Approaches to practice transformation to improve outcomes along the HIV Care Continuum

Panel Session

Integrating Quality Improvement and Population Health Approaches into Panel-based Care through Practice Transformation: A SPNS Initiative

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Outline

- ❑ Practice Transformation Model at the Comprehensive Health Program
  - ❖ Needs Assessment and Planning the Practice Transformation
  - ❖ Implementation of Treatment Adherence Program through Primary Care Nursing
- ❑ Development of Health Information Technology (HIT) for Population Health Management and Quality Improvement
- ❑ Integrating Quality Improvement into Panel-Based Care

1) STaR's Practice Transformation: A SPNS Initiative

Comprehensive Health Program

- Academic medical center in Upper Manhattan, NY
- Provides outpatient & inpatient care to people living with or at-risk for HIV
- Over 2,200 outpatients with HIV and 20 bed inpatient unit
- Growing attention to at-risk population, PrEP, and STI services
- Approximately 100 staff operating in a variety of settings: inpatient, outpatient, community, and home visits
- Multidisciplinary clinical care
  - Providers, nurses, social workers, care coordinators, nutritionist, psychiatrists, patient navigators, medical and nursing assistants

SPNS Workforce Initiative

- **Project Title: Stimulating Transformation of Technology and Team Structure to Reach People Living with HIV**
  - 4-Year SPNS Grant
  - Funded to design, implement, evaluate, and disseminate the intervention
- **Multi-site: 15 demonstration sites across the country**
- **"Practice Transformation Models" or PTMs**
  - System level staffing changes
  - Heavily based on Patient Centered Medical Home (PCMH)
  - Improves capacity to care for people living with HIV, valuing efficiency and sustainability
  - Optimizes resources in changing landscape
  - Improves linkage, engagement, retention in care, and suppression rates
- **Cross-site Evaluation**
  - UCSF's Evaluation and Technical Assistance Center (ETAC)

Demonstration Sites

- **New York and Presbyterian Hospital, New York, NY**
- Bright Point, Bronx, NY
- New York City Department of Health and Mental Hygiene, Rikers Island, NY
- UPMC Presbyterian Shadyside, Pittsburgh, PA
- La Clínica del Pueblo, Washington, DC
- Florida Department of Health, Kissimmee, FL
- FoundCare Inc., West Palm Beach, FL
- University of Miami, Coral Gables, FL
- The MetroHealth System, Cleveland, OH
- Access Community Health Network, Chicago, IL
- Hektoen Institute for Medical Research (Core Center), Chicago, IL
- Coastal Bend Wellness Foundation, Inc., Corpus Christi, TX
- Special Health Resources for Texas, Inc., Longview, TX
- Family Health Centers of San Diego, Inc., San Diego, CA
- Centro de Salud de la Comunidad de San Ysidro, Inc., San Diego, CA

Stimulating Transformation: Needs Assessment

Care coordination

- ❑ Inefficiencies in identifying who to follow-up
- ❑ Separate programs for adherence, care coordination, nursing care, medical care

Communication

- ❑ Complex communication patterns
- ❑ Multiple staff members in *various settings* with variable communication
- ❑ Untapped opportunities for efficiencies through HIT

Accessibility

- ❑ Many providers are not on-site full time (fellows, researchers, etc.)

