2016 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

The Building Blocks of Primary Care and the HIV Care Continuum

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ETAC, Special Projects of Nation Significance. Workforce Development

Disclosures

Presenters have no financial interest to disclose.

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Learning Objectives

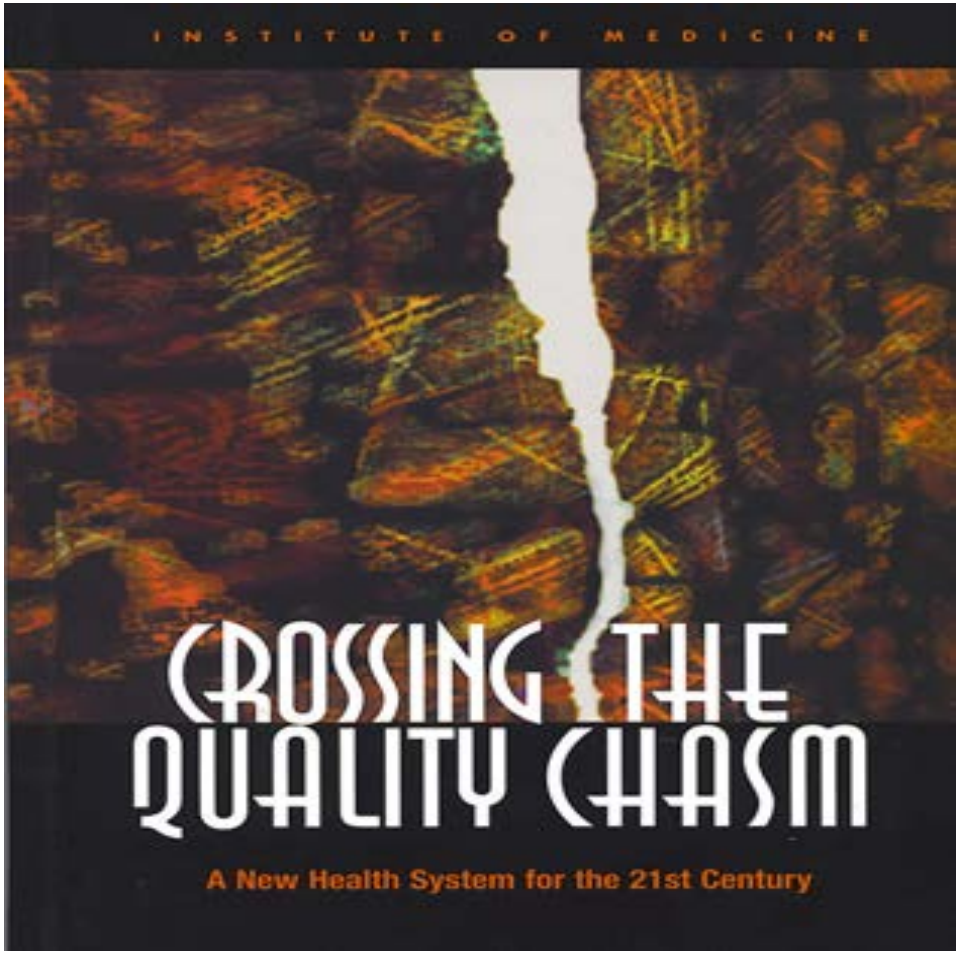
At the conclusion of this activity, the participant will be able to:

1. Name the 4 foundational Building Blocks and discuss 2 ways they relate to the outcomes of the HIV Care Continuum
2. Identify 2-3 key findings from the baseline multi-site organizational assessment in the SPNS Workforce initiative
3. Use the Building Blocks of Primary Care Assessment (BBPCA) tool to identify one organizational challenge and map it to the HIV Care Continuum

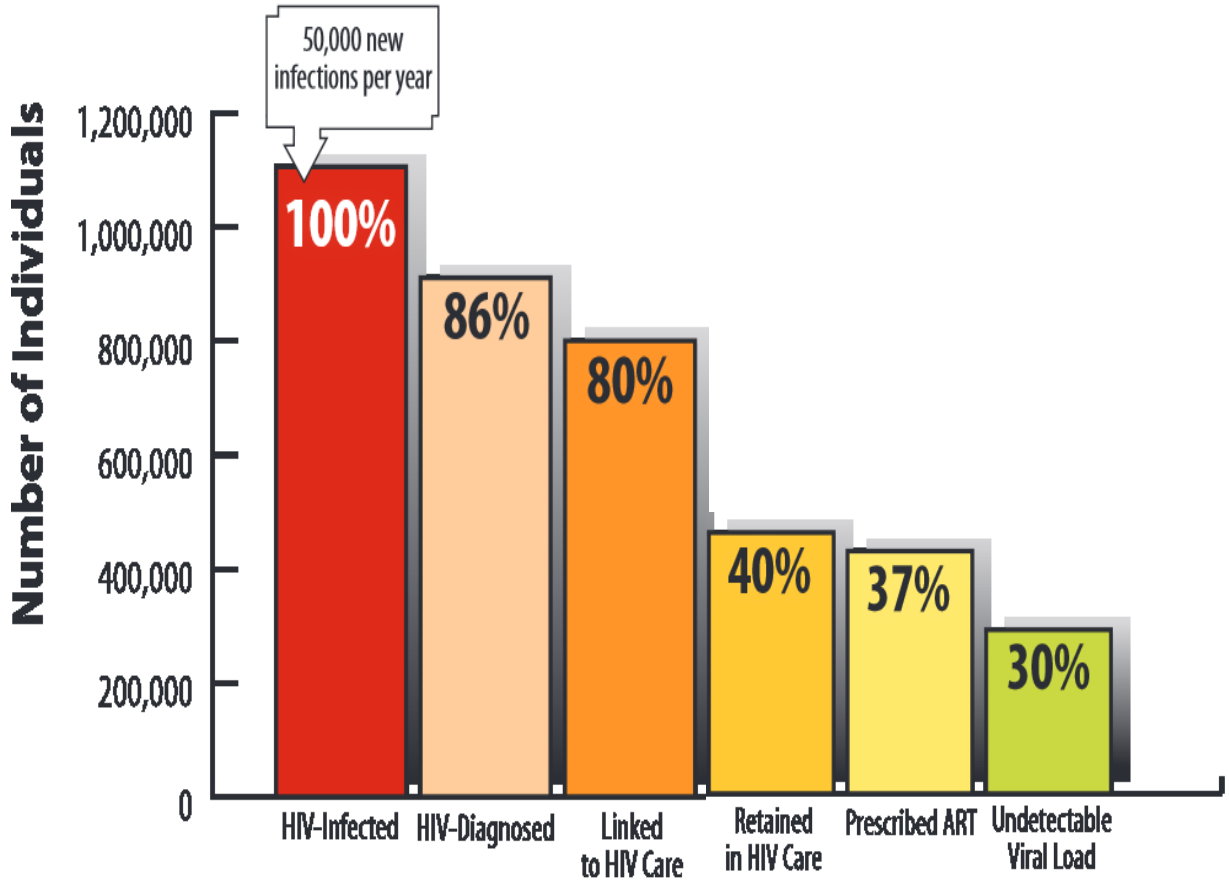
Agenda

10:30	Icebreaker exercise
10:40	Care Continuum exercise
10:50	Introduction to the Building Blocks of Effective Primary Care model
11:20	Findings from the Baseline Organizational Assessment from Workforce Development Initiative
11:40	Case Study
11:55	Closing

