2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

The Triple Effect: Innovation-Prevention and Treatment

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BORINQUEN MEDICAL CENTERS OF MIAMI DADE

Disclosures

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Commercial Support was not received for this activity.

Learning Objectives

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

1. Describe how to optimize the Electronic Medical Record by understanding how algorithms work and their development
2. Identify and develop team members (peer and non-peer) to be champions of HIV Prevention
3. Discuss how to create collaboration with in-house resources such as behavioral health, medical case management, outreach and clinical teams.
4. Use of Patient Centered Medical Home process including Same Day Appointments
5. Implementation of E.H.R technology to track eligible patients and automate call campaigns and reminder calls

History

BHCC started in 1972 with a 4,150 sq. ft. location that delivered pediatric and adult medicine. Today we have 10 primary care and support service sites located throughout Miami Dade County.

BHCC is a AAAHC and NCQA patient centered medical home for many residents offering a comprehensive array of healthcare and support services within a one-stop healthcare shopping model.

History

Borinquen serves a Minority population comprised of 54% Hispanic and 43% Haitian. In 2017, 48,437 were seen and we had 154,796 visits.

BHCC is the largest FQHC healthcare provider to the Haitian Community in Miami Dade.

The Little Haiti and North Miami locations serve primarily Haitians while the West Dade and Flagami (locations) serve mostly Hispanics. The sites located in Wynwood serve a similar patient mix of both Hispanic and Haitian

Currently we provide: Internal Medicine, Ob-gyn, Pediatric and Adolescent Medicine, Behavioral Health(including outpatient substance abuse and MAT) Psychiatry, Podiatry, Oral Health, Healthy Start, Nutritional Services, Neurology, Integrative Medicine, Medical Case Management (including Prevention and Risk Reduction), Outreach , PrEP-PEP-T&T, School Based Program, Benefit eligibility assistance, Laboratory, diagnostics and 340B pharmacy.

Routine HIV testing-the beginning

- Implementation of Standing Orders for Routine HIV testing and process to determine which patients should be highly recommended to be screened “High Risk”.
  - Ages 13 and up
  - Pediatric patients could opt in
- Creation of Algorithm within E.H.R. Athenahealth® including adding a risk assessment questionnaire to identify high-risk individuals during intake.
  - opt in and opt out
  - Clinical staff trained and scripted
- Training of all staff through DOH HIV testing certifications “501”
- Validation of lab entry orders fulfilled as part of the standing order process
- Pilot testing at main site was initiated March 2014 to evaluate impact and workflows: number of patients screened as a result and number of tests performed

Routine HIV testing-the beginning

- After pilot testing and evaluation of patient volume, integration with HCV screening resulted in the following workflow:
- Followed birth cohort for HCV testing : 1945-1965
- Offered HIV testing to patients 13 years old and over: High HIV incidence area
- Special workflow was designed for pediatric patients (insured v non insured) – Parental consent
- Implementation of Organization Champions was key: Clinical Staff- Case Management-Linkage to Care Specialists -E.H.R. support- Behavioral Health-Executive Team & Board of Directors
- Champions supported the integration of HIV screening into routine health screenings during the patient's initial, annual, and any subsequent follow-up visits, which included the "high risk negative" questionnaire.

Routine HIV testing-Evolution

- Improved Algorithm within E.H.R. Athenahealth® related to assessment questions and reporting
- Opt out: Florida Legislation section 381.004,florida statute allowing opt out HIV testing (July 2015)
- Order sets were changed to mimic changes in legislation
- Created signage that included HIV testing as a standard of routine testing offered to all clients (13 and over)
- Increased birth cohort for HCV testing : 1945-1997 (21 and over) due to the high incident rates of infection in our community
- Provider re-training to enhance routine testing and to engage them in a pilot project for Test and Treat

Routine HIV testing-Evolution

- Compliance workflow Insured v uninsured:
  - Uninsured patients are soft handed for screening through the DOH
  - Insured Patients can opt to use insurance (spouse challenges)
  - Positive patients are transferred to the peer navigator for counseling and transfer of care to HIV specialist, case management and entry to care.

