NATIONAL 2018 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

It Takes a Village: Adapting to Changing Healthcare Landscapes in Ryan White Programs and FQHCs

Presenters:

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Facility Level Cascades at a New York FQHC

Rebecca Green, LMSW, Regional Director of HIV Programs, Institute for Family Health

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

1. Learn methods to create facility-level HIV care cascades and understand components of effective, interdisciplinary interventions to support viral load suppression among patients at an FQHC.
2. Understand the benefits, challenges, and solutions to barriers to FQHC/hospital partnerships and describe language and key elements for a subcontracting Memorandum of Understanding.
3. Describe the different approaches to overcoming the barriers to care of insured versus uninsured RWHAP clients.

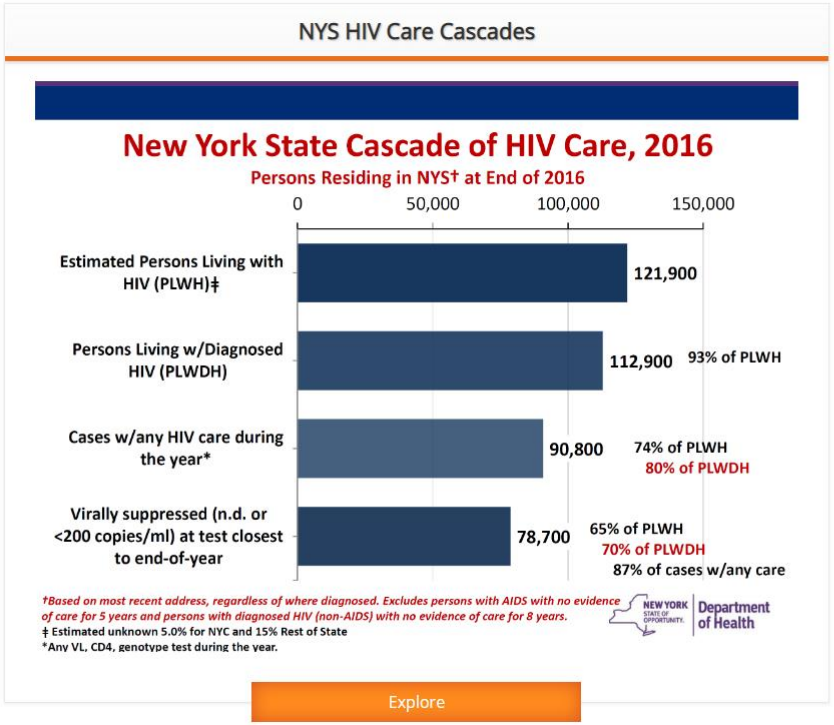
The Institute for Family Health

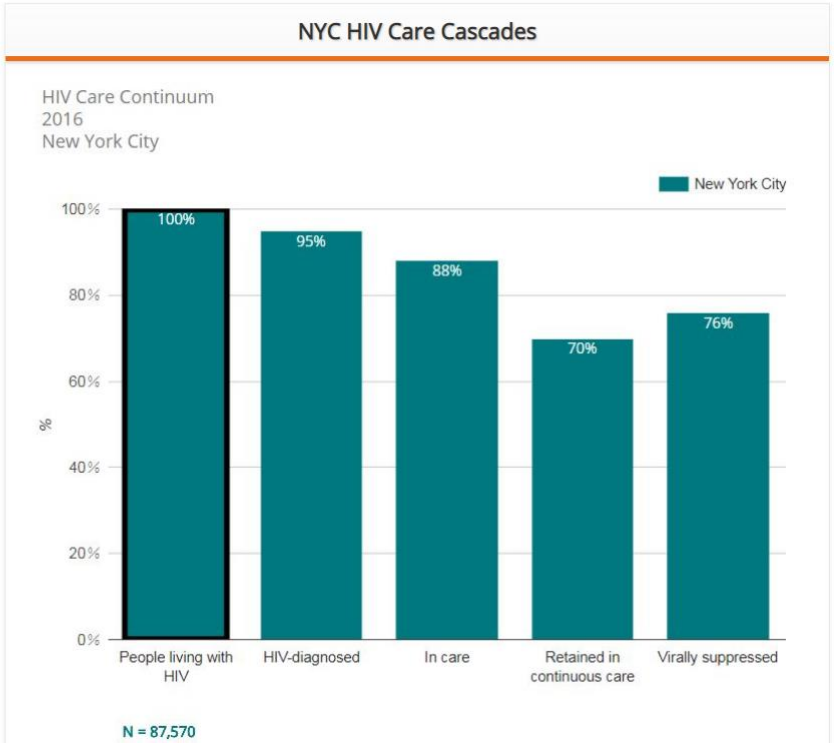
- Federally Qualified Health Center in New York City and the Mid-Hudson region
- Serving over 100,000 patients annually
- Joint Commission accredited, Level 3 Patient Centered Medical Home
- Primary care, mental health, dental care, case/care management, community programs and more
- HIV specific services at 3 locations: Family Health Center of Harlem, Urban Horizons (Bronx), Sidney Hillman/Phillips Clinic (Union Square)
- Ryan White Part A, B and C funding
- Serve approximately 1000 patients with HIV/AIDS annually

HIV Services = COMPASS

- **Integrated, transdisciplinary care teams**
  - **Medical:** MDs, NPs, PAs (all family or internal medicine)
  - **Nursing:** nurse care manager
  - **Psychosocial:** Social workers, peer educators, care/case managers, patient navigators, care coordinators, mental health clinicians
- **Wide range of services available to patients based on acuity of need**
  - Directly Observed Therapy (clinic or home based)
  - Home/field based services (case management, health education, accompaniments)
  - Treatment adherence and safer sex counseling
  - Peer support services
  - Mental health services
  - PrEP and PEP

HIV Care Cascades





http://etedashboardny.org/

Why Facility Level HIV Care Cascades?

