NATIONAL 2016 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Innovative Models Driving Improvements across the HIV Care Continuum

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Learning Objectives:

1. Describe 2 models for improving HIV core performance measures.
2. Identify key personnel for implementation of models/interventions.
3. Explain methods for tracking and measuring quality improvement outcomes.

The Cooper Health System Early Intervention Program (EIP) Clinical Navigation Model: An innovative approach for improving access to care

Presenter:
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Special Recognition:

John Baxter, M.D. – EIP Medical Director, Head, Division of Infectious Diseases

Joshua Hatfield – EIP Data Analyst

Lucy Soukhrie, R.N., MHA – Navigation Model, Project Manager

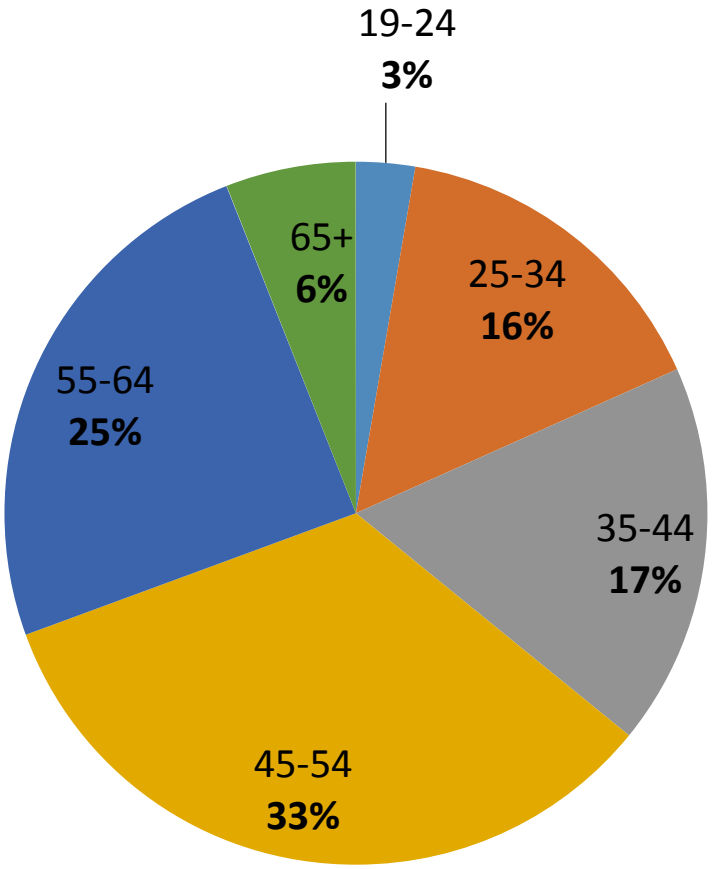
Patrick Coady, R.N. – EIP Nurse Navigator