Stimulating Transformation: Needs Assessment

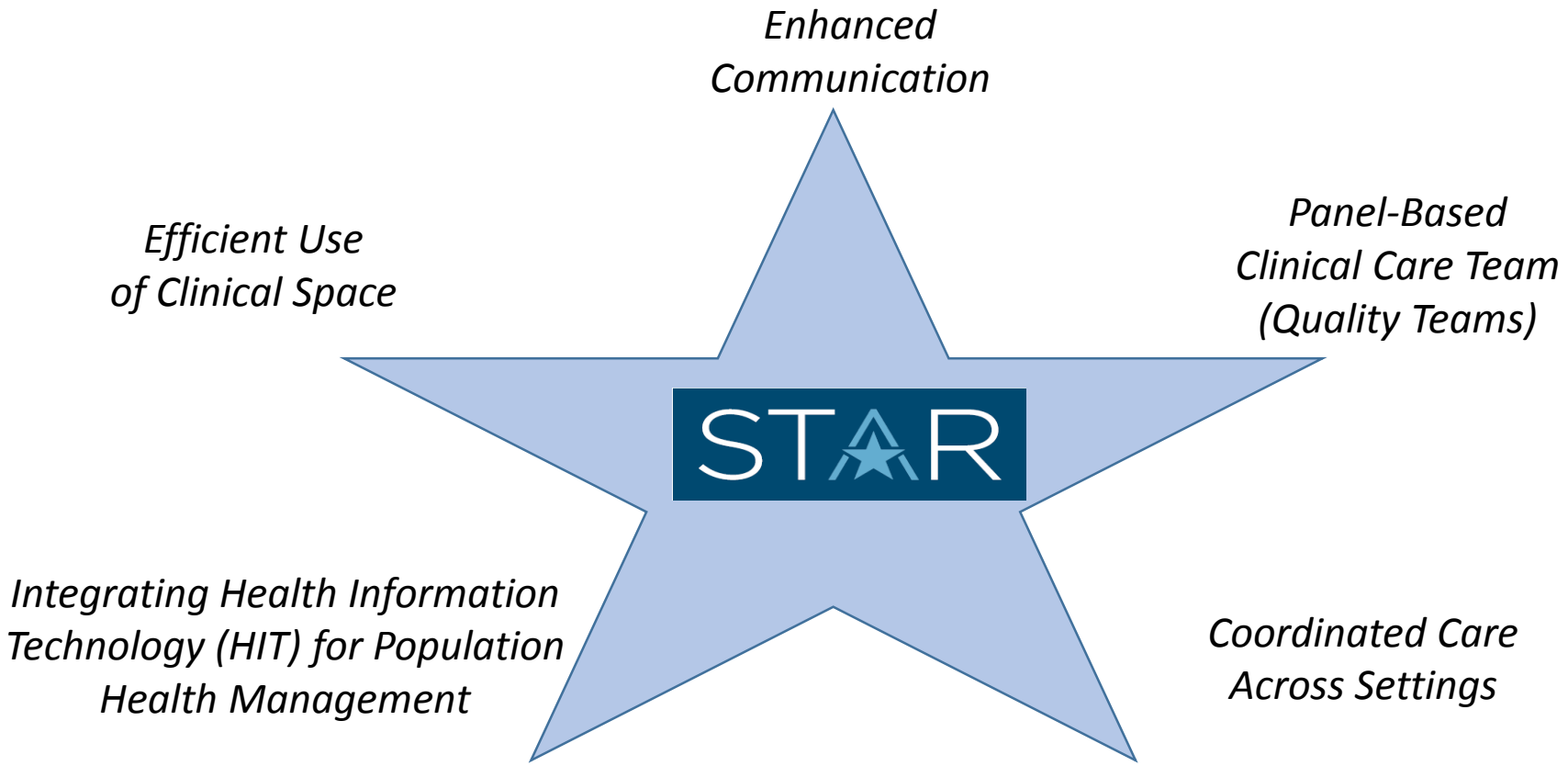
Staff working at the top of their license

