

Three Approaches for Transforming Practice to Optimize HIV Care

*The SPNS System-level Workforce Capacity Building
for Integrating HIV Primary Care in Community
Health Care Settings Initiative*

Introduction to the Session

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Background

Trends affecting primary care generally and HIV care specifically:

- Growing population
- Aging population
- Improved access to care
- First generation of HIV providers nearing retirement
- Ongoing changes to the health care system and funding as a result of ACA

Outcome: Demand for services is eventually expected to exceed capacity

Workforce Development Questions

How can we ensure that we will be able to deliver high quality HIV care to everyone who will need it?

How can we ensure that quality of care is not sacrificed?

SPNS Workforce Initiative

Purpose: Develop and evaluation practice transformative models to enhance access to and optimize the delivery of HIV care

- Initiative started: August 1, 2014
- Funding runs for 4 years

Participating Sites

- 15 demonstration projects
 - ACCESS, Chicago, Illinois
 - Brightpoint Health, New York, New York
 - Coastal Bend Wellness Foundation, Corpus Christi, Texas
 - The Ruth M. Rothstein CORE Center, Chicago, Illinois
 - Family Health Centers of San Diego, San Diego, California
 - Florida Department of Health, Osceola County, Kissimmee, Florida
 - Foundcare, Inc., West Palm Beach, Florida
 - La Clinica del Pueblo, Washington, DC
 - MetroHealth Medical Center, Cleveland, Ohio
 - NYC Health + Hospitals - Correctional Health Services, Rikers Island, New York
 - New York Presbyterian Hospital, New York, New York
 - Special Health Resources for Texas, Inc., Longview, Texas
 - San Ysidro Health Center, San Diego, California
 - University of Miami Health System/Jackson Memorial Medical Center, Miami, Florida
 - University of Pittsburgh Medical Center, Pittsburgh, Pennsylvania
- 1 cross-site evaluation center
 - University of California San Francisco (UCSF), San Francisco, California

Practice Transformative Models (PTMs)

- Efficiencies in structural workforce systems that optimize human resources and improve health outcomes
- PTMs tackle workforce challenges in multiple ways

Potential PTM Approaches

1. Expand the workforce

- Increase the number of providers able to offer care to people living with HIV

2. “Share the care” or task shifting

- Distribute responsibilities among a wider set of primary care and mid-level providers
- Makes delivery of care more efficient

3. Improve patient engagement

- Implement services to ensure patients are more reliably engaged in routine HIV care
- Reduces the need for services that respond to acute ailments and late stage HIV complications (i.e., reduced urgent care visits, hospitalizations, ED visits, long-term care)

Outline of Session

1. Accelerating Access as the Demand for Services Grows: Practice Transformations that Expand the HIV Workforce
2. Optimizing Care Amidst HIV Demand: Transforming Practice to 'Share the Care' Among Providers and Staff
3. Workforce Capacity Building and Patient Engagement in Community Healthcare Settings

Accelerating Access as the Demand for Services Grows: Practice Transformations that Expand the HIV Workforce

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SPNS Challenge: Expand the HIV Workforce

“Propose a Practice Transformative Model”:

Achieve restructuring that will result in sustainable, extensible and efficient service delivery practices that optimize human resources, reduce costs and improve health outcomes.

“Innovative methods and strategies for structural changes may include:”

- *Task shifting or physician extension;*
- *Restructuring staff to meet the standards of patient-centered medical home;*
- *Integration of community health workers and patient navigators into the medical team;*
- *Interprofessional team-based practice coordination or co-management, such as generalist physicians overseeing HIV care while under regular consultation with an HIV expert.*



Approaches

- **Train primary care clinicians to provide HIV care**
 - Requiring intensive training, shadowing, one-on-one preceptors (AETC)
 - Focusing on next generation of HIV clinicians (Family Medicine, Internal Medicine)
 - Developing HIV Physician Champions (HIV Track in Family Medicine) for underserved areas
- **Integrate HIV care with primary care**
 - Training and educating clinicians, staff at all levels (AETC)
 - Co-managing patients with HIV experts (shared EMRs)
- **Shift HIV+ patients on suppressive HIV regimens to FQHCs**
 - Transferring insured patients from RW clinics in planned waves to minimize surges
 - Ensuring HIV care is provided according to DHHS Guidelines