Luz Avila – EIP Clinical Outreach Navigator

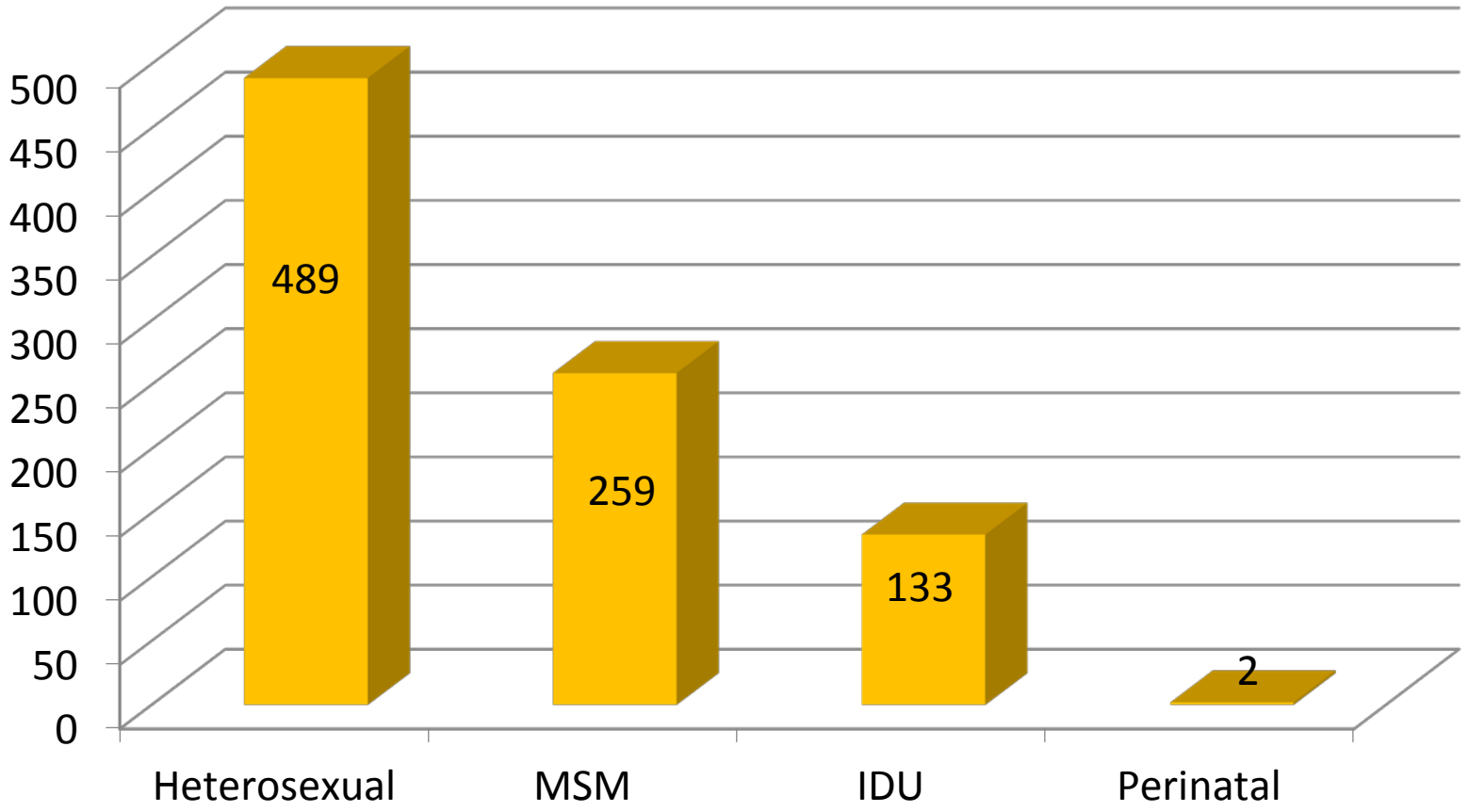
Cooper EIP Clinic

- Cooper University Hospital – Camden, New Jersey
- Ryan White program established in 1990
- Chronic Care Model approach for providing comprehensive multidisciplinary care
- HIV counseling and testing; HIV primary care and phlebotomy services; medical case management; behavioral health services; patient centered health education; clinical pharmacists, 340B pharmacy services and research program