- Helpful tool to conceptualize progress towards HIV care goals
  - Visual, infographic
- Forces agencies to interact with/assess data, reporting and QM capacity
- Produces actionable areas for quality improvement focus
- Can be used to create buy-in for multiple stakeholders (patients, psychosocial staff, medical providers, leadership)

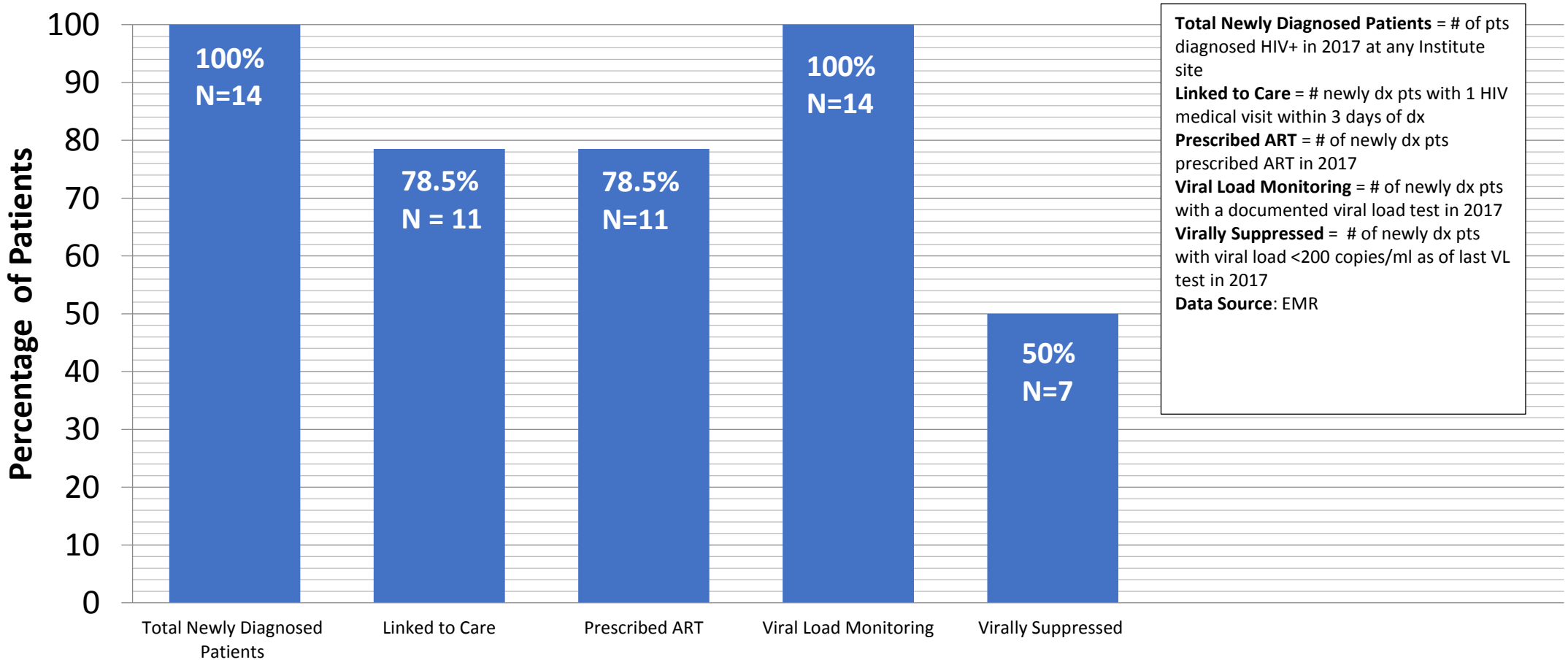
How Facility Level HIV Care Cascades?

