Partnership for Care: Developing real and sustainable partnerships with health centers

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Outline

NYSDOH	Project activities
	Description of procedures
	Highlighting outcomes
Cornerstone	Success of partnership
	HIV Care Team
	Outreach Efforts

Project activities at a glance

1. Use HIV surveillance data & health center patient data to improve health outcomes for PLWH
2. Expand partner notification, linkage, retention, and re-engagement with care services for PLWH
3. Support training and TA activities for health centers (e.g., expand routine HIV testing, prevention services for PLWH)
4. Develop Sustainable Partnerships with Health Centers

Data to Care Initiative

Quality of Care Initiative

Creating partnerships

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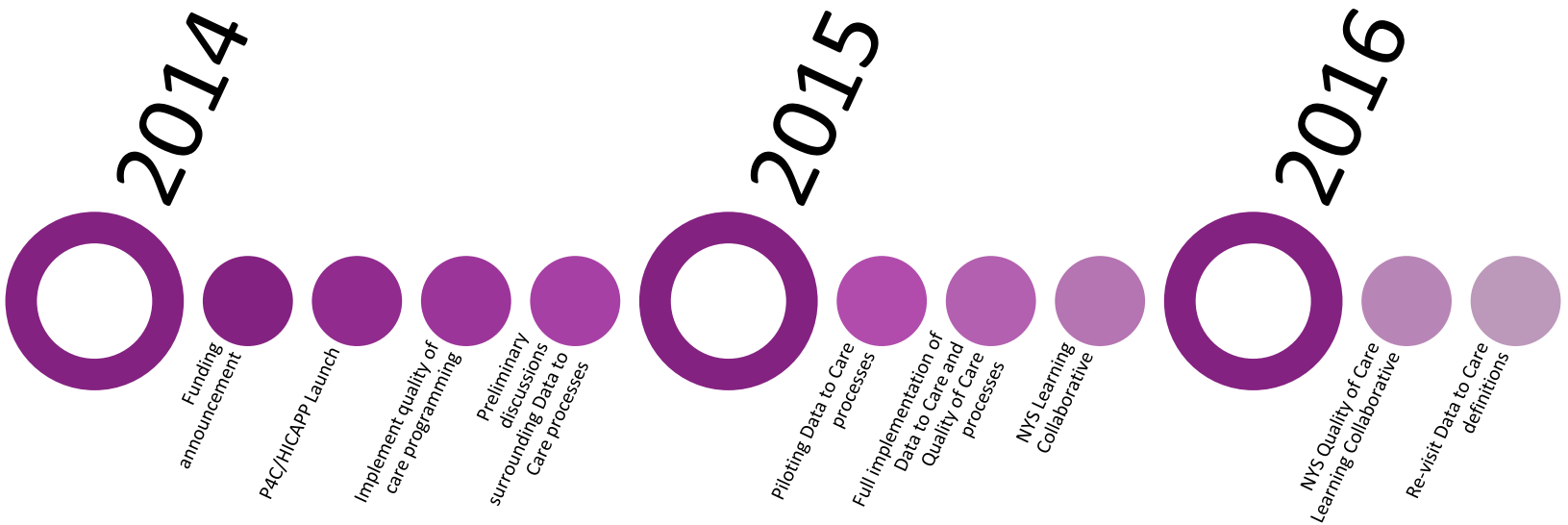