Institute of Medicine Report



Care Continuum



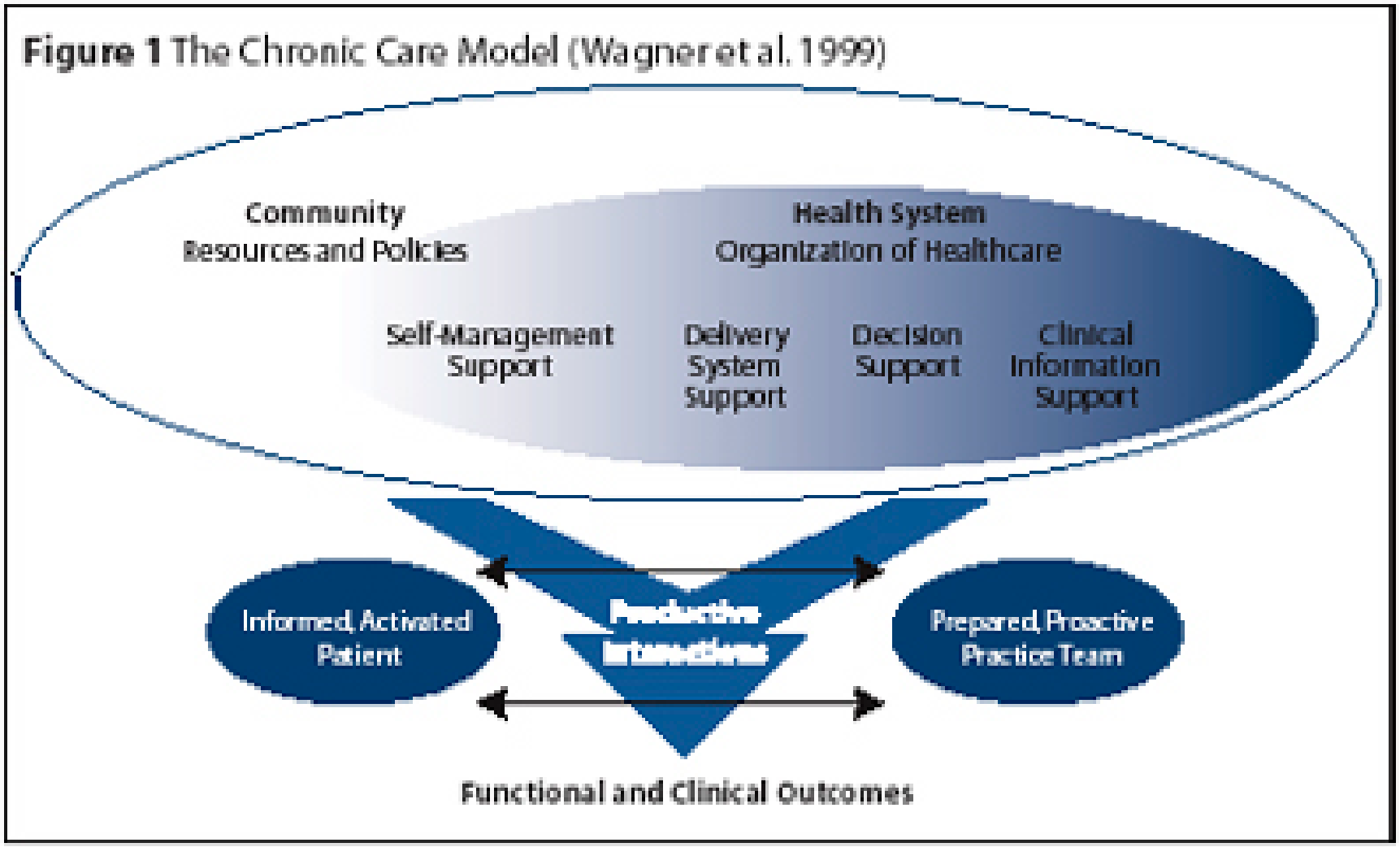
1. Gardner EM, McLees MP, Steiner JF, del Rio C, & Burman WJ. The spectrum of engagement in HIV care and its relevance to test-and-treat strategies for prevention of HIV infection. Clin Infect Dis. (2011) 52(6): 793-800 doi:10.1093/cid/ciq243
2. CDC. Vital Signs: HIV Diagnosis, Care, and Treatment Among Persons Living with HIV — United States, 2011. MMWR. 2014;63(47):1113-1117

Continuum of Care

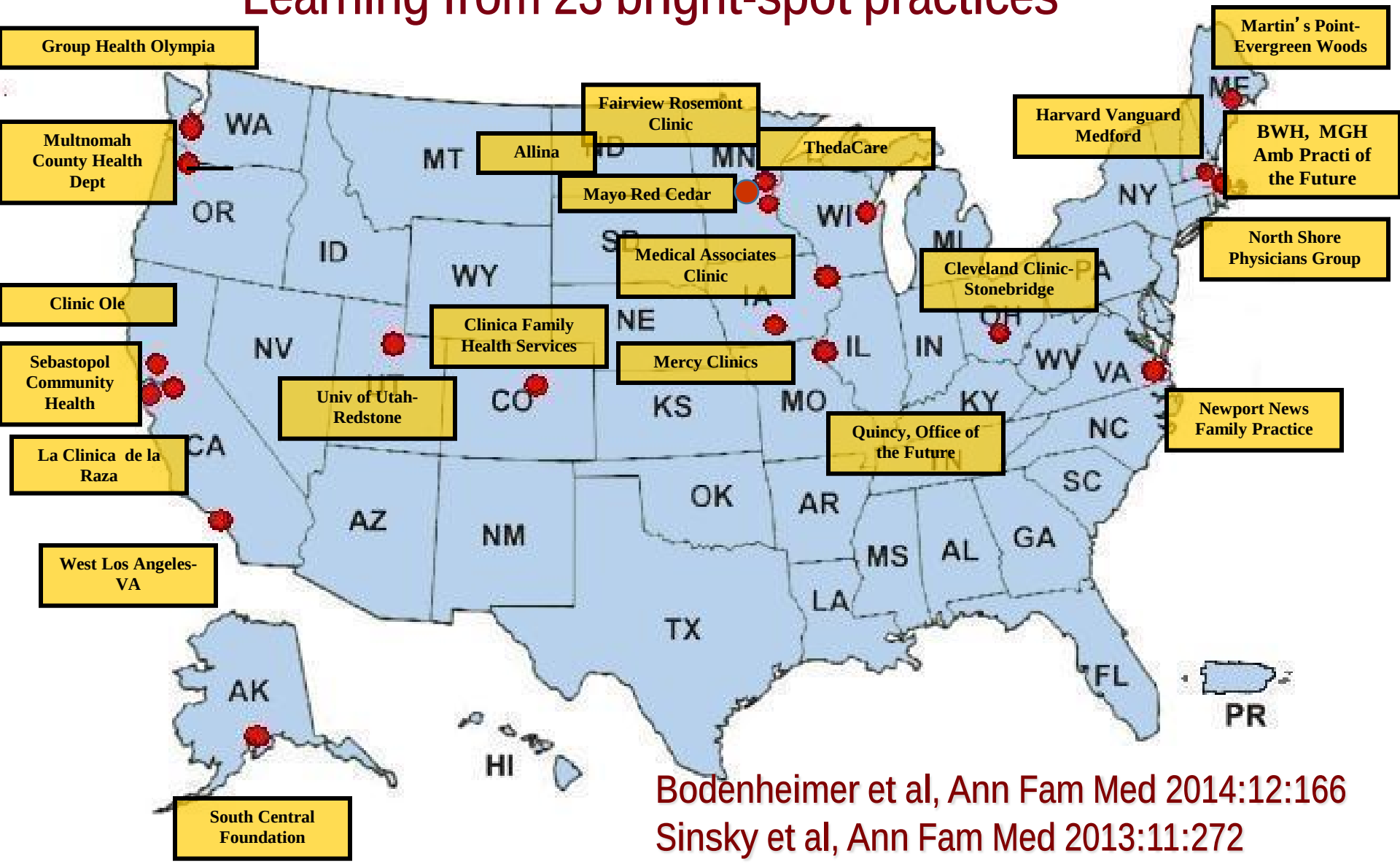
Care Continuum Exercise:

1. Unaware of HIV status
2. Not linked to care
3. Accessing some care but not HIV care
4. Linked but not retained in care
5. Not taking ARVs
6. Taking ARVs but not suppressed
7. Fully suppressed on ARVs

Where are the barriers?