- Start small – one clinic, one program, one provider's panel
- Assess resources before starting
  - Data source
  - Staff expertise
  - Existing QM/QI structure
- Creating the cascade is just the beginning – consider from early on how you will use the cascade

Creating a Meaningful Facility Level Cascade: Methodology

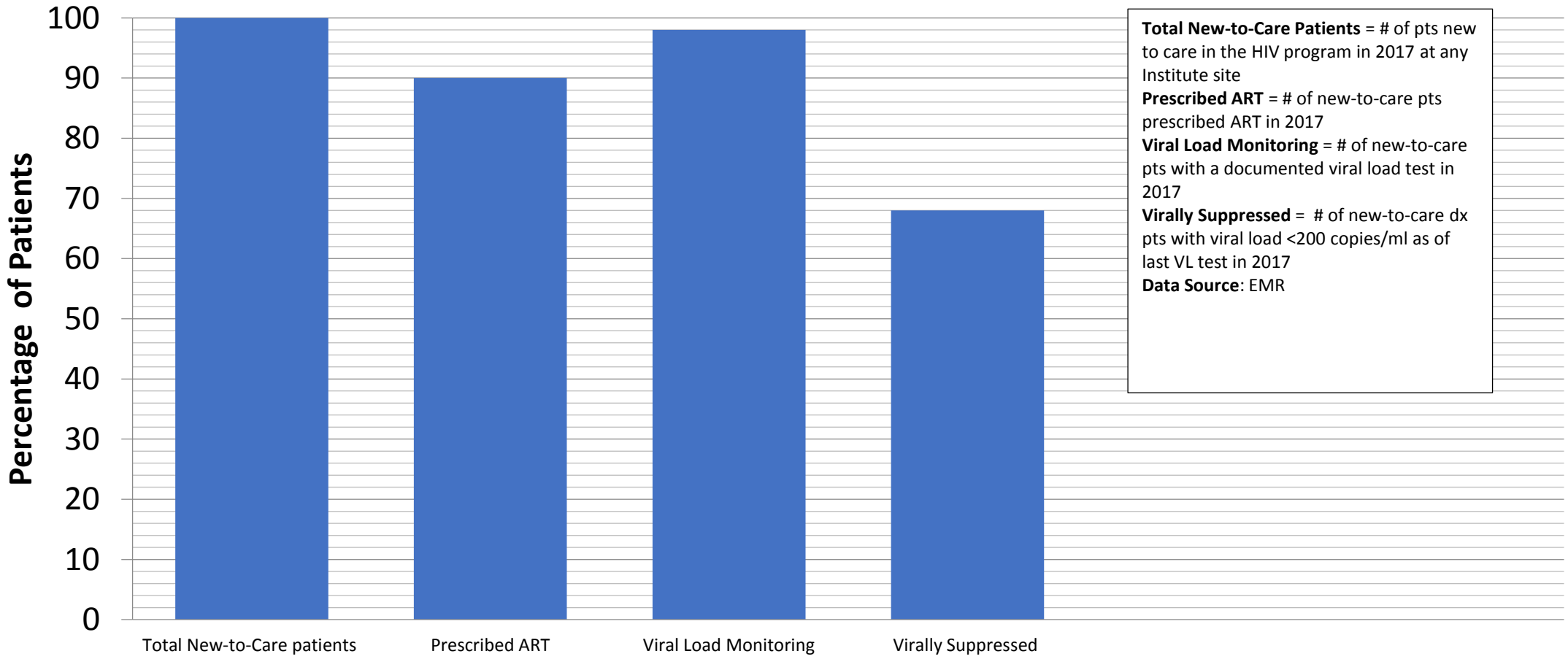
- **Data source: Electronic Medical Record, EPIC**
  - HIV Registry
  - Other Reporting (all new HIV dx; visit codes; when dx are added to the problem list, etc)
  - Chart Reviews
  - Limitations: only data in structured fields can be pulled via reporting; differences in documentation across providers/clinics; differences in workflows across providers/clinics
- **Staff**
  - Extraction vs. Analysis vs. Presentation of Data
- **Defining your universe (denominator)**
  - Newly diagnosed
  - New to care
  - Active vs Open