- Routine HIV testing and screening evolved and opened the opportunity to initiate Rapid Access Treatment

Rapid Access Treatment-Evolution of Routine Testing

- Spring 2017:
  - Met with JMH, DOH and coordinated with our then contracted 340B pharmacy to evaluate the possibility of implementing a Test and Treat program.
  - Training for Providers on Test and Treat, benefits of prevention and cost of early intervention.
  - 2016 data revealed over 300 patients screened positive for HIV, some of which were lost to care and would benefit from a program such as test and treat
- Summer 2017:
  - BOD, Executive team, providers and staff agreed to initiate Test and treat
  - Order sets implemented
  - Schedule same day appointments created
  - Linkage to care specialist job description created

Rapid Access Treatment- workflow

- Patient/client is screened inhouse or outreach
- If positive inhouse/outreach patient is warm handoff to provide:
  - Complete Eligibility and required documentation by outreach linkage specialist an internal referral is created for the Patient Navigator
  - Same day medical appointment and perform initial battery of tests (Draws blood for Confirmatory Testing, HCV Panel, STD's (Chlamydia, Gonorrhea, Syphilis)
  - Warm handoff to patient navigator for coordination of care including, case management, behavioral health, medical and initiate medication and adherence as well scheduling follow up appointments
- Patient's information is entered in BHCC's electronic health record (E.H.R.)
- The PLWH is walked over/hand delivered to the Patient navigator always
- Our Linkage Specialists work Monday-Friday 8:00am to 7:00pm and Saturday's 8:00am to 3:00pm; However, they are on call 8:00am to 10:00pm, 7 days a week. Providers are available all Weekdays including every other Saturday, if need to they will be on call.

Rapid Access Treatment- Patient Navigator Role

The Navigator once more assesses for the need for support services specifically behavioral health and substance abuse treatment.

The Navigator explains their role throughout the process and that Borinquen's goal is for them to leave our center with having taken their first dosage of medication; and leave our center with a 30-day supply of medication.

After Navigator finished processing patient a warm hand-off to the HIV specialist provider is performed.

Rapid Access Treatment- Patient Navigator Role

Initial visit includes complete assessment and laboratory tests plus a 30-day supply of medication is prescribed which is electronically sent to our pharmacy.

The pharmacy hand delivers the medication to the office of the Navigator, the PLWH takes their first dosage with the Navigator present

The Navigator also begins the process of linking PLWH to a Peer, Ryan White medical case management, ADAP, and any other referral services as needed

The Navigator conducts HIV counseling and prevention education prior to ART therapy, also medication adherence counseling is assisting the PLWH understand the Provider instructions and compliance (of such instructions). Follow-up laboratory and primary care appointments are scheduled.

Rapid Access Treatment- Care Team and Tracking

The Patient Care Team includes: medical case management, behavioral health, Specialty and Wellness Center clinical manager and Providers, Outreach/Linkage Specialists, QIQA team and the Information Technology Team.

The E.H.R. is the book that contains the story – above mentioned have the ability to view the PLWH status, progress as well as communicate with each other via the E.H.R.

Patients within 30 days complete at least two office visits with the provider

During the first 30 days, Ryan White allows (for those eligible) for the use of the “TTRA” codes, these codes allow the billing of medical and behavioral health visits.

High Risk Negatives-Preventive workflow

Based on the idea of increasing preventive efforts we created an algorithm to evaluate high risk questionnaire to coordinate their care and ensure constant screening and counseling

Identification of High-Risk negatives based on an algorithm within our electronic health records (E.H.R.)

Yes- No answer to risk assessment.

High Risk responses result on order set (referral) entered alerting the Provider to ensure referral to to the Comprehensive Risk Counseling Services counselor.

MSM question(s) yes or unprotected sex = **high risk**

High Risk Negatives-Preventive workflow

High Risk patients are provided with detailed assessment, including labs and referrals to CRCS or Navigator counseling for PrEP and a follow up visit within two weeks.

High Risk answers result in referrals to a CRCS counselor or a Navigator for PrEP counseling and assessment to be assessed same day

Low risk answers result in a referral and scheduling visit with CRCS.

High Risk patients are included in a tickler list to alert CRCS for rescheduling and follow up.

Obtaining CME/CE Credit

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

http://ryanwhite.cds.pesgce.com