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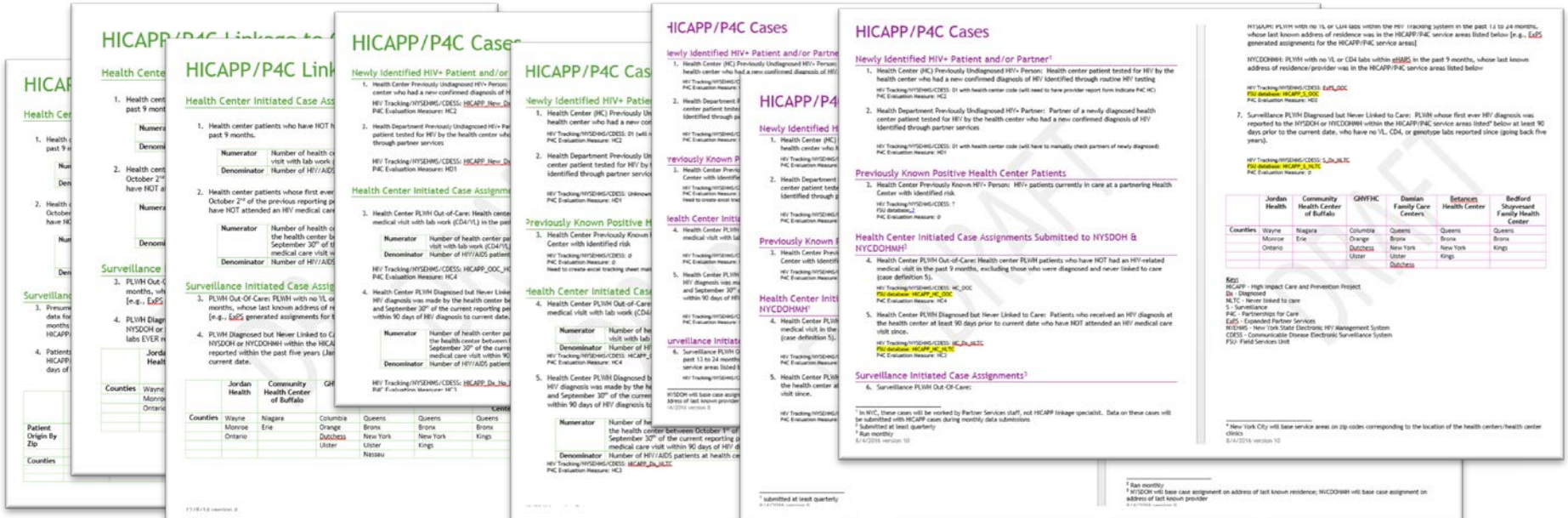
Data to Care initiative

Defining “out of care”

- Four definitions developed with input from our health centers



Final definitions for “out of care”

HEALTH CENTER INITIATED CASE ASSIGNMENTS SUBMITTED TO HEALTH DEPARTMENTS

- **Health Center PLWH Out-of-Care**: Health center PLWH patients who have NOT had an HIV-related medical visit in the past 9 months, excluding those who were diagnosed and never linked to care
- **Health Center PLWH Diagnosed but Never Linked to Care**: Patients who received an HIV diagnosis at the health center at least 90 days prior to current date who have NOT attended an HIV medical care visit since