2017 IFH Facility Level Cascade: Newly Diagnosed



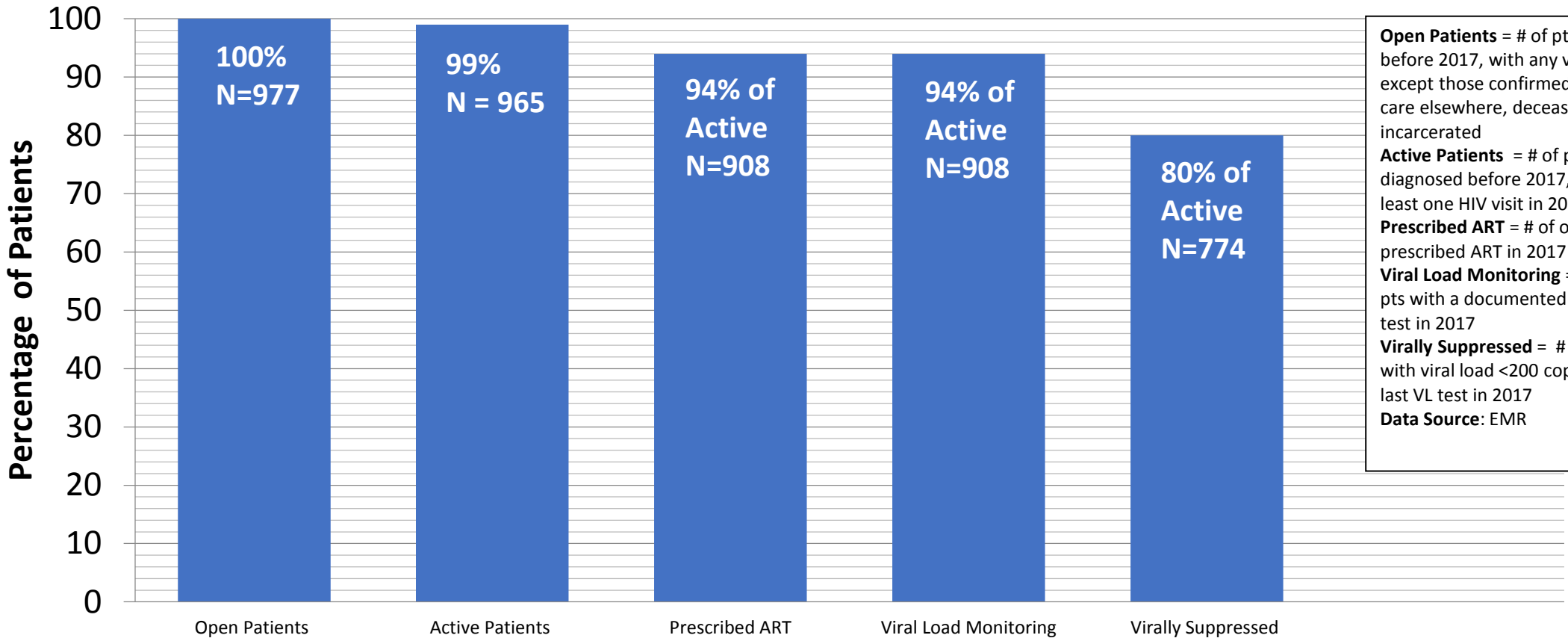
Total Newly Diagnosed Patients = # of pts diagnosed HIV+ in 2017 at any Institute site
Linked to Care = # newly dx pts with 1 HIV medical visit within 3 days of dx
Prescribed ART = # of newly dx pts prescribed ART in 2017
Viral Load Monitoring = # of newly dx pts with a documented viral load test in 2017
Virally Suppressed = # of newly dx pts with viral load <200 copies/ml as of last VL test in 2017
Data Source: EMR

2017 IFH Facility Level Cascade: New-to-Care



Total New-to-Care Patients = # of pts new to care in the HIV program in 2017 at any Institute site
Prescribed ART = # of new-to-care pts prescribed ART in 2017
Viral Load Monitoring = # of new-to-care pts with a documented viral load test in 2017
Virally Suppressed = # of new-to-care dx pts with viral load <200 copies/ml as of last VL test in 2017
Data Source: EMR

2017 IFH Facility Level Cascade: Previously Diagnosed



Open Patients = # of pts diagnosed before 2017, with any visit in 2017, except those confirmed to be in care elsewhere, deceased or incarcerated
Active Patients = # of pts diagnosed before 2017, with at least one HIV visit in 2017
Prescribed ART = # of open pts prescribed ART in 2017
Viral Load Monitoring = # of open pts with a documented viral load test in 2017
Virally Suppressed = # of open pts with viral load <200 copies/ml as of last VL test in 2017
Data Source: EMR

2017 IFH Facility Level Cascade Summary

Total number of patients with HIV/AIDS seen at any Institute site in 2017 for any reason = **1211**

Total number of patients with HIV/AIDS engaged in HIV primary care, at any Institute site = **965**

Patients new to the Institute in 2017 (newly diagnosed and new to care) = **140**

Overall viral load suppression rate = **80%**

2017 Cascade Results and Analysis

Meaningful gaps and discussion of results:

- ART prescription and viral load suppression among the cohort of newly diagnosed patients continues to remain an area of focus.
- Viral load suppression rates vary among age groups, with patients ages 60+ having the highest viral load suppression rates (86%) and those ages 30-39 having the lowest rate (73%)
- Transgender patients had the lowest viral load suppression rates across gender
- Across race, Black patients are the largest racial group served but have a slightly lower viral load suppression rate than Latino/as or non-Hispanic whites, the second and third largest racial groups served, respectively.
- Patients unstably housed had a significantly lower viral load suppression rate (59%) than stably housed patients (82%)

2017 Cascade Results and Analysis

Comparison of 2016 and 2017 treatment cascades:

- We had far fewer open non-active patients in 2017 compared to 2016, indicating efforts made to train providers to better document external care were successful.
- The cohort of newly diagnosed (internally or externally) patients continues to remain an area of focus, as we have the poorest viral load suppression rates among this group, largely due to disengagement in care and lack of confirmation of engagement with care elsewhere.
- Rates of viral load monitoring and ART initiation remain high.
- Viral load suppression rates generally increased across most clinics, with the exception of the Family Health Center of Harlem (decreased by 6%) and Urban Horizons (decreased by 1%). Further analysis is needed to explore the drop at the Family Health Center of Harlem.