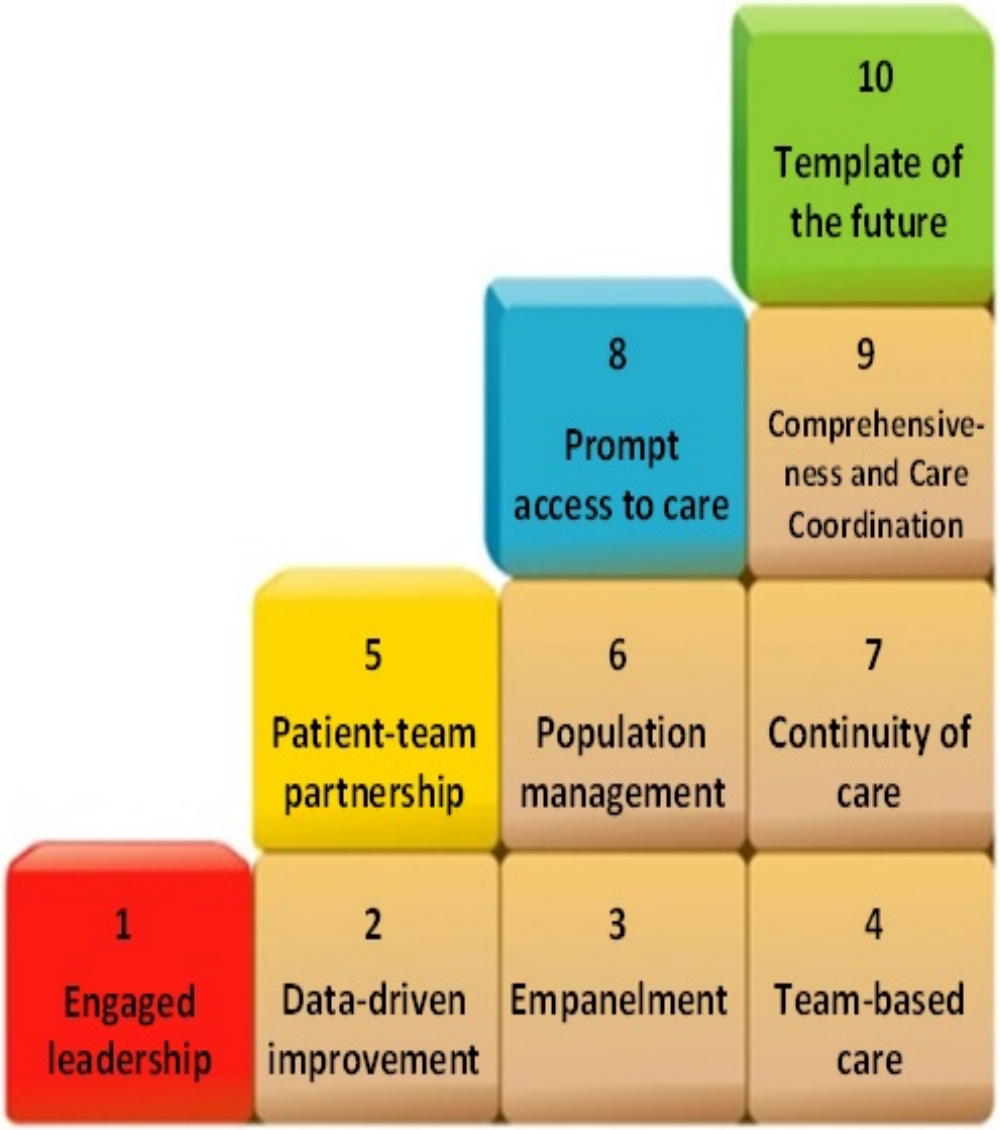
Learning from 23 bright-spot practices



Bodenheimer et al, Ann Fam Med 2014:12:166

Sinsky et al, Ann Fam Med 2013:11:272

Building Blocks of High-Performing Primary Care



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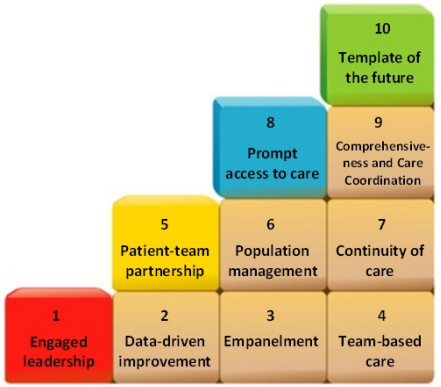
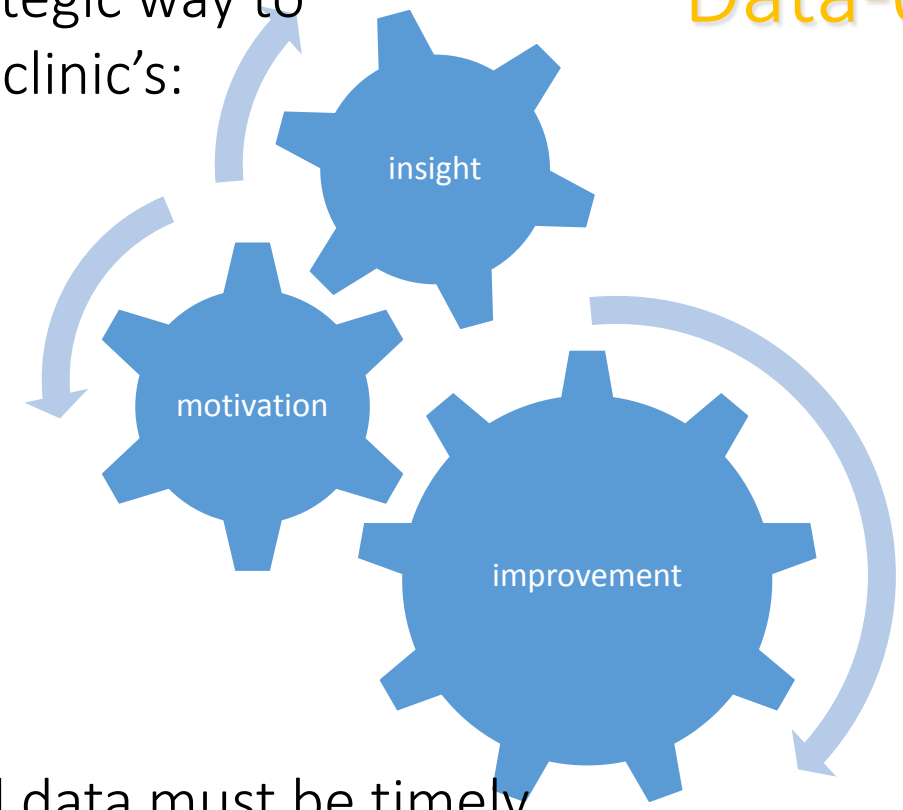
Building Block 1:
Engaged Leadership

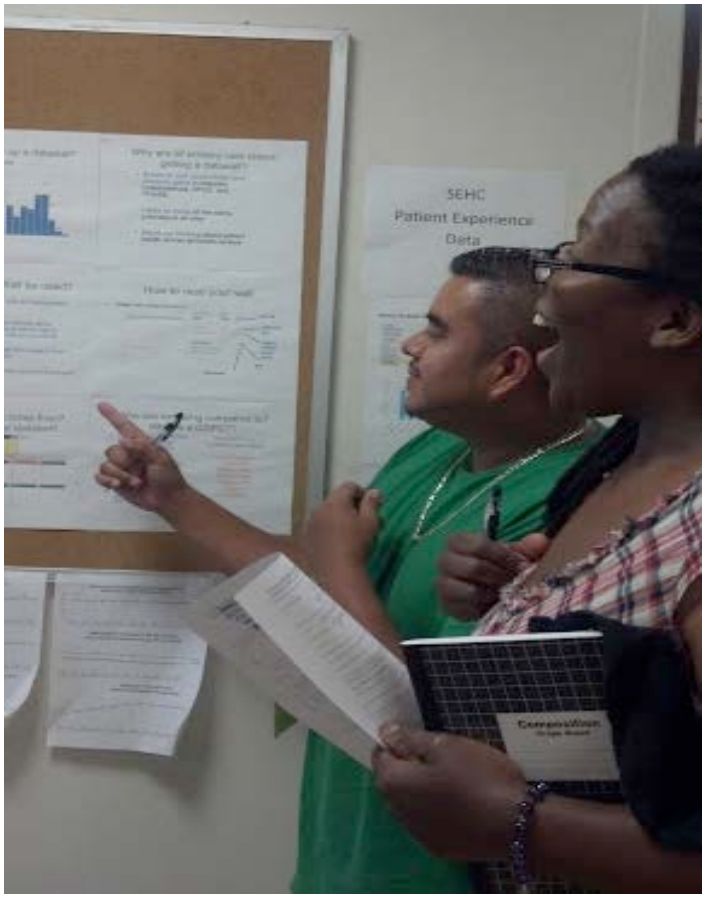
- Deep understanding of need for change
- Clear vision of where we are going
- Effective communication of vision
- Change management
- Engagement of leadership at all levels of organization



Building Block 2 – Data-driven Improvement

Data is collected in a strategic way to drive clinic's:



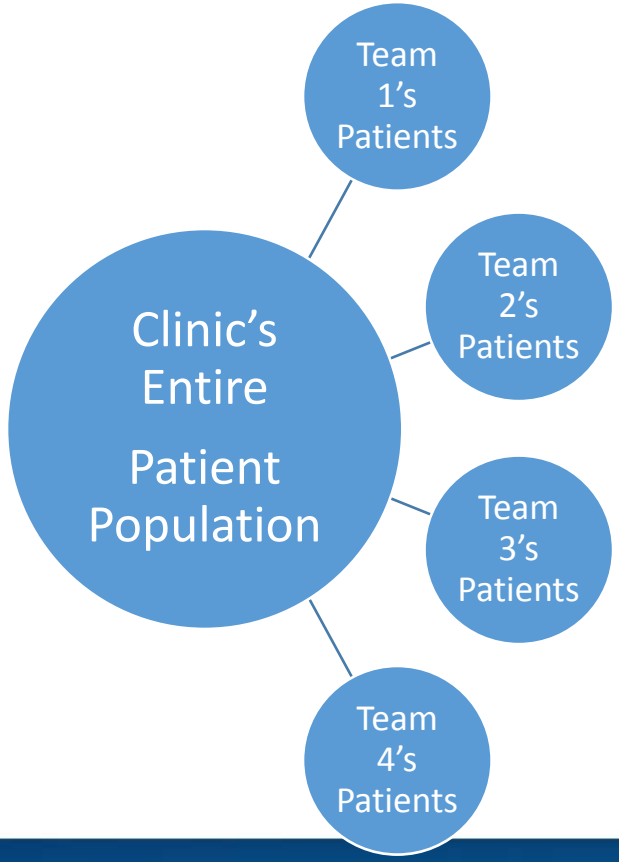


…and data must be timely and actionable in order to reach this goal!

Metrics Aligned with Care Continuum

- Percent of patients 15-65 who have been tested for HIV at least once in their lifetime
- Number of patients with a first time diagnosis of HIV
- Percent HIV+ patients who did not have a medical visit within the last six months
- Percent of HIV+ patients who are prescribed ART
- Percent of HIV+ patients who had a viral load <200 at last test within the the previous 12 months

Building Block 3 – Empanelment



Linking patient with a team essential population management, continuity and access

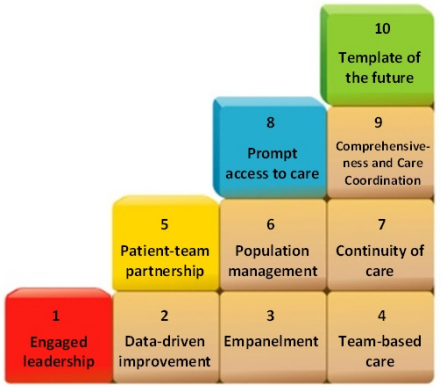
Understand supply and demand

Whose panel is it?

Shift: Clinician's panel → Team's panel

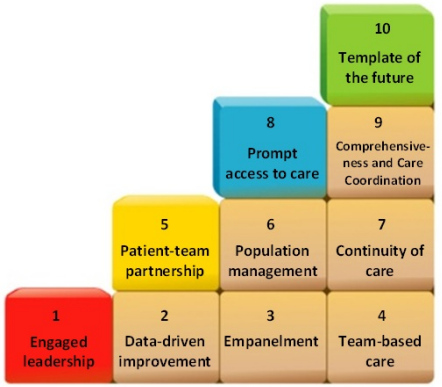
Building Block 4:
Team Based Care

- Organizational culture supporting teams
- Stable Teams (Teamlets)
- Co-location
- Communication strategies
- Staffing ratios
- Defined roles and responsibilities
- Refinement of workflows
- Standing Orders/Protocols
- Training on roles/skills checklists



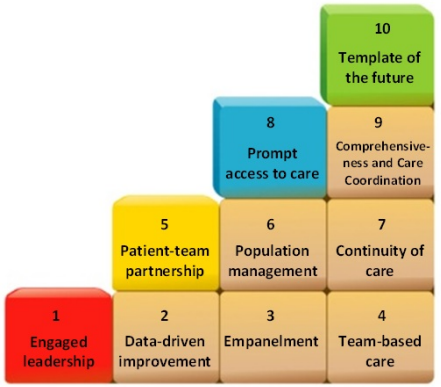
Building Block 5:
Patient Team Partnerships

- Peer navigation
- Self-management support
- Motivational Interviewing
- Health Coaching
- Patient engagement in QI



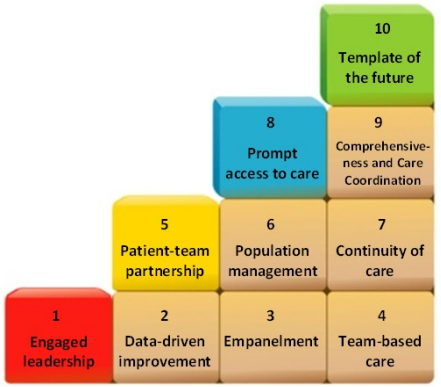
Building Block 6:
Population Management

- Identification of gaps in care
- Dedicated population manager
- Team organized to close gaps
- In-reach and out-reach
- Retention, lab follow-up are both part of population management



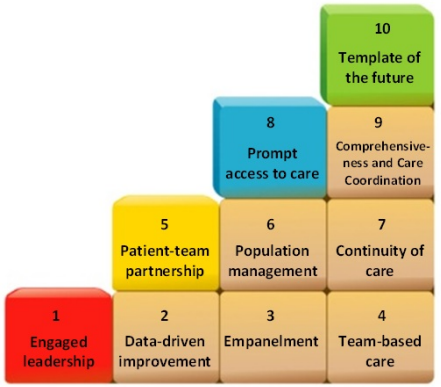
Building Block 8: Comprehensive and Coordinated Care

- Operationalize one-stop care
- Effective interface with the medical neighborhood
- Effective coordination between extended care team



Building Block 10:
Template of the future

- How can we organize our time in a health care setting to make the work manageable for the care team and more patient-centered?
- One possible solution----



Template of the Present

Time	Primary care physician	Medical assistant 1	RN	Nurse Practitioner	Medical Assistant 2
8:00	Patient A	Assist with Patient A	Triage	Patient H	Assist with Patient H
8:15	Patient B	Assist with Patient B		Patient I	Assist with Patient I
8:30	Patient C	Assist with Patient C		Patient J	Assist with Patient J
9:00	Patient D	Assist with Patient D		Patient K	Assist with Patient K
9:15	Patient E	Assist with Patient E		Patient L	Assist with Patient L
9:30	Patient F	Assist with Patient F		Patient M	Assist with Patient M
10:00	Patient G	Assist with Patient G		Patient N	Assist with Patient N