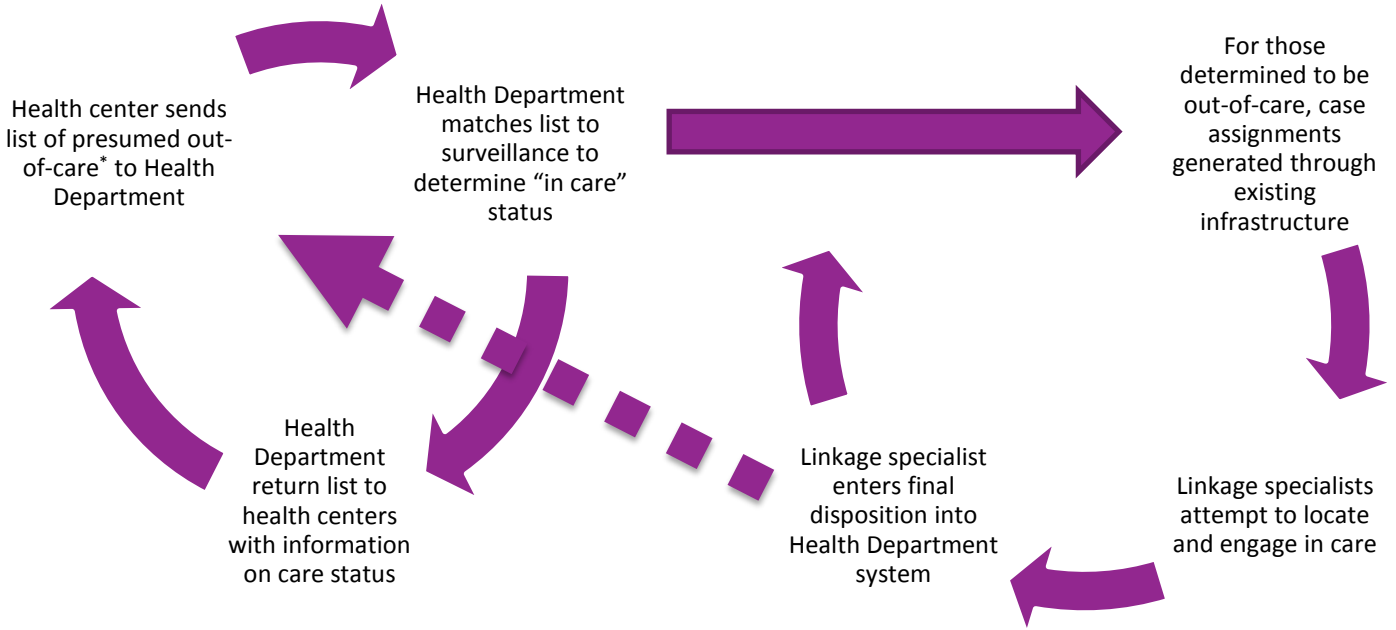
SURVEILLANCE INITIATED CASE ASSIGNMENTS

- **Surveillance PLWH Out-Of-Care**: PLWH with no VL or CD4 labs in the past 9 months in NYC, and13 to 24 months in rest of state (ROS), whose last known address of residence was in the HICAPP/P4C service areas
- **Surveillance PLWH Diagnosed but Never Linked to Care**: PLWH whose HIV diagnosis date (as determined via diagnostic test, detectable VL, or physician’s diagnosis) was reported to the New York State Department of Health (NYSDOH) or New York City Department of Health and Mental Hygiene (NYCDOHMH) within the HICAPP/P4C service areas at least 90 days prior to the current date, who have no VL, CD4, or genotype labs reported since (going back five years)

Data sharing agreements

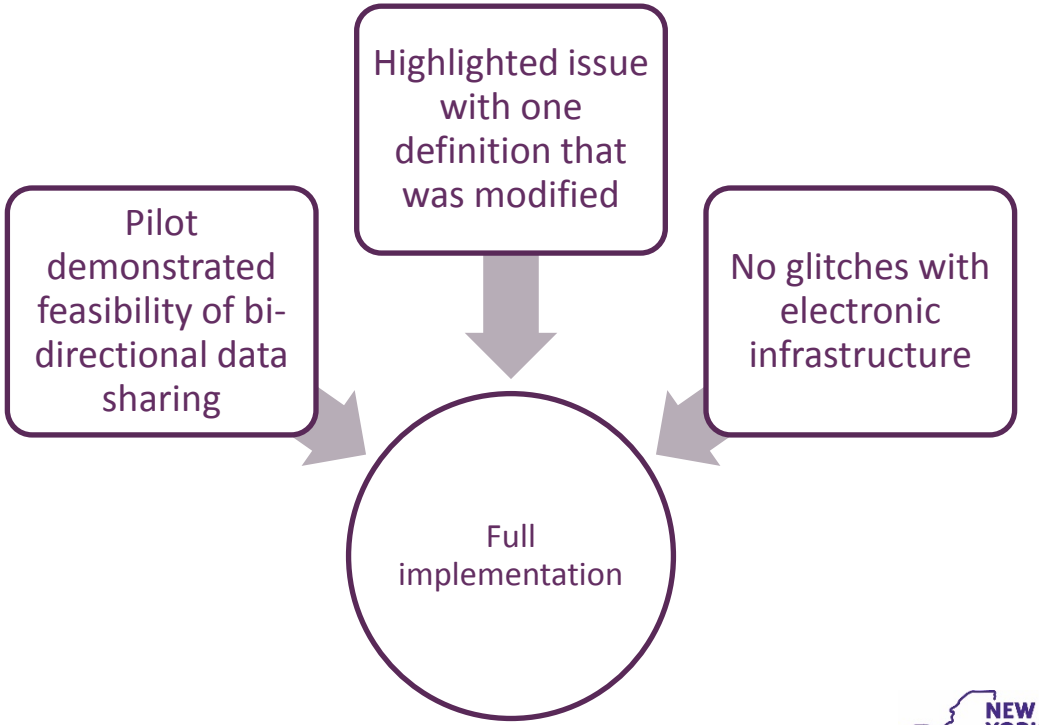
In April 2014, changes to public health law permits that **HIV-related information** reported to the NYS Department of Health or a local department of health **can be shared between** authorized health department staff and medical providers treating HIV positive patients, **in order to promote linkage and retention in health care**