Using the Cascades to Improve Care

- **Share the results widely**
  - Patients
  - Agency Leadership
  - Medical Providers
  - Psychosocial staff
  - Quality Improvement/Assurance Staff
- **Drill down the data**
  - Look at outcomes across race, gender, age, housing status, substance use history, etc
  - Look at unsuppressed cohorts – lessons to learn?
  - Look at suppressed cohorts – lessons to learn?
- **Develop CQI projects and/or program changes to target the gaps identified**

Patient input

Sharing results with Consumer Advisory Board (CAB)

Getting feedback on proposed CQI projects from CAB members

Creating interventions in partnership with patients:

- DOT flyer
- Motivational Interviewing handout

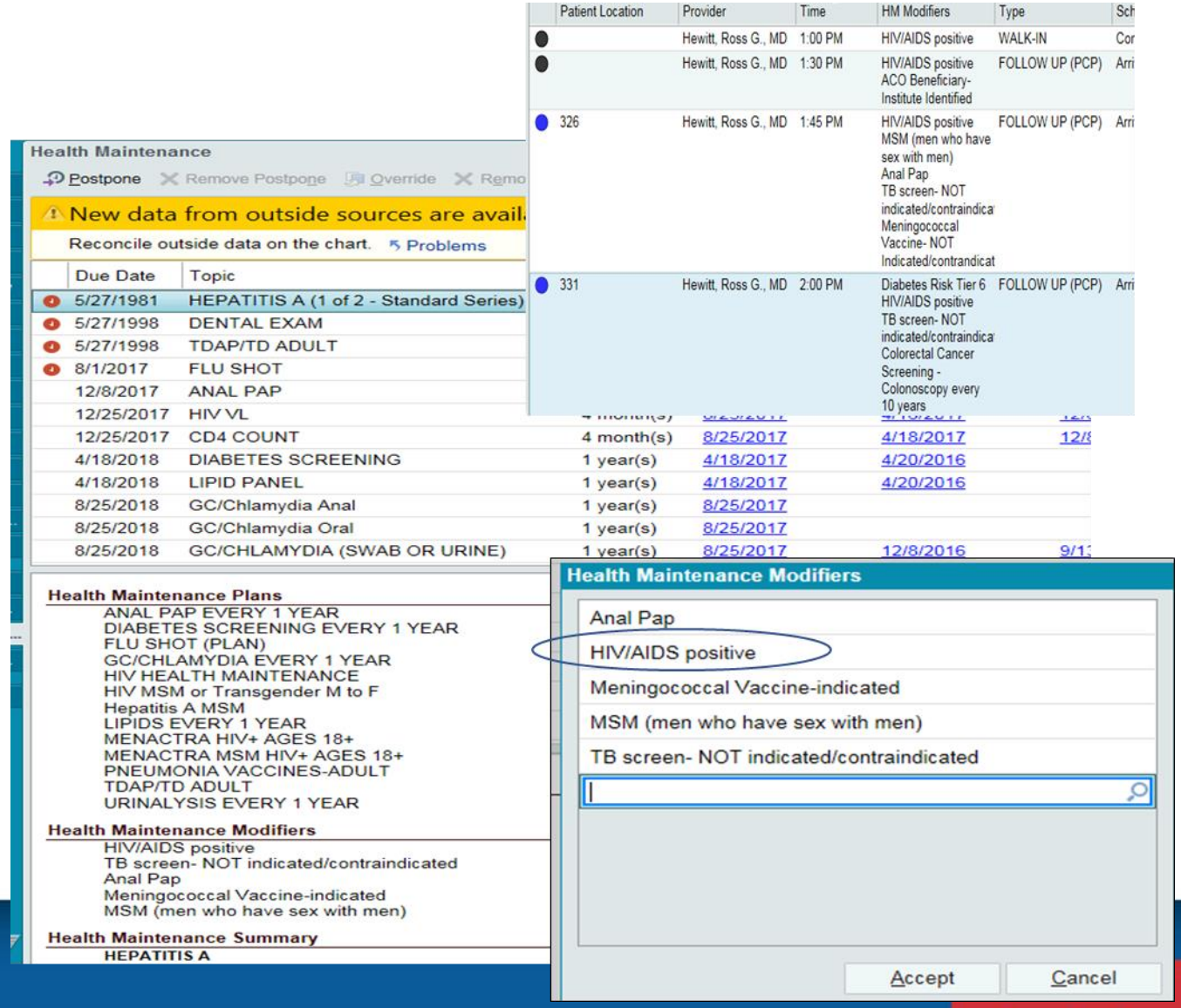
Creating staff buy in

“Hearing about the improvement of our patient's health after implementing the new QI intervention was nice to hear! It definitely helps motivate me to continue working on the QI protocol. It's always a benefit to learn about the improvement that may be an indication of the efforts that were made to help our clients.” (Social Worker)

“First and foremost, anytime the patient's viral load improved or became suppressed was tremendously encouraging to me as being able to be part in improving their health, with support and inspiration. It was motivating because my effort did pay off in better health for the patients.” (Case Manager)

Interventions: Strategic Use of our EMR

- In EPIC all positive patients have the “HIV/AIDS positive” health maintenance (HM) modifier
- HM modifiers guide medical best practice
- Allows EPIC to identify positive patients throughout our system



Gap: Linkage to Care

Interventions to address linkage to care:

- Joint post-test counseling for newly diagnosed HIV+ patients
- Close follow-up
- Linkage to Peer staff
- Track new diagnoses by report weekly
- Assertive outreach

Gap: Retention in Care

Interventions to address retention in care:

- Build relationships
- Appointment reminders and outreach following every missed appointment
- Pre-triaging patient appointments day before
- Day-of huddle
- Joint visits
- Creative outreach cards

Gap: Viral Load Suppression

Interventions to address viral load suppression:

- Monthly Case conferences
- 200 below – Incentive program
- Rapid iART
- DOT

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Is It Really Worth It? FQHC/Hospital Partnership

Sarah DeChamplain, MSW – Hamilton Health Center

Rebecca Geiser, MPA – UPMC Pinnacle

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3. Participants will describe the different approaches to overcoming the barriers to care of insured versus uninsured RWHAP clients.