Approaches Used by Sites

- **Train primary care clinicians to provide HIV care**
 - Family Health Centers of San Diego (Residents and Providers)
 - Florida Department of Health, Osceola County
 - Special Health Resources for Texas
 - University of Pittsburgh Medical Center/ Latterman Family Health Center (Residents and Providers)
- **Integrate HIV care with primary care**
 - Family Health Centers of San Diego
 - University of Pittsburgh Medical Center/ Latterman Family Health Center
 - Special Health Resources for Texas
- **Shift HIV+ patients on suppressive HIV regimens to FQHCs**
 - Florida Department of Health, Osceola County

Family Health Centers of San Diego

- **Multi-modality longitudinal HIV training program for Family Medicine Residents (FMR's) & Primary Care Providers (PCP's)**
- **12-24 month longitudinal training program**
 - In-person clinical precepting with HIV specialist
 - Online Self-directed learning (www.hivwebstudy.org plus additional pilot materials such as HIV Question bank)
 - Longitudinal Telehealth Mentoring through Pacific AETC's biweekly HIV Learning Network
- **Goal to train PCP's and FMR's to be competent HIV care providers in the Patient-Centered Medical Home model.**
- **First two PCP's passed AAHIVM certification, two additional FMR participants currently taking exam.**
- **New class of 2 PCP's and 2 FMR's started 7/2016**

University of Pittsburgh Medical Center, Latterman Family Health Center

Project S.E.T.T. – Screen, Engage, Treat, Train

Building HIV Care Capacity for Today and Tomorrow



- ✓ **Build HIV/AIDS care capacity in a primary care setting:**
 - ✓ Latterman Family Health Center (LFHC) aims to have its clinicians and staff capable of readily identifying, treating, and caring for PLWHA.
- ✓ **Sustain and expand HIV/AIDS treatment capacity for the future:**
 - ✓ LFHC is integrating a robust HIV/AIDS track into its Family Medicine (FM) Residency Training Program, which can serve as a model for other FM programs across the country.
- ✓ **Develop a replicable & sustainable model to build HIV/AIDS care capacity locally and nationally:**
 - ✓ LFHC is integrating the HIV service line into its existing infrastructure in a cost-conscious manner and serve as a model for similar health centers which increasingly are asked to do more with less.

Special Health Resources for Texas Inc. (SHRT)

- SHRT has been the leader providing HIV care in east Texas for over 25 years. FQHC Look-a-like status granted in 2006, but was only adopted by the Longview location.
- In May 2015 received full FQHC status and implemented Primary Care at Longview Clinic and expanded to Tyler and Texarkana Clinics. Paris office still pending for approval as access point.
- New staff has been added to clinics for Primary Care but needed to be trained on HIV care. Online training with HealthHIV.org and preceptorships with AETC have been essential.
- Family Nurse Practitioners providing HIV care are supervised by the Chief Medical Officer and Co-managed with other Infectious diseases specialist at satellite locations where available.
- Development of Policies and Procedures along protocols for both HIV and primary care for all staff.

Florida Department of Health, Osceola County

- Expanding community care by moving it's existing public health HIV/AIDS patients to the local FQHC-PCMH.
- This approach increases patient access, reduces ART medication barriers, and creates individualized care through our inter-professional teams located at each site.
- The transformation seeks to decrease provider & clinical staff stigma of treating PLWHA and increase provider and staff confidence through education, staff cycling and provider shadowing.
- Utilization of patient cohorts to ensure a seamless process during transformation.
 - Also managing risk stratification, quality improvement, and data collection elements of cohorts.