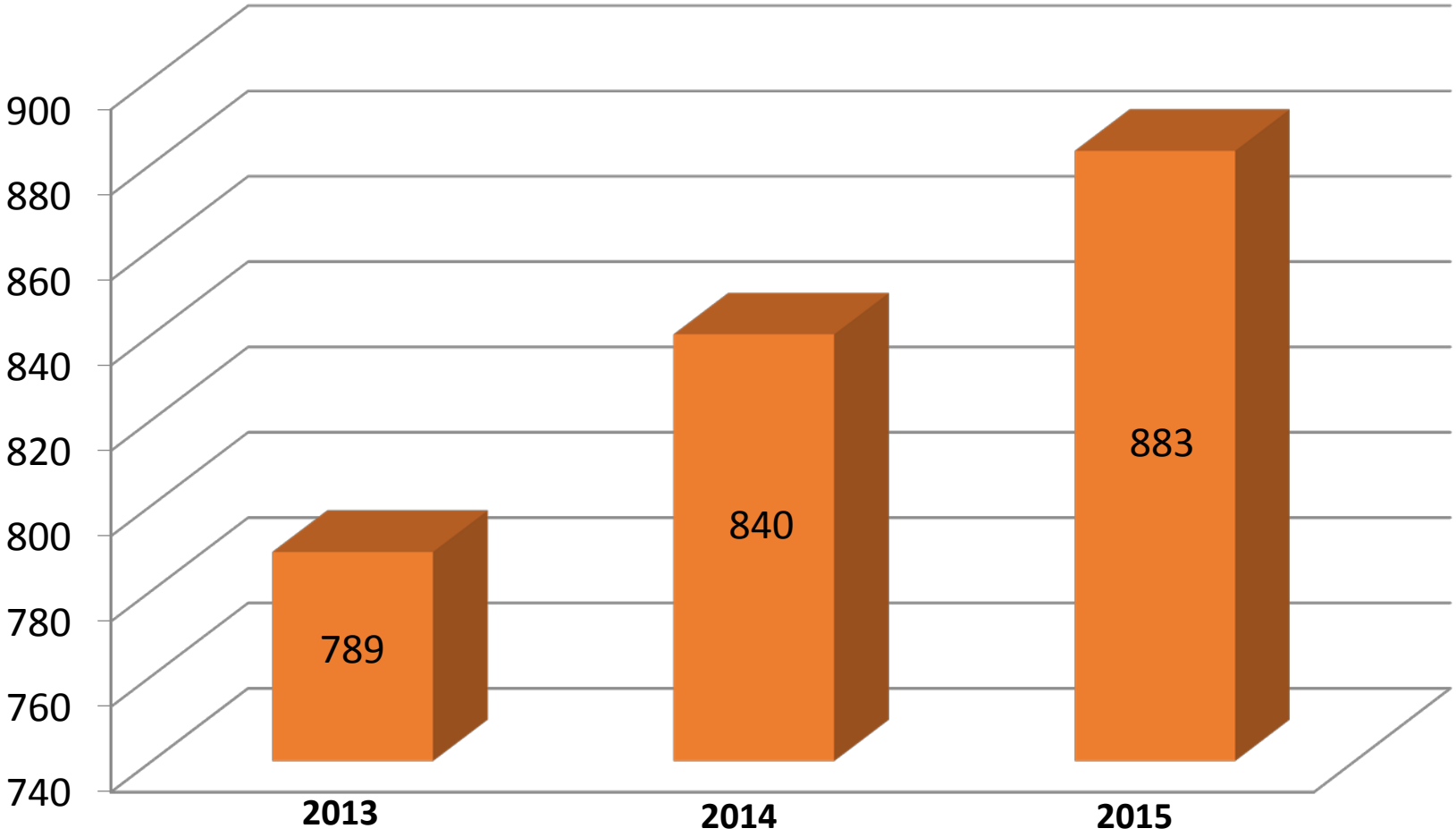
Patient Population Age



Patient Population Risk Factors



Patient Population Growth



Navigation Model

- Two pathways for linking/re-engaging HIV + persons to care
- Nurse Navigation occurs on site to assure linkage to care
- Outreach Navigation occurs through community partnerships focusing on re-engaging those out of care
- Drives patients into care through internal and external communication channels between program staff, hospital staff, state and county health departments, community based organizations (CBO), private physician practices, federally qualified health centers (FQHC), addictions' services, and correctional facilities.

Nurse Navigator Role

- First point of contact with external provider for patient referrals
- Receives patient at first medical appointment within 24-72 hours of referral
- Performs nursing assessment and documents in EMR
- Assures initial laboratory tests are collected at first visit
- Assures mental health and substance abuse assessment are completed and provides introduction to Clinical Psychologist
- Assures linkage with on site medical case management services if applicable