Hamilton Health Center - HOPE

- FQHC founded in 1969
- Located in the “Allison Hill” neighborhood of Harrisburg
- Patient Centered Medical Home providing comprehensive medical, dental, vision, and social services to the children and adults in the city of Harrisburg and across South Central Pennsylvania.
- Began providing comprehensive Ryan White funded HIV services in 2001. HOPE provides HIV primary care, case management, outreach, education and HIV testing.

UPMC Pinnacle REACCH Program

- Part of UPMC Pinnacle, the leading hospital and healthcare system in Central Pennsylvania
- Located in midtown Harrisburg
- Founded in 2000 to provide HIV care to pregnant women
- Provides comprehensive care and treatment including specialty HIV care and embedded primary care, case management, support services, and HIV testing

Program Challenges

FQHC Challenges

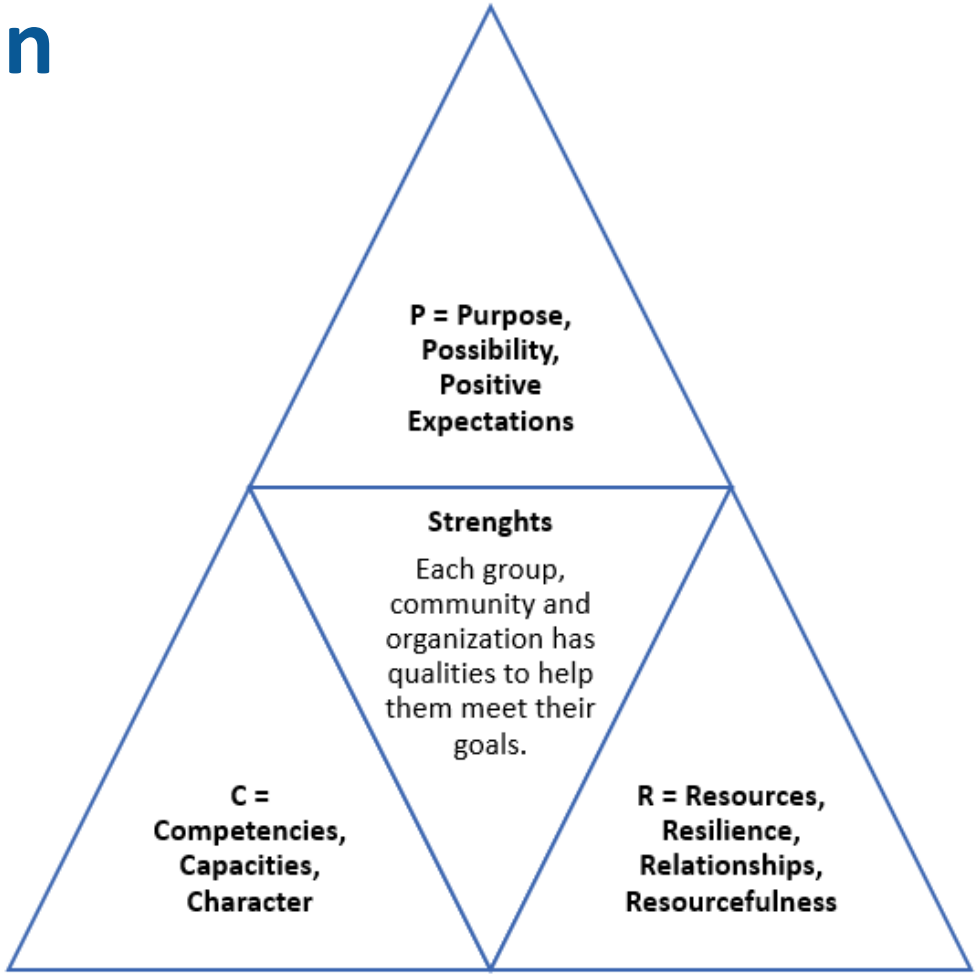
- In 2016 Senior Leadership at HHC considered pulling-out of Part C funding
  - Concerns over 340B Program Income
  - Administrative Burden and lack of Administrative Capacity
  - Integration of the Ryan White Program into Adult Medicine
- Continuing Viability of the HIV program without Ryan White support

Hospital System Challenges

- Compliance with 340 B Program Income Requirements
- Limited engagement with the greater Harrisburg Community

Using a Strengths Based Perspective for Organizational Collaboration

- Approach taken from direct service social work practice.
- Instead of focusing on problems and deficits, the strengths perspective centers on abilities, talents, and resources of the individual or organization.