Template for the Practice of the Future

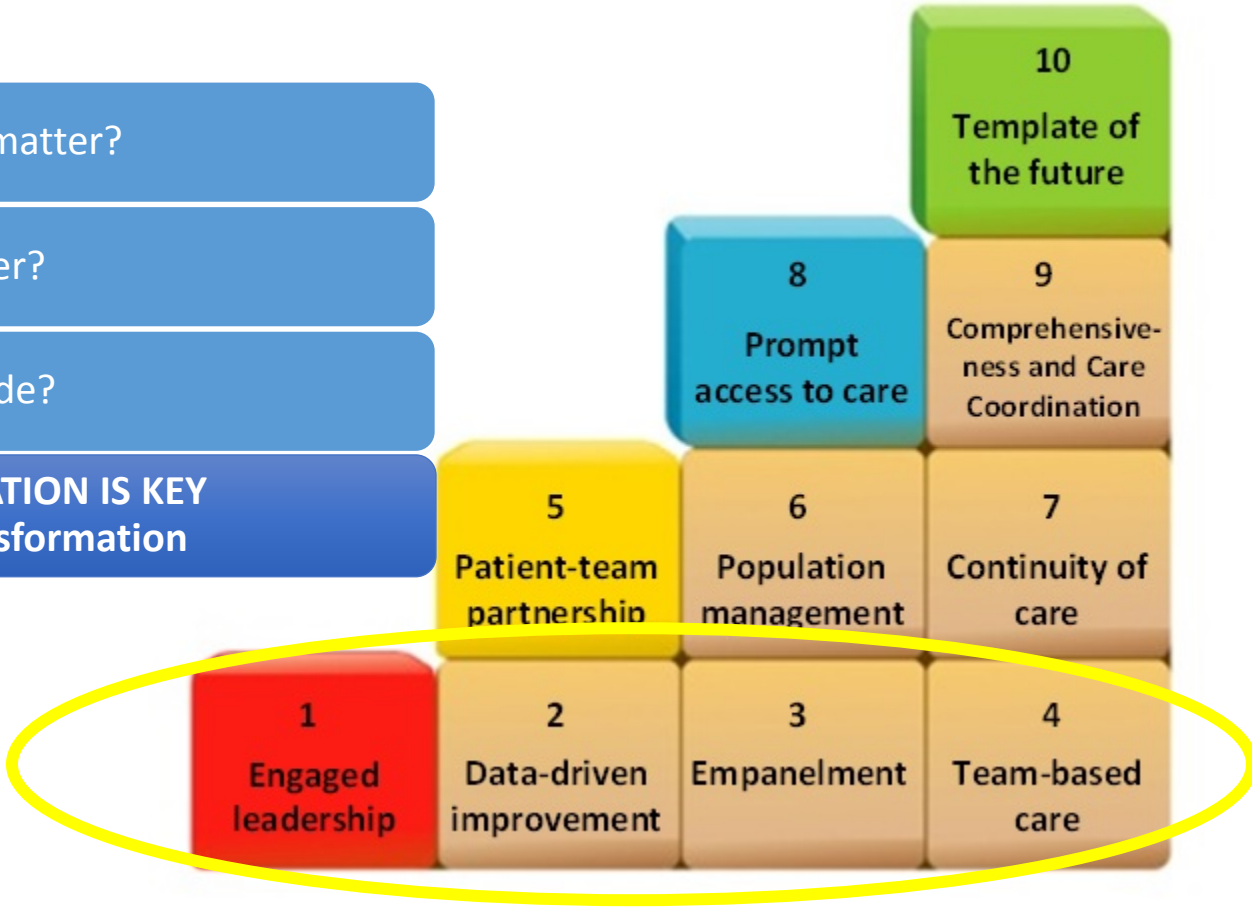
Time	Primary care physician	Medical assistant 1	RN	Nurse Practitioner	Medical Assistant 2
8:00	Huddle				
8:10	E-visits and phone visits	Panel manage-ment	RN Care manage-ment	Acute Patients	
8:30					
9:00	Complex patient				
9:30	Complex patient			E-visits and phone visits	Panel manage-ment
10:00	Coordinate with hospitalists and specialists	BP coaching clinic			
10:30	Huddle with RN, NP		Huddle with MD		

- 20 patients are seen or contacted in the first 3 hours of the day

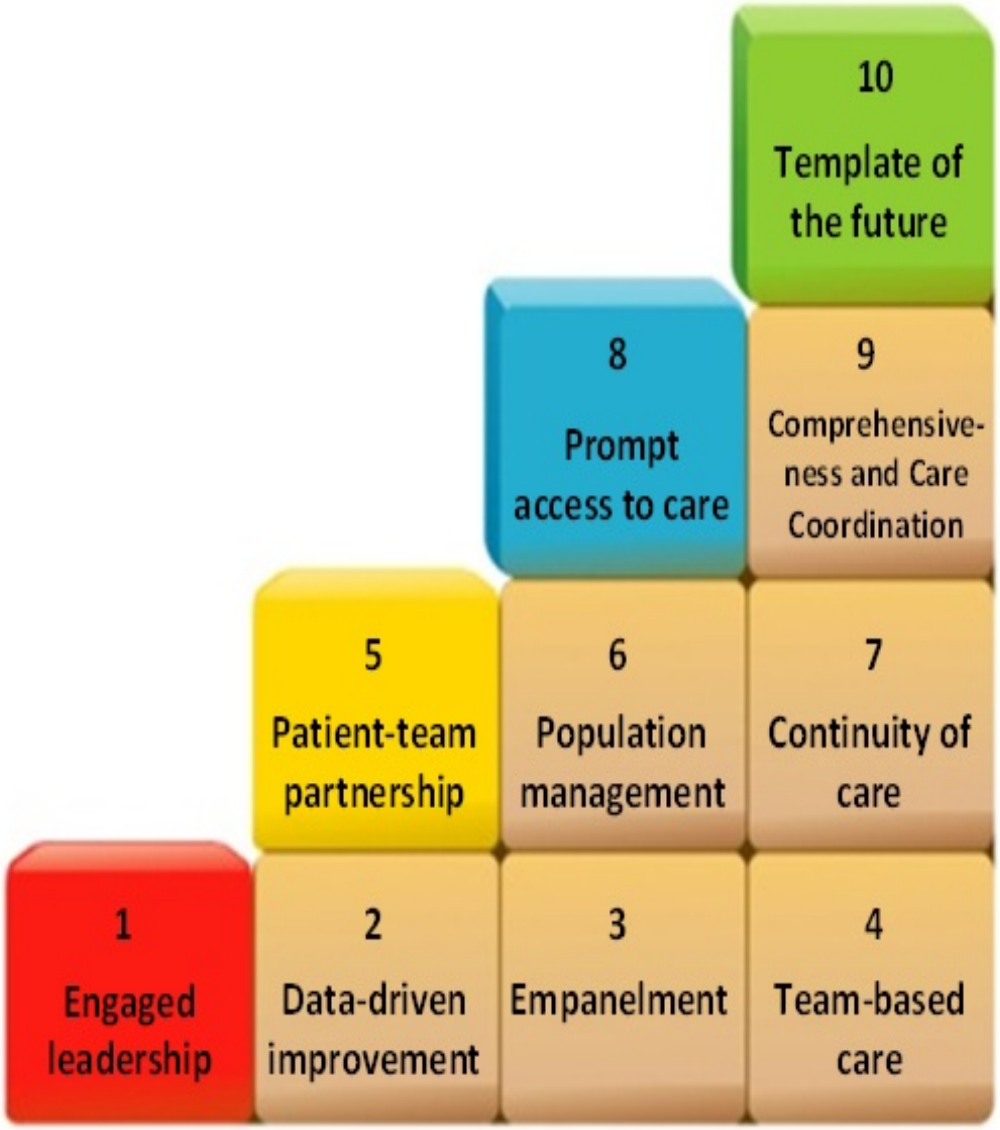
Sequencing Transformation:
The 4 Foundational BBs

- Does the sequence of change matter?
- Why might the sequence matter?
- How can *lasting* change be made?

A STRONG FOUNDATION IS KEY for successful transformation



Building Blocks of High-Performing Primary Care



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Care Continuum Exercise: Questions???????

What are the barriers?

Where in the system are the barriers?

What are some possible changes that would lower barriers?

How is Health Care part of that change?

Can the change be mapped to Building Blocks in the model?

What are the upstream changes?

SPNS Initiative

- System-level Workforce Capacity Building for Integrating HIV Primary Care in Community Health Care Settings
  - Initiative started: August 1, 2014
  - Funding runs for 4 years

- Purpose: Develop and evaluation practice transformations to enhance access to and optimize the delivery of HIV care
  - Seeks to address future HIV workforce capacity challenges

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

Assessing Practice Changes

- Building Blocks of Primary Care Assessment (BBPCA)
  - Adapted from the PCMH-A
  - Organized around the tenants of the Building Blocks of High-Performing Primary Care
- Total of 46 questions, organized into groupings that correspond to each Building Block
- Each question asks a clinical site to characterize its current practices
- Responses marked on an 12 point Likert-type scale
  - Higher scores correspond to practices in line with the principles of the Building Blocks Model

BBPCA

Building Blocks of Primary Care Assessment

(version 12.28.12)

Block 1: Engaged leadership

Components	Level D	Level C	Level B	Level A
1. Executive leaders	are focused on short-term business priorities.	visibly support and create an infrastructure for quality improvement, but do not commit resources.	allocate resources and actively reward quality improvement initiatives.	support continuous learning throughout the organization, review and act upon quality data, and have a long-term strategy and funding commitment to explore, implement and spread quality improvement initiatives.
Score	1 ☐ 2 ☐ 3 ☐	4 ☐ 5 ☐ 6 ☐	7 ☐ 8 ☐ 9 ☐	10 ☐ 11 ☐ 12 ☐
2. Clinical leaders	intermittently focus on improving quality.	have developed a vision for quality improvement, but no consistent process for getting there.	are committed to a quality improvement process, and sometimes engage teams in implementation and problem solving.	consistently champion and engage clinical teams in improving patient experience of care and clinical outcomes.
Score	1 ☐ 2 ☐ 3 ☐	4 ☐ 5 ☐ 6 ☐	7 ☐ 8 ☐ 9 ☐	10 ☐ 11 ☐ 12 ☐
3. The responsibility for conducting quality improvement activities	is not assigned by leadership to any specific group.	is assigned to a group without committed resources.	is assigned to an organized quality improvement group who receive dedicated resources.	is shared by all staff, from leadership to team members, and is made explicit through protected time to meet and specific resources to engage in QI.
Score	1 ☐ 2 ☐ 3 ☐	4 ☐ 5 ☐ 6 ☐	7 ☐ 8 ☐ 9 ☐	10 ☐ 11 ☐ 12 ☐

BBPCA Responses

- Level D: Responses of 1, 2, or 3
  - Generally reflective of little commitment to, resources for, or practices related to the objectives of a Building Block

- Level C: Responses of 4, 5, or 6
  - Generally reflective of there being an acknowledgement of a Building Block's importance (and/or a stated commitment to its objectives), but with little evidence of there being practices or resources to meet the goals of the Building Block

BBPCA Responses

- Level B: Responses of 7, 8, or 9
  - Generally reflective of there being a commitment to the objectives of a Building Block and evidence of practices consistent with those objectives. But the practices tend to be driven by individual providers or conducted at specific times, rather than being used consistently throughout the clinic and across time.