Piloting data sharing process



*Includes presumed diagnosed and never linked to care

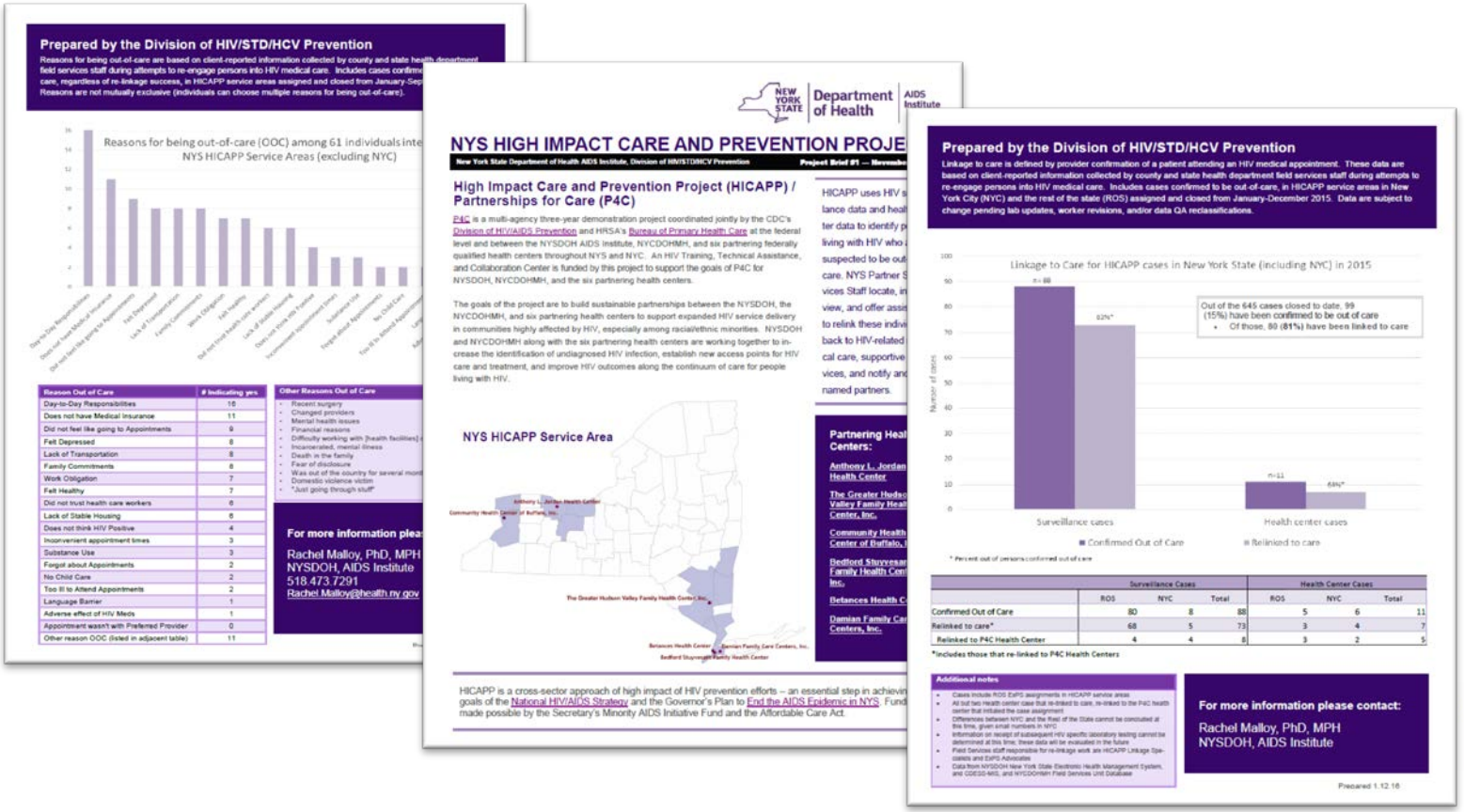
Implementing Data to Care



Continued implementation requires:

- re-visiting definitions
- evaluating and sharing success of the program/definitions
- continuing open discussions about what works/what is not working

P4C News Briefs



Quality of Care Program

The NYSDOH AIDS Institute's Quality of Care Program (QOC) conducts tailored trainings, technical assistance (TA), capacity-building, and coaching related to quality improvement (QI) activities for health centers (HCs) providing HIV care throughout NYS, including all P4C HCs.