Nurse Navigation

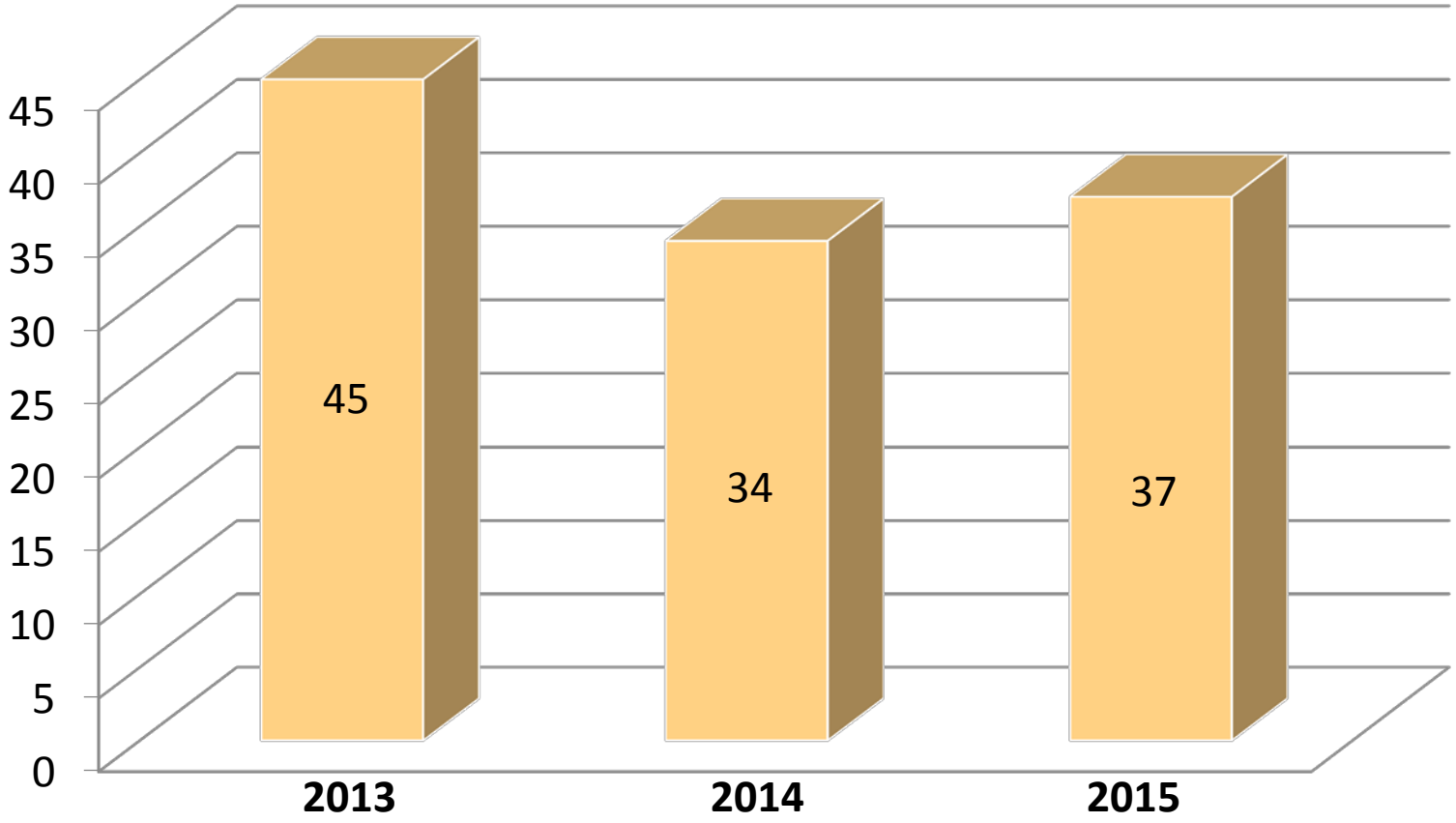
	2013	2014	2015
Referred for 2nd Rapid	7	9	9
Re-Engaged to Care	63	50	99
Transfers of Care	30	39	31
Partners	3	7	7
Newly Dx'd linked to care	32	53	47
Referred to other agencies	1	1	1
Total Seen by Navigator	**136**	**159**	**194**

Starting in January 2015 through March 2016, 91.74% of patients linked to care through the Nurse Navigator are retained in care.

Outreach Navigator Role

- Primary resource for community based partners
- Works in the field collaboratively with external agencies
- Functions as a liaison for the Program Director facilitating new memoranda of agreements (MOA)
- Performs HIV counseling, testing and risk reduction education for patient populations at substantial risk for HIV infection at external agencies
- In partnership with AIDS Service Organization staff, performs outreach to locate persons not in care visiting homeless shelters, drop-in centers, home addresses.
- Searches publicly available data to locate persons that may be incarcerated or deceased.

Patients Re-engaged Through Outreach



Tools for data collection and analysis:

- Tracking logs – paper or electronic logs identifying service type, date, and patient name
- Microsoft excel spreadsheets: pivot tables, filters, and formulas allow data to be collated and analyzed.
- Software programs such as CAREWare to query data base for custom reports
- HIV AIDS Bureau (HAB) performance measurements are effective quality indicators to evaluate healthcare outcomes

Performance Measurements

Viral Load Suppression- Active clients who's last Viral Load was <200 copies/mL

Prescription of ART- Active clients prescribed to antiretroviral therapy (ART)