- Level A: Responses of 10, 11, or 12
  - Generally reflective of a broad commitment to the objectives of a Building Block. Practices consistent with the objectives of the Building Block are implemented widely and across time.

BBPCA

Building Blocks of Primary Care Assessment

(version 12.28.12)

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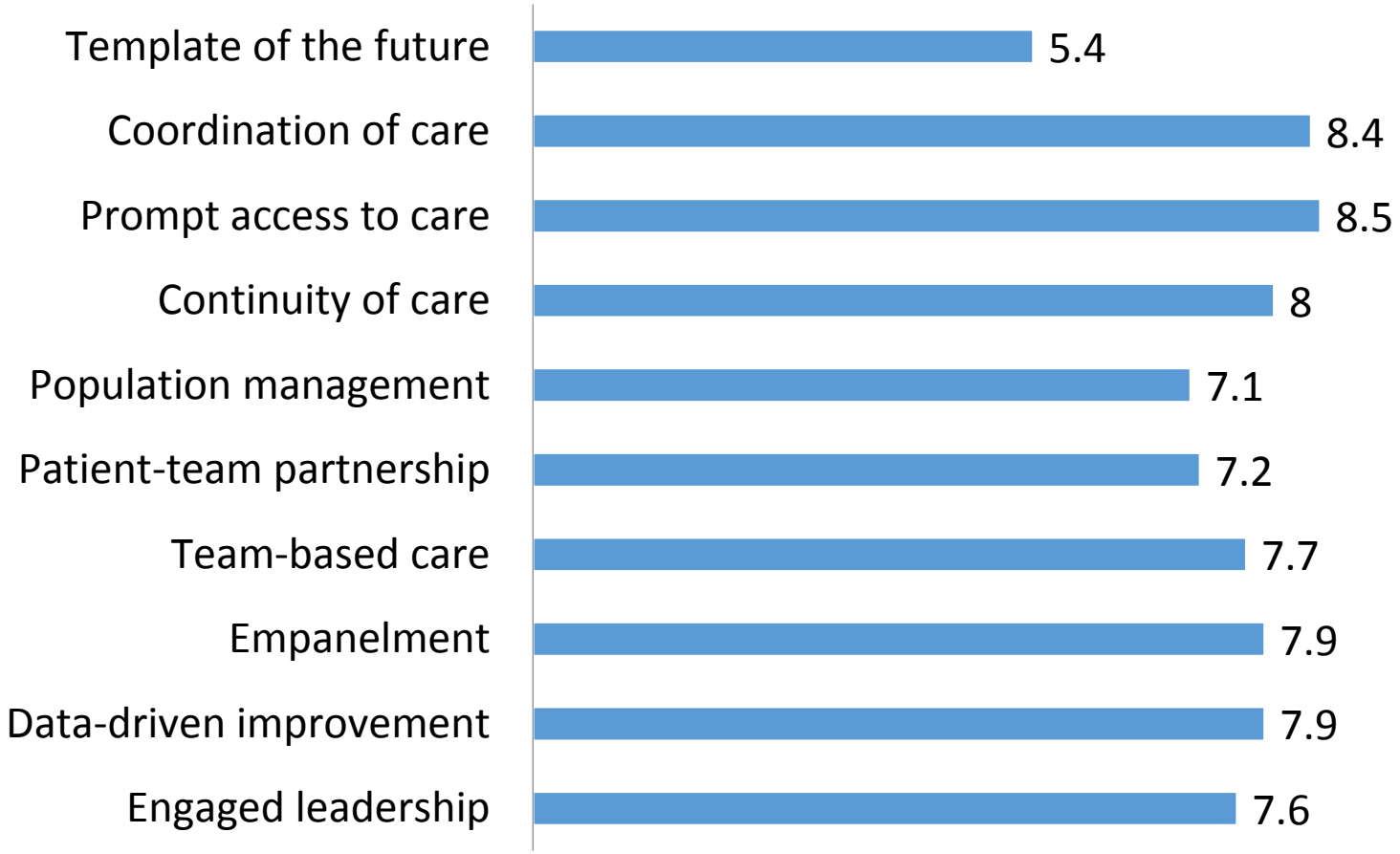
BBPCA in SPNS Initiative

- Each site completes a BBPCA every six months
  - Baseline completed just prior to launch of practice transformations
- Site teams meet to select BBPCA answers. Teams then review answers and logic behind those answers with evaluation center investigators.
  - Process ensures that scores are informed by those who know best the practices at the local clinic
  - Process also ensures that all demonstration projects are working with a similar understanding of all questions and applying uniform logic in selecting answer options