As part of the P4C/HICAPP initiative, the QOC Quality Program Coordinator conducts annual organizational assessments (OAs), ongoing TA, in-person or web-based trainings, tailored coaching, facility-level QI profiles, and resource sharing.

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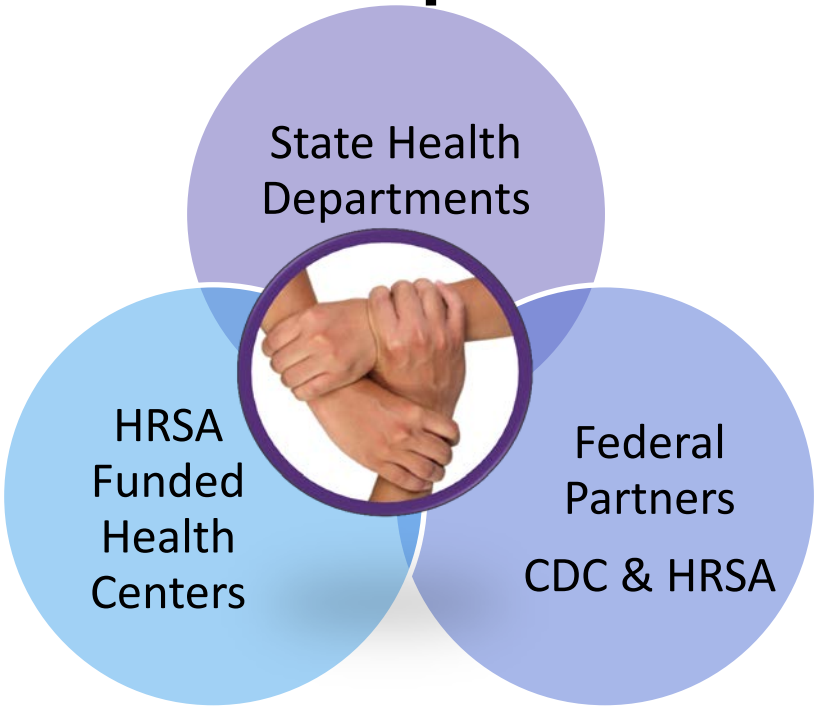
Creating sustainable partnerships

Additional partnerships



Have we been successful?

Data to Care

- As of July, 2016 29 lists of presumed out of care submitted to DOH for reconciliation (10 NYC, 19 ROS) (264 people in total)
  - 73 individuals assigned for potential re-linkage work (20 ROS, 53 NYC)
  - 11/15 (73%) individuals re-linked to care (7 to a P4C HC)

Quality of Care

- 12 organizational assessments conducted
- 15 TA coaching sessions
- 4 QOC quarterly webinars
- 3 in-person QI trainings

Sustainable partnerships

- 3 specialized trainings from DOH provided
- Peer-to-peer relationships established
- Connections created between health centers and DOH
- More on this from Marilyn…

NYS DOH & Cornerstone Family Healthcare

- Improved relationship with NYS DOH
  - From authoritative body to a partnership
- Feedback was solicited and used to make decisions for the “final definitions”
- Outreach Specialist and Linkage Specialists worked together to bring patients back to care
- Ensuring newly diagnosed and new to the health center patients are linked to care and their partners were tested and linked (if applicable)
- Improved relationships with other P4C Health Centers
- Expansion of PrEP program
- HIV testing

HIV Care Team

- 2 HIV Primary Care Providers
  - MD and FNP
- 1 Infectious Disease Provider
- 3 Case Managers
- 2 Nurses
  - RN and LPN

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Preventative Outreach Efforts

- Texting
- Vinelinks
- Pharmacy
- Home visits
- Use of alerts in EMR
- Insurance attainment
- Street outreach/search
- Transportation arrangements
- Case conferencing and Provider outreach
- Working with other agencies collaboratively
- Partnership with families and emergency contacts
- Close monitoring of patients with a history of being lost to care and keeping them engaged in services

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- Mara Sanantonio-Gaddy, MSN
- Tarak Shrestha, MS

Partnering Health Centers

- Betances Health Center
- Bedford Stuyvesant Family Health Center
- Community Health Center of Buffalo
- Damian Family Care Centers
- Jordan Health
- Cornerstone Family Healthcare

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