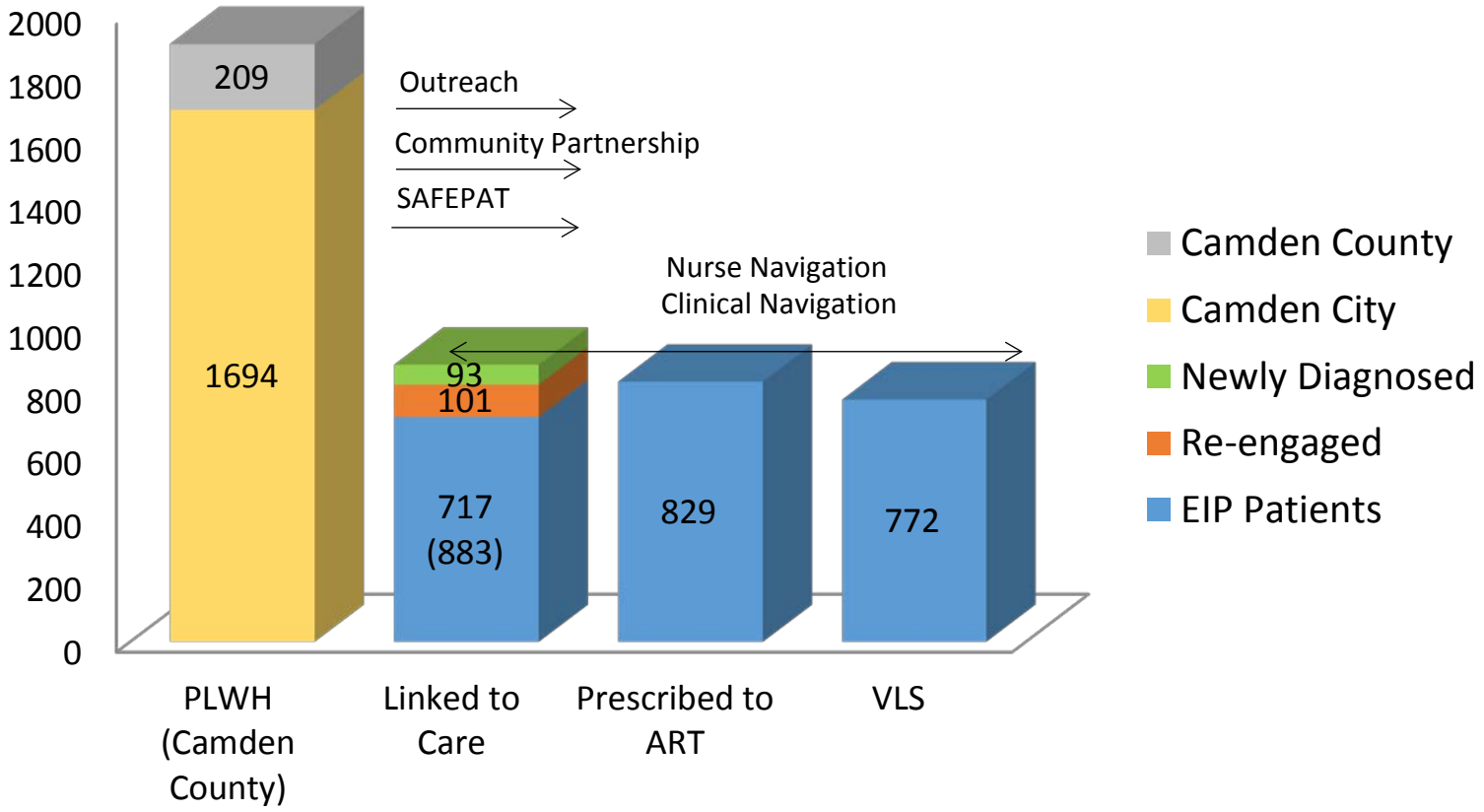
HIV Medical Visit Frequency- Clients who had at least one medical visit in each 6-month period over 24 months with a minimum 60 days between visits

Gap in HIV Medical- Clients who did not have a medical visit in last 6 months of measurement year

Performance Measurements

Year	VLS Suppression	Prescription of ART	HIV Medical Visit Frequency	GAP in HIV Medical Visits
2013	65.52%	73.16%	72.32%	12.45%
2014	85.78%	92%	71.51%	12.55%
2015	87.03%	94.20%	70.00%	12.20%

EIP Continuum of Care



Partnerships and MOAs

Effective partnerships:

- Community collaboration committee with regularly scheduled meetings, agendas, meeting minutes, and attendance
- Formal agreement such as a MOA that includes individual agency location, hours of operation, services, contact information and designated resource person signed by each agency's representative
- Shared responsibility for meeting facilitation including agenda topics, minutes, and attendance
- Provides a forum for educational opportunities and sharing data to drive committee activities