Adapted from Saleebey, D (Ed.). (2006). The Strengths Perspective in Social Work Practice (4th ed.) Boston: Allyn & Bacon.

Organizational Strengths

Hamilton Health Center HOPE

- **C** = Diversity (Competency), Outreach Skill (Capacity), Trusted by the Community (Character)
- **P** = Dedication to providing highest quality care (Purpose), History of Collaboration (Positive Expectations)
- **R** = Strong relationships with community organizations (Relationships), Grass roots history (resilience and resourcefulness), high quality providers and support staff (Resources)

UPMC Pinnacle REACCH

- **C** = Administrative Expertise(Capacity), Well known and respected provider (Character)
- **P** = Dedication to providing highest quality care (Purpose), History of Collaboration (Positive Expectations)
- **R** = Part of a comprehensive health system (Relationships), High quality providers and staff (Resources), 340 B Income (Resources)

Getting to Yes by Fisher, Ury and Patton

1. Separate the people from the problem

"A working relationship where trust, understanding, respect, and friendship are built over time can make each new negotiation smoother and more efficient."

"Failing to deal with others sensitively as human beings prone to human reactions can be disastrous for negotiation. Whatever else you are doing at any point during a negotiation…it is worth asking yourself, 'Am I paying enough attention to the people problem?'"

Fisher, R., Ury, W., & Patton, B. (2011). *Getting to yes.* New York, NY: Penguin Books.

2. Focus on Interests, not positions

"The basic problem in a negotiation lies not in conflicting positions, but in the conflict between each side's needs, desires, concerns, and fears… Such desires and concerns are interests. Interests motivate people; they are the silent movers behind the hubbub of positions."

"Behind opposed positions lie shared and compatible interests, as well as conflicting ones."

Interests

Hamilton Health Center

- Maintain organizational independence and integrity of current model
- Get timely payment
- Longevity of partnership
- Accepting quality processes in an FQHC

UPMC Pinnacle

- Maintain overall performance measure quality
- Getting timely reports
- Ensuring administrative capacity in both organizations

Collaboration Philosophy

- Retain patient choice and unique strengths of each program
- Unified quality management plan and established HAB performance measure goals
- Centralized grant administration and reporting to HRSA
- Unified patient communication about the transition and collaboration

3. Invent Options for Mutual Gain

"A creative option…can often make the difference between deadlock and agreement. One lawyer we know attributes his success directly to his ability to invent solutions advantageous to both his client and the other side." p. 58

"You should consider the desirability of arranging an inventing or brainstorming session…In a brainstorming session, people need not fear looking foolish since wild ideas are explicitly encouraged."

Key elements of an MOU

- Timeframe: 5 Years
- Solid definition of roles
- Clear reporting formats and timelines
- Clear payment processes and timelines

Collaboration Roles

Hamilton Health Center

- Ongoing excellent care and services to HIV+ patients
- Participate in monthly meetings
- Provide monthly and quarterly reports
- Participate in join CQM meetings
- Actively conduct PDSA cycles

UPMC Pinnacle

- Provide oversight to all HRSA policies and guide programs to meet requirements
- Provide oversight to CQM process
- Serve as the Project Director
- Lead collaborative grant-writing process
- Include Hamilton staff in all HRSA meetings, including conference

How's it going now?

- Quality Management Framework
- Collaboration and monitoring model

- Expanding the scope of relationship
  - Testing
  - Prison outreach
  - Part B
  - Collaborative grant projects

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Ryan White/HIV Program (RWHAP) Outcomes Study

Michael Costa, MPH

Principal Associate

Abt Associates

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Study Goals

- Examine the effect of enrollment in new health care coverage options on clients related to their health outcomes, as well as to examine any remaining gaps in health care, and issues related to utilizing health care services.

- Understand how RWHAP provider sites meet the needs of clients under the variety of health care coverage options clients are encountering with the new health care coverage options throughout the country.

Impact of Changes in Health Care Coverage Options on RWHAP Clients and Providers

Mixed Methods Study Design

Data Collection Activities

- Chart/records abstraction
- Data extraction from RSR
- *Site surveys (~200 respondents)*
- *Provider interviews (23 sites)*
- Client focus groups (4 groups)

Survey Results

Tables contain counts (number of providers), percentages (proportion of providers who selected a certain response, or percent change) and/or averages (responses scored on a -2 to +2 scale)

N values are calculated at the question level, meaning respondents that skipped questions are dropped only from the question(s) skipped

All slides use the same key to denote statistical significance:

‡ Statistically significant difference, pre 2014 vs post 2014
† Statistically significant difference, Medicaid vs marketplace
* Statistically significant difference, expansion vs non-expansion

Responses on Overall Impact of New Coverage on Health Outcomes for RWHAP Clients

Impact of New Care Coverage on	Medicaid Expansion	Marketplace Insurance		
	Expansion State	All	Expansion State	Non-Expansion State
	N = 116	N = 185	N = 115	N = 70
HIV-Related Health Outcomes	1.22	0.91	0.93	0.89
-2 - Very Negative	0%	0%	0%	3%
-1 - Negative	2%	5%	4%	7%
0 - Neutral	15%	17%	21%	11%
+1 - Positive	44%	54%	52%	56%
+2 - Very Positive	40%	23%	23%	23%
Other Primary Care Outcomes	1.21	0.92	0.91	0.94
-2 - Very Negative	0%	0%	0%	0%
-1 - Negative	1%	6%	5%	7%
0 - Neutral	14%	16%	21%	9%
+1 - Positive	48%	52%	50%	56%
+2 - Very Positive	36%	24%	23%	26%