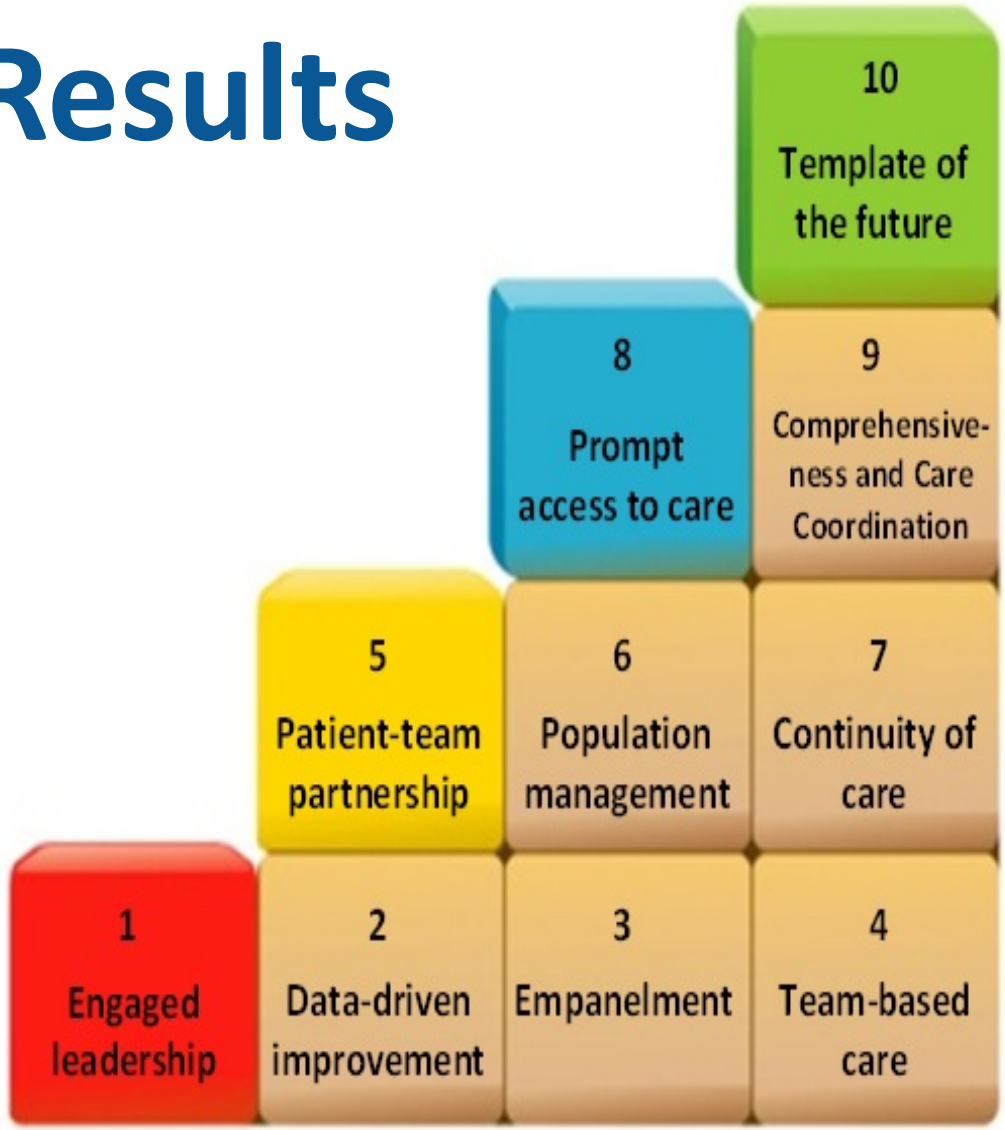
BBPCA in SPNS Initiative

- Initiative has created an addendum specifically focused on HIV care practices
- 12 questions cover 4 major domains
  - Provision of HIV care
  - HIV cultural competence
  - HIV team-based care
  - HIV coordination of care
- Uses similar response options to BBPCA

Practices at Baseline



BBPCA Results



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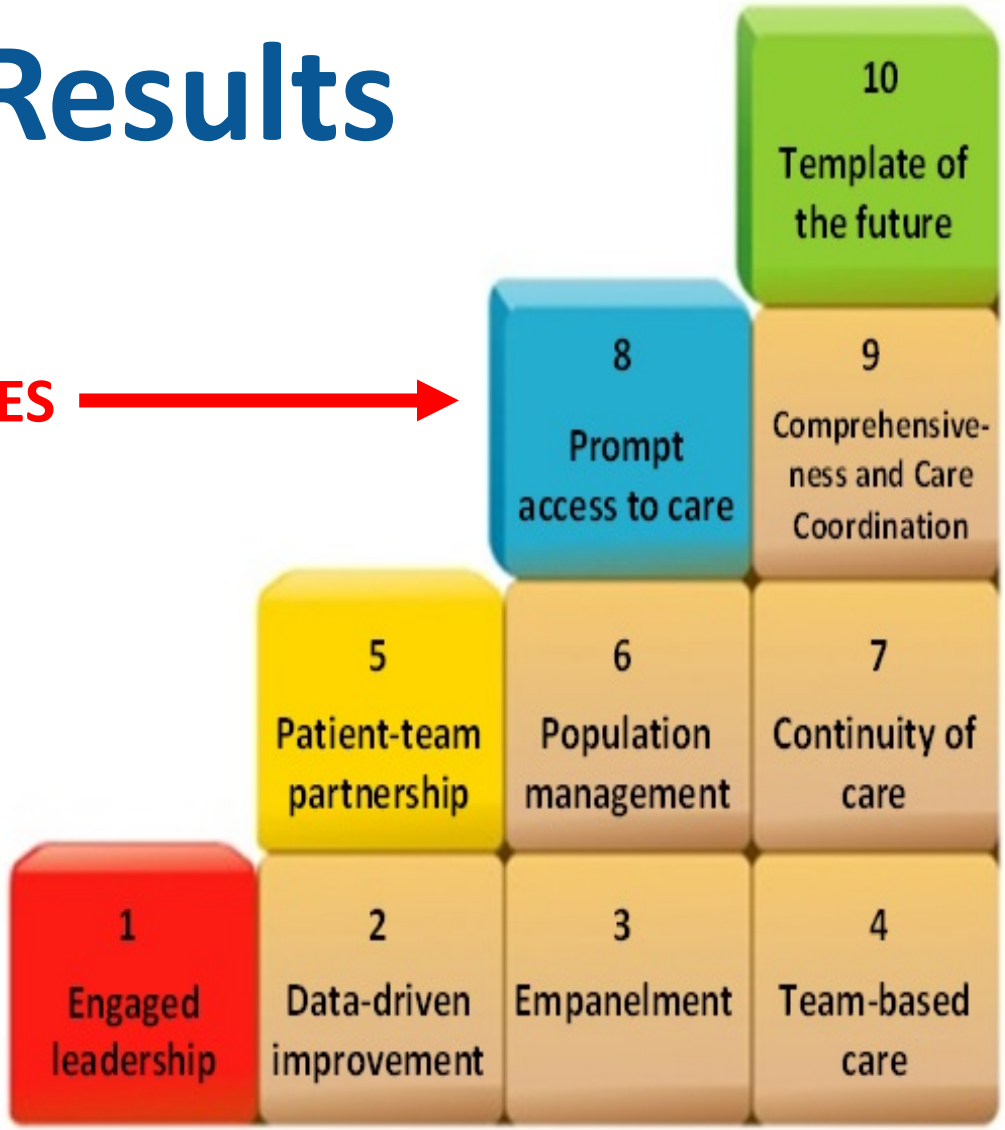
BBPCA Results

HIGHER SCORES →



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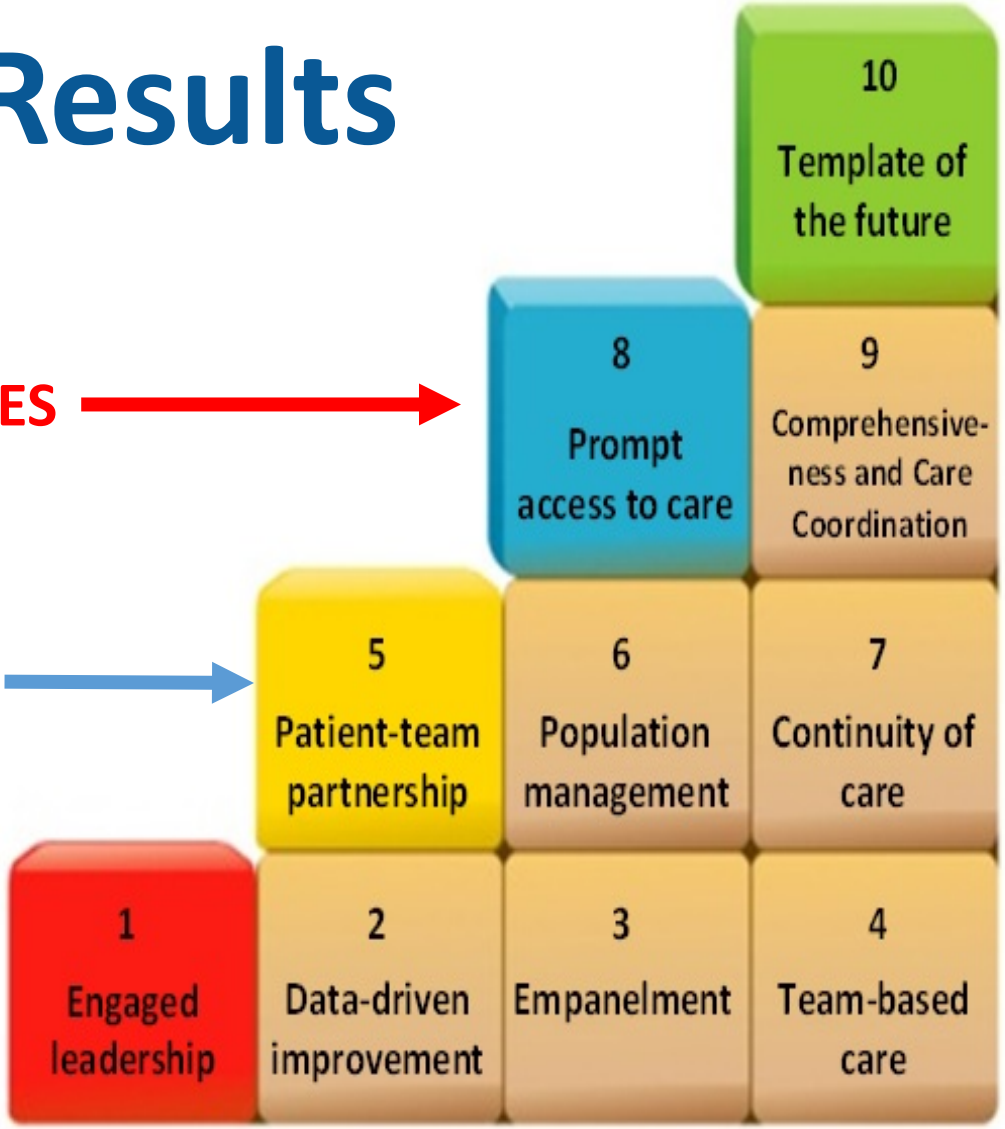
BBPCA Results