- Opportunities with experienced nursing team:
  - Primary Care Nursing

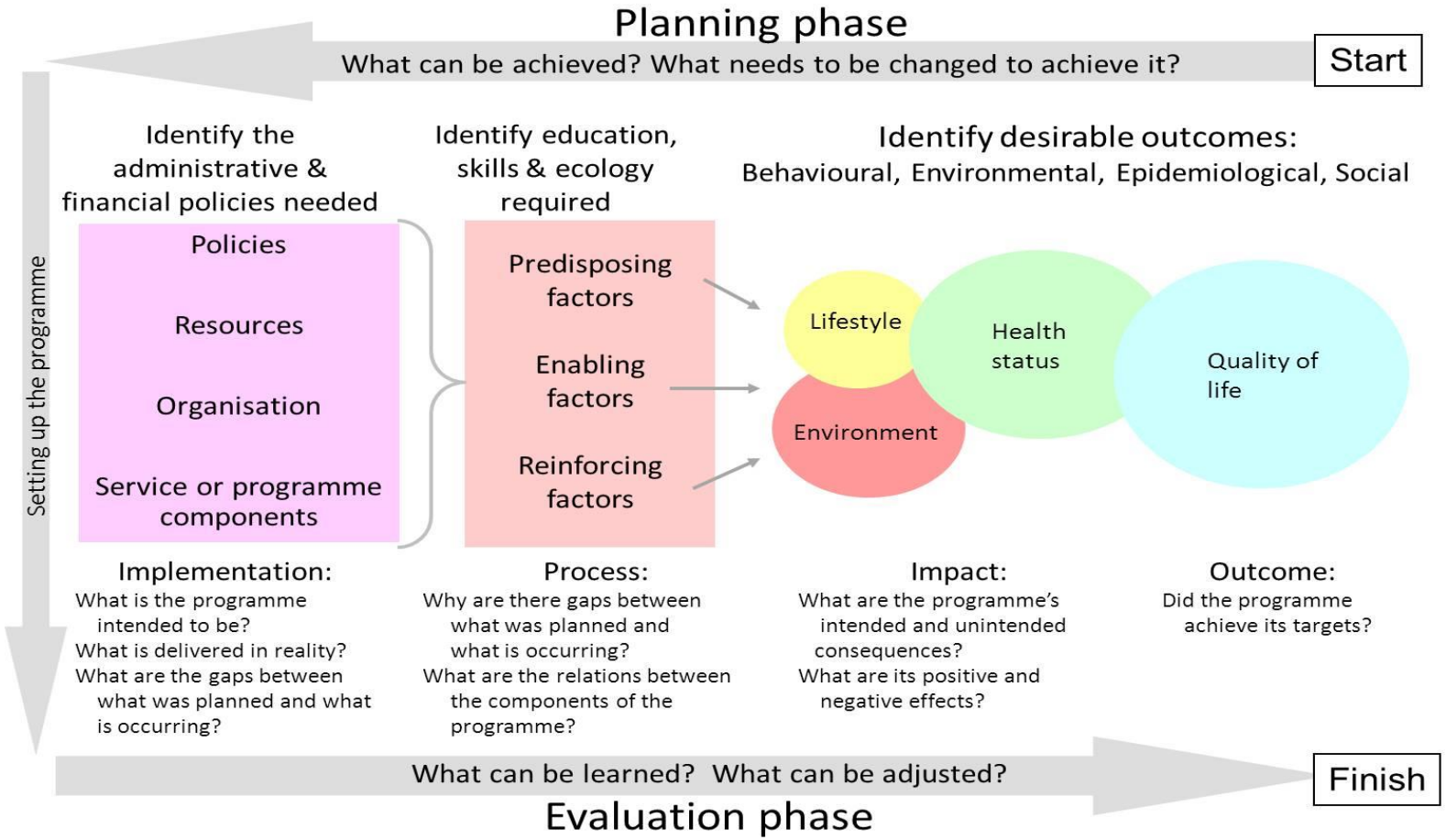
No-shows and walk-ins

- High no-show rates resulting in lost capacity
- Need for strengthening patient access to same-day walk-in care

STaR Practice Transformation Model: Providing More Care Through Harmonious Redesign *(without sacrificing quality)*