Impact of Insurance-related Factors: Categories

Access to	Lack of	Overall
HIV Services	Providers Accepting Insurance	Management of Comorbidities
HIV Medications	HIV Experienced Providers	Gaps in Care
Other Care	Primary Care Physicians	Cost Sharing
Non-HIV Medications		Prior Authorizations
SUD Services		Insurer Administrative Reqs
Mental Health Services		Enrollment Challenges

Positive Impact of Insurance-related Factors (-2, +2)

Factor	Medicaid Expansion		Marketplace Insurance		
	Expansion State	Non-Expansion State	All	Expansion State	Non-Expansion State
	N = 110	N = 50	N = 167	N =102	N = 65
Access to:					
HIV Services	1.11†	-	0.83	0.84	0.81
HIV Medications	1.04†	-	0.76	0.78	0.73
Other Care	1.15†	-	0.92	0.87	0.98
Non-HIV Medications	1.12†	-	0.93	0.87	1.02
Management of Comorbidities	0.96	-	0.81	0.79	0.84

† Statistically significant difference, Medicaid vs marketplace

Negative Impact of Insurance-related Factors (-2, +2)

Factor	Medicaid Expansion		Marketplace Insurance		
	Expansion State	Non-Expansion State	All	Expansion State	Non-Expansion State
	N = 110	N = 50	N = 167	N =102	N = 65
Prior Authorizations	-0.28	-	-0.29	-0.37	-0.17
Insurer Administrative Reqs	-0.37	-	-0.37	-0.40	-0.32
Enrollment Challenges	-0.12	-	-0.41	-0.39	-0.43
Lack of:					
Providers Accepting Insurance	-0.37†	-	-0.09	-0.01	-0.23*
HIV Experienced Providers	-0.14	-	-0.13	-0.04	-0.26
Primary Care Physicians	-0.08	-	-0.06	-0.01	-0.15

* Statistically significant difference, expansion vs non-expansion

† Statistically significant difference, Medicaid vs marketplace

Changes in Service Utilization: Core Medical

Core Medical Services	
Outpatient Ambulatory Medical Care	Local AIDS Pharmaceutical Assistance
AIDS Drug Assistance Program	Medical Case Management
Early Intervention Services (Parts A/B)	Medical Nutrition Therapy
HIP/Cost Sharing Assistance	Mental Health Services
Home and Community-based Serv.	Oral Health
Home Health Care	Substance Abuse Services
Hospice Services	

Percent Providing Often or Very Often

Service Category	Expansion State			Non-Expansion State	
	Pre	Post Medicaid	Post Market	Pre	Post Market
	N = 85	N = 96	N = 93	N = 48	N = 60
OAMC	86%	83%	76%	85%	88%
EIS	21%	30%	28%	13%	12%*
HIP	8%	16%	22%‡	23%	48%‡*
Local APA	16%	9%	10%	38%	27%‡*
Oral Health	41%	44%	39%	52%	58%*

‡ Statistically significant difference, pre 2014 vs post 2014

* Statistically significant difference, expansion vs non-expansion

Changes in Service Utilization: Support

Support Services	
Case Management	Medical Transportation Services
Child Care Services	Outreach Services
Pediatric Developmental Assess	Permanency Planning
Emergency Financial Assistance	Psychosocial Support
Food Bank/Home Delivered Meals	Referral for Health Care/Support Serv.
Health Education/Risk Reduction	Rehabilitation Services
Housing Services	Respite Care
Legal Services	Substance Abuse Services – Resident.
Linguistic Services	Treatment Adherence Counseling

Percent Providing Often or Very Often

Service Category	Expansion State			Non-Expansion State	
	Pre	Post Medicaid	Post Market	Pre	Post Market
	N = 68	N = 77	N = 75	N = 39	N = 52
Case Management	63%	56%‡	55%	90%	75%*
Referral for Health Care/Support Serv.	40%	39%	41%	44%	50%

‡ Statistically significant difference, pre 2014 vs post 2014

* Statistically significant difference, expansion vs non-expansion

Challenges Reported by Sites

Limited familiarity led to clients cycling in and out of coverage

Clients (and providers) were new to both Marketplace and Medicaid-expansion requirements

- Enrollment
- Service provision
- Maintaining coverage

Challenges of Marketplace plan requirements

- Retaining current providers (i.e., PCP designation)
- Retaining services
- Medications (i.e., non-generics)

Solutions/Adaptations Reported by Sites

To prevent churning sites adapted by:

- Adding dedicated insurance navigators
- Modifying case management role

Site employed several strategies to reducing negative effects “churning” for clients

- Alternate funding strategies
  - Health Insurance Premium/Cost Sharing Assistance
  - Using ADAP
  - Local Pharmacy Assistance Program

Obtaining CME/CE Credit

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http://ryanwhite.cds.pesgce.com