HIGHER SCORES →

LOWER SCORES →



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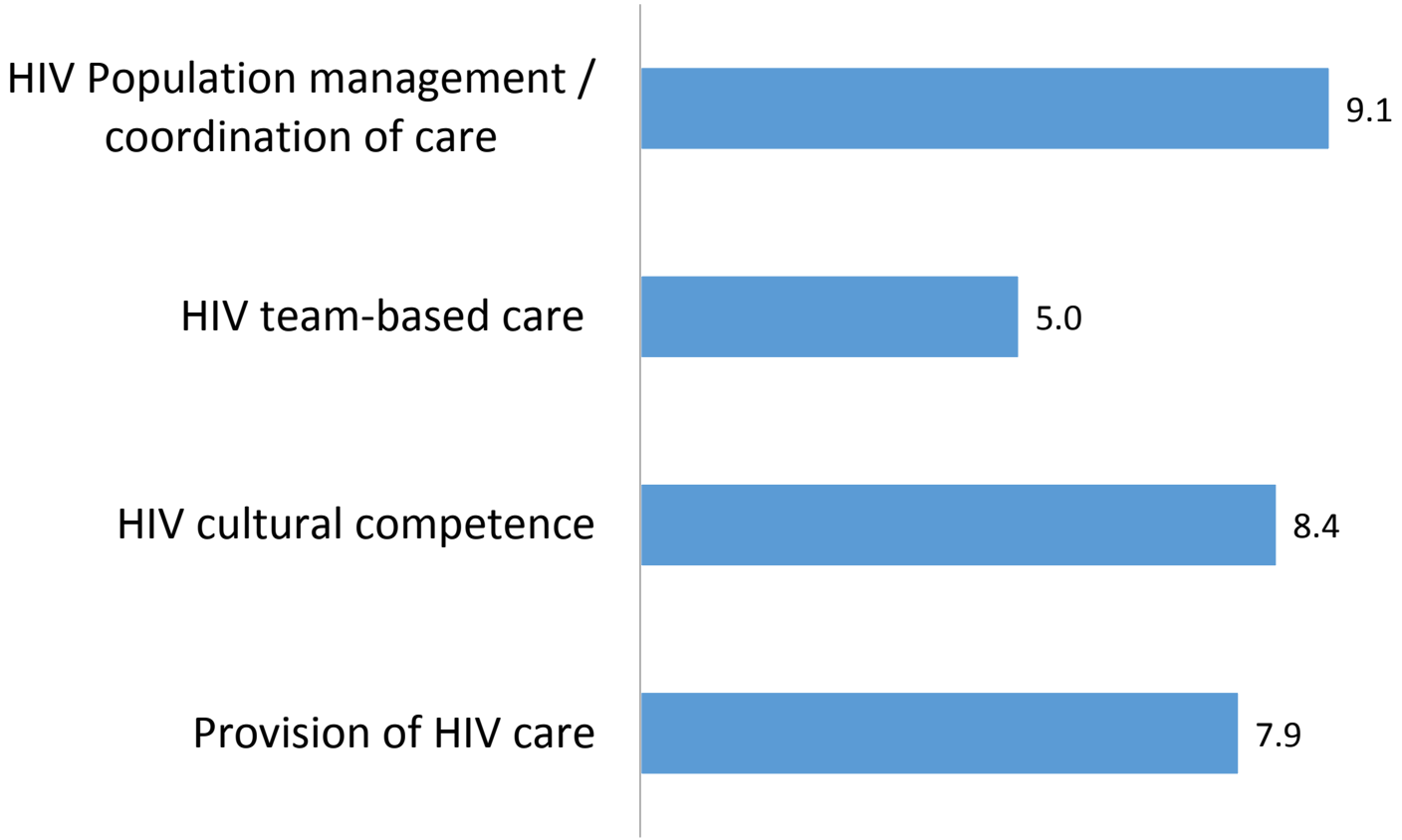
Practices at Baseline (II)

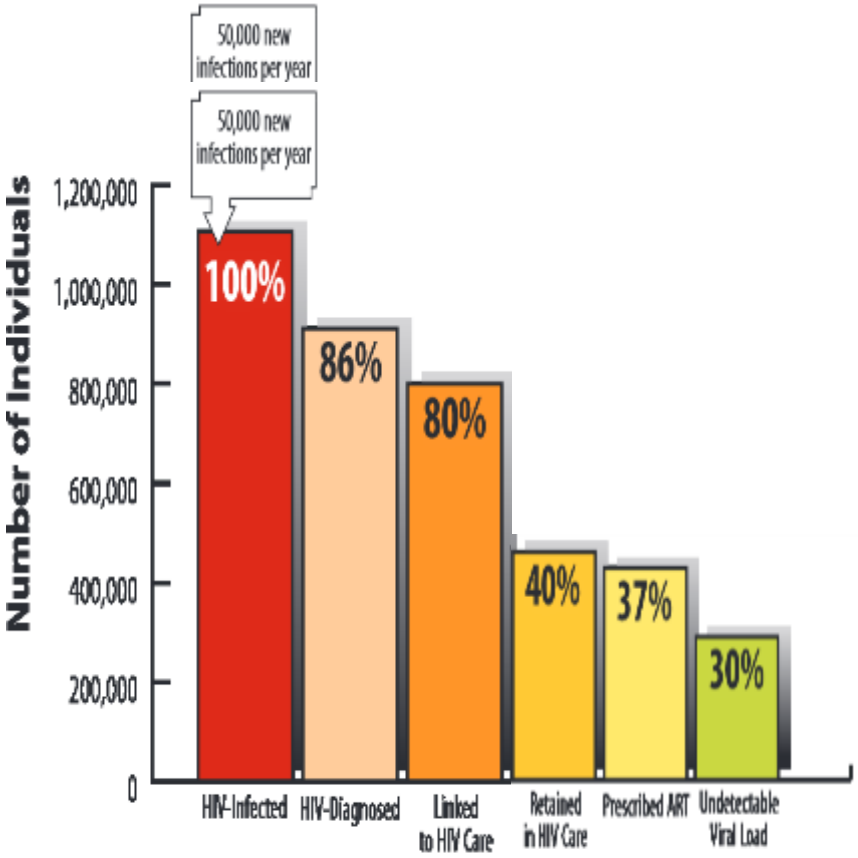


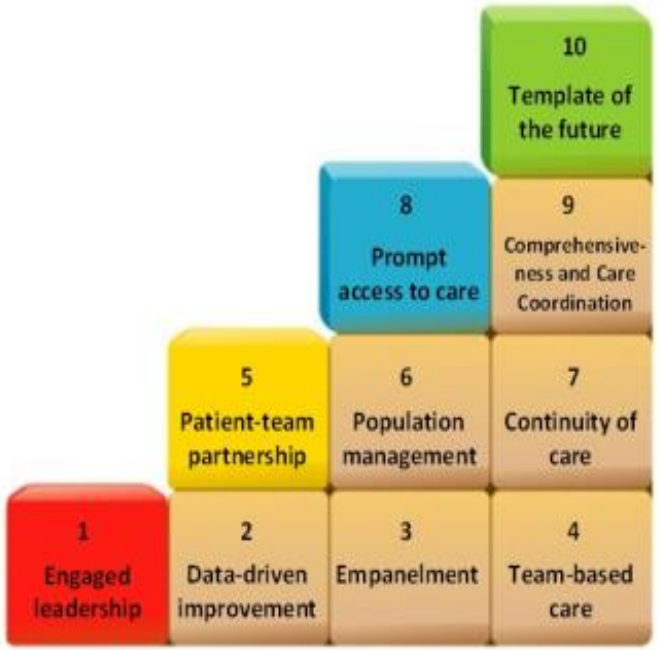
Case Study: CHC in urban setting

A Community Health Center (CHC) with 330 funding and also RWHAP part A funding located in a large, urban area, serving patients with many barrier to retention in care.

The site's principle goal is to link newly diagnosed patients (often referred to the CHC by other community providers) to care and to improve retention rates once patients are linked to care.

Building Block Model and the Care Continuum





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- Pacific AIDS Education and Training Centers
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  - Amanda Newstetter
  - Sophy Wong, MD

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