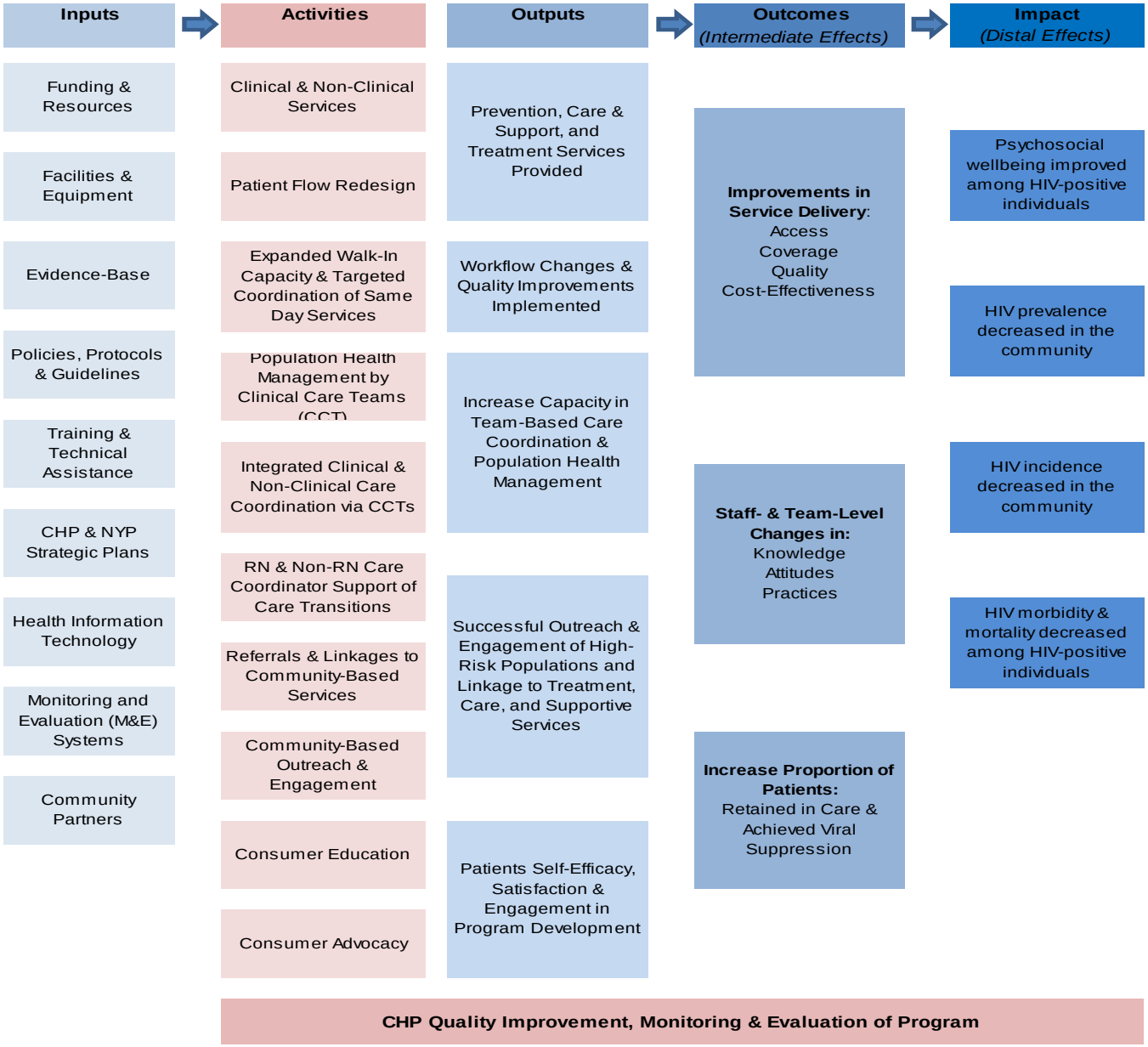


Planning the Practice Transformation: PRECEDE PROCEDE Framework



Adapted from: Green L. http://www.lgreen.net/precede.htm (Accessed May, 2009)

CHP Program Impact Pathway (Logic Model)



PCMH 2014
(6 standards/27 elements/100 points)

1) Patient-Centered Access (10)
- A) *Patient-Centered Appointment Access
- B) 24/7 Access to Clinical Advice
- C) Electronic Access

2) Team-Based Care (12)
- A) Continuity
- B) Medical Home Responsibilities
- C) Culturally and Linguistically Appropriate Services
- D) *The Practice Team

3) Population Health Management (20)
- A) Patient Information
- B) Clinical Data
- C) Comprehensive Health Assessment
- D) *Use Data for Population Management
- E) Implement Evidence-Based Decision Support