MOA Example for a Community Collaborative Agreement:

SAFEPAT

Strategic Alignment for Effective Prevention and Treatment

Memorandum of Agreement

This document constitutes as a memorandum of agreement (MOA) between the Cooper Health System Early Intervention Program (EIP), Camden Area Health Education Center (AHEC), Hispanic Family Center (HFC), South Jersey AIDS Alliance (SJAA),the HIV CTR Program of The Children's Regional Center of Cooper University Hospital (SRC), Our Lady of Lourdes Medical Center Emergency Department Rapid HIV Counseling Testing and Referral Program (OLLMC-ER/HIV CTR Program), Urban Treatment Associates, EIP at Kennedy and Burlington County Health Department. These agencies have established a partnership as the Strategic Alignment for Effective Prevention & Treatment (SAFEPAT). The "SAFEPAT" aim, "The collaboration of prevention and treatment services to assure coordinated healthcare practices and a healthy community". The SAFEPAT team agrees to facilitate coordination of program services irrespective of funding sources as indicated below:

Project CAATCH (Consumer Access and Adherence to Care for HIV) An initiative of the MA DPH MassCARE Program

Presenter:
Sandra Broughton, MHA
Director, Community Support
MA Department of Health

Project CAATCH

Project CAATCH (Consumer Access and Adherence to Care for HIV) An initiative of the MA DPH MassCARE Ryan White Part D Funded Program

Project Goal:

Increase the HIV primary care retention rate and rate of viral load suppression among enrolled HIV+ women and transitioning youth by designing an educational intervention using peers

Project CAATCH

The sites

- Four community health center sites were selected to participate

The staffing

- Each site included a Peer and a MassCARE coordinator

The training and support

- The Coordinators and Peers attended a two day intensive training
- Attend quarterly follow-up trainings
- Participate in monthly conference calls

Project CAATCH Intervention

Population

Primarily Black and Latino women of childbearing age and youth over 18 who are transitioning and/or at risk of falling out of care

Eligibility: *(either or both)*

- Not retained in care
- Not virally suppressed

Building a list for the intervention and outreach

- Using EMR, CareWare, and interviews with the clinic team
- Peers/Coordinators conduct outreach by phone, email, text or in person – including home visits

Project CAATCH Intervention

Educational sessions *(4 required sessions)*

- HIV, the Life Cycle and Medications at Work
- Communicating with Your Health Care Provider
- Understanding Lab Tests
- Managing Stigma and Disclosure
- Substance Use (optional)
- HIV and Mental Health (optional)

Stipends provided on a tiered approach

Sessions location convenient to consumers

Project CAATCH Intervention

Supportive Services

- Weekly contact and check-ins
- Appointment reminders
- Coordination of transportations
- Accompaniment to appointments
- Emotional and practical support
- Follow up, follow up, follow up!

Project CAATCH Activities

N = 42 clients

- 192 Trying to locate/reach clients (when enrolled)
- 57 Appointment reminders
- 49 Assist with making appointment housing/other services
- 36 Mentor/coach around specific need/emotional support
- 33 Coordinate transportation
- 17 Assist with making health care appointment
- 9 Assist with making mental health/substance use health appt.
- 9 Accompany client to a medical appt.
- 4 Accompany client to MH/SU appointment

Project CAATCH Data

As of FY16 a total of **42 clients across four sites were identified**

And **64% have completed** the required sessions

Of the originally identified clients

- **55% are now engaged** in care
- **25% are now virally suppressed** with another 18% showing improvement
- **36% are adherent** to their medication

MA HIV Care Continuum

	VL Suppression	Retained in Care
Youth 18-24	57%	70%
Women over 25	62%	63%

Project CAATCH Outcomes

	VL Suppression	Retained in care
2013 (pre-intervention)	78%	79%
2014	81%	89%
2015	84%	90%

Project CAATCH Challenges/Opportunities

- Engagement takes LOTS of time contacting clients, again and again
  - Phone, text, home visits and/or at community locations
- Continually identify new creative approaches to engage
- 25% of clients have mental health/substance use challenges
- Peers included in model a PLUS
- Team approach to follow up within health system
- Collaborative monthly calls with other sites

Success Story

A consumer *"has stayed sober and is on treatment for her sobriety. Since she went through the sessions, she is able to understand more about her health, speak with her provider, understands the virus more and the effect it has on her body if she is not adherent with her meds."*

As reported by her MassCARE Coordinator

Thank you!

Any questions?

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