Barriers to Implementation

- Stigma (fear of HIV status disclosure, fear of HIV exposure)
- Patient perception of provider competence to deliver HIV care
- Clinician perception of competence to deliver HIV care
- Shortage of HIV providers for training , precepting, and care
- Lack of HIV knowledge even among recent graduates

Facilitators to Implementation

- AIDS Education and Training Centers (AETCs)
 - Access to on-line curricula (Health HIV, case-based webinars, others)
 - Day-long trainings by HIV faculty
 - Ongoing didactic sessions
 - On-site clinical training with HIV Preceptors
- Strong leadership at medical education training programs
 - Long-term HIV continuity clinical rotations for development of HIV Physician Champions
- Buy-in from FQHC leadership, support staff
- FQHC capacity to absorb transferred HIV-infected patients
 - Reduce travel time to HIV care for patients
- Co-management with HIV experts
 - Shared EMR, shared case conferences, back-up

Strategies for Success Going Forward

- Placing outreach workers in underserved community to address stigma of seeking HIV care locally
- Warm hand off of patient from HIV expert to primary care provider to foster trust
- Inviting FQHC providers and clinical staff to shadow clinical team in HIV specialty clinic to build skills and address stigma
- Employing a train the trainer model to address capacity issues
 - HIV expert trains one provider. That provider then trains other providers
- Using rigorous quality improvement practices: Develop, assess, refine, and implement clear protocols to ensure continued delivery of high quality services

Optimizing Care Amidst High Demand: Transforming Practice to 'Share the Care' Among Providers and Staff

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Share the Care

Problems:

- Increased demand
- Reduced workforce
- Lack of Integrated care
- Co-morbidities complicate treatment
- Disproportionate psychosocial needs
- Silos

PTM Solutions:

- Team-based Care
- Mid-level provider training
- Integrated Care Teams
- Stakeholder driven PTM implementation
- Care Coordination
- HIT Solutions



Practice Transformative Models (PTMs) by Site



CHS: Working across systems: From Intake Jail to Community HIV Care [Puerto Rico & the Bronx]



Metro: Integrating depression screening and care into HIV primary care [Cleveland, OH]



Miami: Designating health care personnel with specific roles and duties to address the various patient HIV primary care needs [Miami, FL]



NYPH: Creating panel-based teams and updating information technology to enhance uptake of population health QI strategies [New York, NY]





How are PTMs addressing the Problem?

- Team-based Care (all)
- Training Mid-level clinicians (CHS, Miami, NYP)
- Integrated Care Teams (Metro, Miami, NYP)
- Stakeholder driven PTM implementation (all)
- Care Coordination (CHS, Metro, Miami, NYP)
- IT Solutions (CHS , Metro, NYP)



Sharing the Care – Key Themes

Similarities:

- Less physician-centric
- Multidisciplinary approach
- Expanding the Care Team
- Optimizing communication
- Stakeholder investment
- Quality implementation
- Integrated Care Coordination
- Use of HIT

Differences:

- Focus on specific vulnerable populations versus primary care systems
- Sharing care across systems
- Sharing care with HIT
- Use of HIT for Team Building



Barriers and facilitators

Barriers

- Resistance to change – patients and staff
- Investing now for future improvements
- Formal v. Informal authority concurrence
- Logistics

Facilitators

- Leadership / mission
- Consistency and time
- Stakeholder participation
- Collaboration & creative, participatory solutions
- Supportive changes in the healthcare landscape
- SPNS' forum for sharing challenges and solutions
- ETAC Practice facilitators



Working to create successful practice transformation – next steps:

- Ongoing stakeholder buy-in and feedback
- Fine tune interventions
- Increasing consumer involvement
- Advance local evaluation & feedback to site
- Evaluate outcomes



Wrap-up – Share the Care

- Team-based Care
- Training Mid-level clinicians
- Integrated Care Teams
- Stakeholder driven implementation
- Care Coordination
- IT Solutions

Workforce Capacity Building and Patient Engagement in Community Healthcare Settings

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Matching workforce to demand

- Demand for HIV services is growing
- HIV workforce not growing at pace
- The HRSA SPNS Workforce Capacity Building Initiative: sites propose different strategies to help increase capacity
- Several sites aim to support increased capacity by enhancing patient self-management

Approaches

- Self-management training and tools
 - patient self-management training programs
 - EMR report cards, other tools
- Patient engagement tools
 - patient forums, surveys, advisory committees
- Infrastructure improvements to facilitate access to care
 - enhanced telephone access lines
 - utilization of Care Coordination Medical Record
 - Clinical Transition Liaison

RMR CORE Center (Chicago, IL)

Cook County Health and Hospitals System – Public “safety-net” facility caring for a large portion of PLHIV in Chicago area. Patient population is predominantly low-income men of color.