* Must-pass

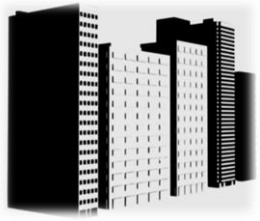
4) Care Management and Support (20)
- A) Identify Patients for Care Management
- B) *Care Planning and Self-Care Support
- C) Medication Management
- D) Use Electronic Prescribing
- E) Support Self-Care & Shared Decision Making

5) Care Coordination and Care Transitions (18)
- A) Test Tracking and Follow-Up
- B) *Referral Tracking and Follow-Up
- C) Coordinate Care Transitions

6) Performance Measurement and Quality Improvement (20)
- A) Measure Clinical Quality Performance Measure Resource Use and Care Coordination
- A) Measure Patient/Family Experience
- B) *Implement Continuous Quality Improvement
- C) Demonstrate Continuous Quality Improvement
- D) Report Performance
- E) Use Certified EHR Technology

NCQA Measuring quality. Improving health care.

Panel-Based Clinical Care Teams & Coordinated Care Across Settings



STaR Clinical Care Coordinator at the Comprehensive Health Program

CCT A	CCT B	CCT C	CCT D
Social Worker(s)	Social Worker	Social Worker	Social Worker(s)
Registered Nurse	Registered Nurse	Registered Nurse	Registered Nurse
Clinicians	Clinicians	Clinicians	Clinicians
Care Coordinators	Care Coordinators	Care Coordinators	Care Coordinators
Patient Navigators	Patient Navigators	Patient Navigators	Patient Navigators

Adherence Supervisor, Case Managers, Community Health Workers, Peer Educators, Nutritionist, Psychiatrists, Patient Financial Advisors, & Other Staff

STaR Clinical Care Coordinator:

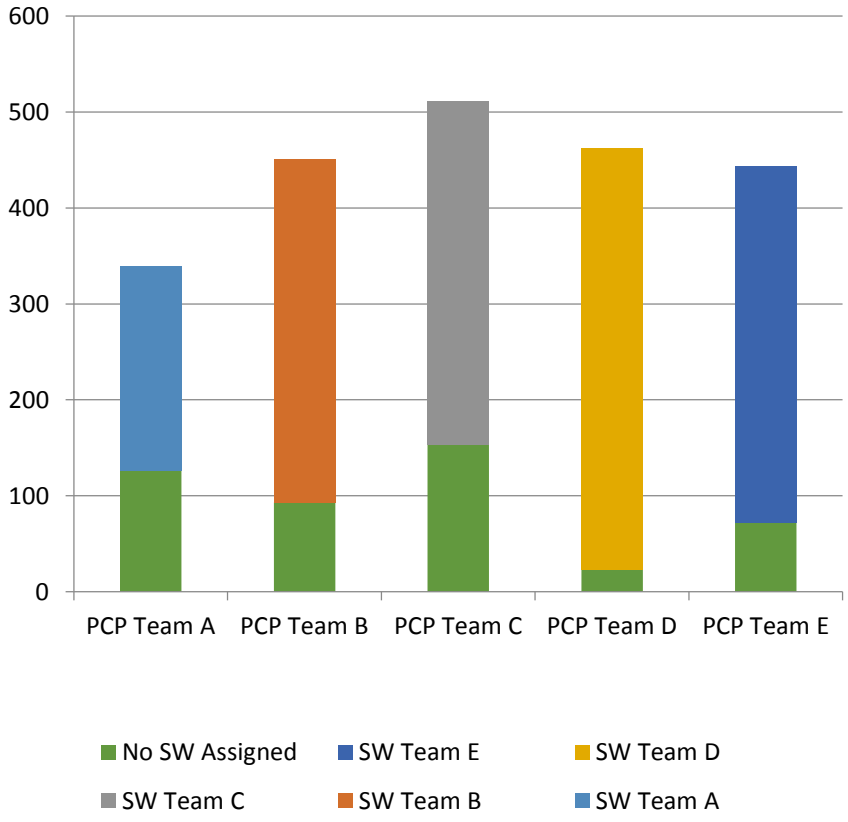
- Dedicated to supporting the care team structure
- Provide clinical support to
  - Care Coordinators
  - Patient Navigators
  - Community Health Workers

