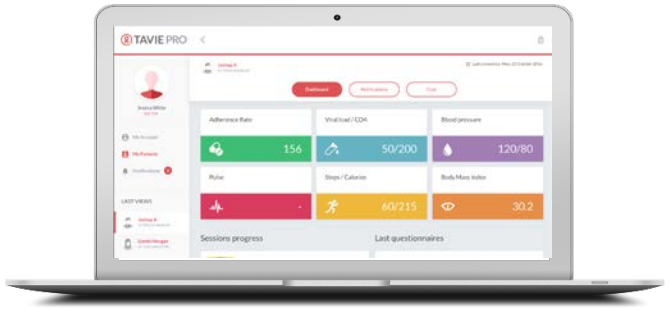
Gamification

- User actions are incentivized through points and rewarded through raffles.
- User rehearse healthy behaviors as they complete quests.



Approach:
Same Hybrid platform but Tailored to the Identified Needs

Clinically Validated Virtual Nurse App for Patients. Users receive personalized coaching sessions, treatment reminders and tracking tools



Provider Console to Monitor and Intervene. An interface for case managers and providers to stay in touch and assist patients.

Stakeholder Analytics. Customizable dashboard to **track performance measures**, view clinical outcomes and track engagement to inform decision-making.

HIGHLIGHTS

01 Ability to design to Needs/performance measures

- New mechanisms to improve CM-client communication
- Vehicle to achieve performance measures
- Social determinants are inextricably linked to the performance measures – *moving from isolation of a SDoH to a solution*

02 Greater Understanding of the population

- In-app assessments
- Patient-reported outcomes
- Contextual data
- Performance measures
- Greater understanding of clients' needs, challenges and abilities

03 Positive Outcomes

- Heightened technological literacy
- Satisfaction with the platform
- Ability to roll out new versions and iterate upon the design
- Agencies are working together

Panel Discussion

- Kenya Young, MPH HRSA Project Officer, Facilitator
- Amy Black, PhD John Snow International
- Tonya Glantz, MSW, PhD Rhode Island College
- Paul Loberti, MPH RI Executive Office of Health and Human Services

Panel Questions

- How does the CoEXIST Project dovetail with the HRSA service categories?
- What are the advantages of working with public institutions of higher education? Any barriers or challenges?
- Achieving effective strategies and interventions can be daunting- how have you approached that process? What are you expecting?
- What role does JSI play in the CoEXIST project, and how does their presence assist the state Ryan White Part B program?
- I saw where you have focused upon such things as behavioral health integration and social determinants? How's that going?
- Audience Questions

Thank You!