PTM includes:

- Systemness Model: common shared vision; service needs are anticipated, planned for, and readily accessible
- Tenets of PCMH:
 - Enhance access: implementation of access line
 - Track and coordinate care: Nurse Care Coordinators
 - Team based care: Clinical Transition Liaison
 - Coordinates with multidisciplinary primary care team
- Provide the support for patient’s empowerment through self-management goals

Brightpoint Health (Bronx, NY)

Patient population consists of individuals who have severe mental health issues, substance dependency, and are transient.

PTM activities include:

- Patient registry: standardizing systems for identifying high-risk HIV-positive patients
- Huddles, case conferencing: formalizing communication, collaboration, and care coordination between primary care and behavioral health clinics; collaboration within the interdisciplinary team to devise a plan on how to keep the client retained in care and deliver the best possible care
- Purchased Care Coordination Management Record (CCMR) from eClinicalWorks to allow providers to collaborate in an individual patient's care by creating an interdisciplinary care plan.
- Implemented self-management groups at one location, including the Stanford model for Positive Self-Management Program (PSMP) and the Whole Health Action Management (WHAM) model, to encourage and provide tools for patients to better manage their health.

La Clínica del Pueblo (D.C.)

La Clínica del Pueblo

- Federally Qualified Health Center (FQHC), Ryan White provider since 1994
- Founded by Central American immigrants in early 80s, serves primarily Latino immigrants
- Integrates primary medical care, mental health and substance abuse, language access, and community health promotion
- 3500 Patients served annually at core medical facility; 8-10% living with HIV

PTM includes:

- Patient Centered Medical Home as vehicle for Practice Transformation, with goal of fully integrating HIV services in the primary care practice
- Provider Training; Workflow-Redesign around care team organization and responsibilities; Data Driven Quality Improvement
- Patient engagement activities are designed to enhance voice and leadership of patients in service delivery and organization
- La Clínica currently employs patient forums and advisory committees; has integrated HIV specific patient experience survey
- Plans to integrate an EMR report card as part of PTM activities in future



Barriers to Implementation

- Institutional bureaucracy: large organizations
- Personnel: hiring, layoffs, identifying sustainable funding for new positions
- Technology can be a barrier: EMR improvement, version issues
- Patient-level barriers: housing instability, substance use issues, language, immigration status, literacy
- Challenges to Survey and report card design: appropriate language and method of administration for patient population, stigma



Facilitators to Implementation

- Improvements to within-team communication
- Technology can be a facilitator
- Caring, compassionate and passionate staff and providers
- Buy-in from leadership
- Synergy with county-wide initiatives
- Flexible staff and adaptable frameworks



Strategies for Future Success

- Evaluate which interventions patients most enjoyed and found helpful, and focus future interventions on those tools
- Qualitative and quantitative methods for obtaining patient feedback, analysis by sub-group to capture disparities
- Develop critical new roles and identify sustainable resources to support innovative staffing
- Increasing and standardizing care coordination
- Using continuous quality improvement to monitor and make changes
- Care team dashboards

Concluding Thoughts

Types of PTMs

- We have presented three ways in which practice transformation can address workforce challenges
 - Expand the workforce
 - Share the care
 - Improve patient engagement in routine and preventive services
- Most practice transformative models accomplish more than one objective
 - The three models that we presented are not mutually exclusive

Practice Transformation Success

- All practice transformations benefit from:
 - Clearly defining the practice transformative model
 - Engaging relevant stakeholders in the planning phases
 - Defining roles and responsibilities
 - Writing down protocols, policies, and procedures
 - Training providers and staff on new procedures and information systems
 - Assessing data needs
 - Establishing a timeline and work plan for rolling out the PTM

Questions?

For more information about the initiative:
<http://workforce.ucsf.edu>