Care Enhancements:

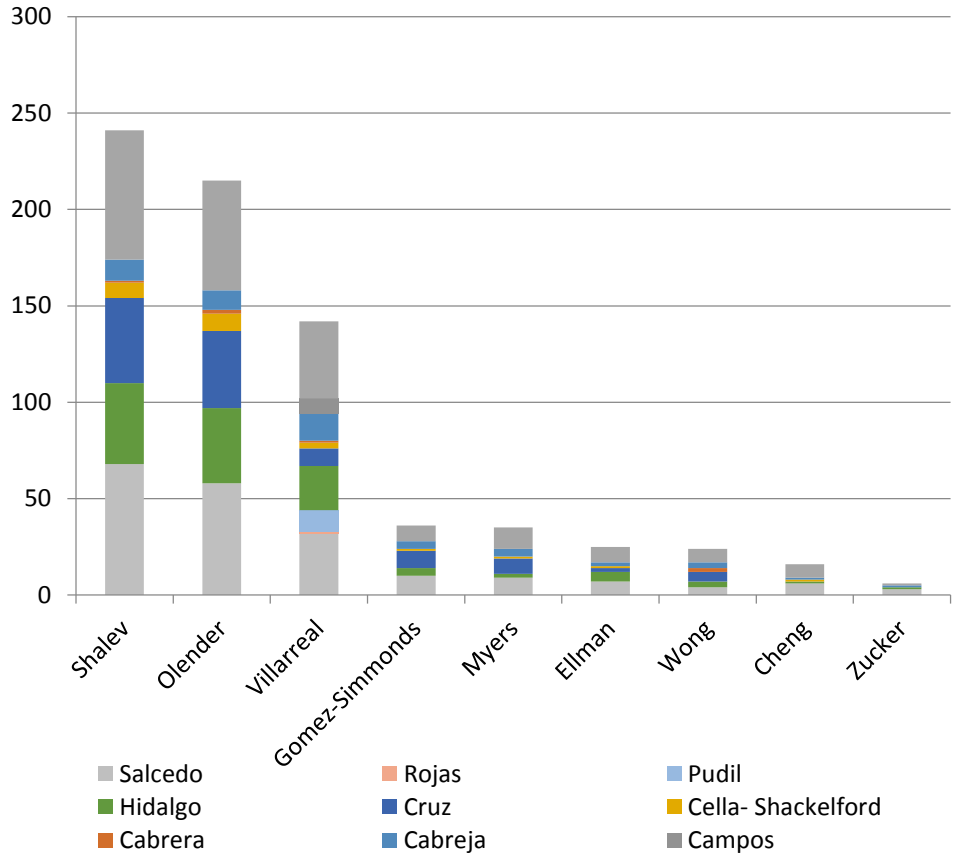
- Better communication
- Social Worker co-lead Clinical Care Teams
- Medication adherence through Primary Care RN

Building the Clinical Care Teams

Provider (PCP)-Social Worker (SW) Team Alignment



Social Worker Distribution by Team A Provider



Coordinating Weekly Care Team Meetings

- ❑ RN Care Coordinators send out daily email reminders
- ❑ Pre-meeting planning between RN Care Coordinators and Social Worker (Team Co-Captains)
- ❑ Theme-based discussion calendar
- ❑ Review of Dashboard indicators

DATES AND TIME	TOPIC	FACILITATOR(S)
11/30-12/3; 12/7-12/10	**Week 6 & 7 Team-Based Care**	
1 hour	*Subtopic: Care Planning for Patients with Complex Psycosocial Issues*	Social Workers
Mo 9-10 am (Team D) Tu 1-2 pm (Team A) We 1-2 pm (Team C) Th 1-2 pm (Team B)	*Objectives:* • Discuss progress in reducing number of patients with significant viremia and/or highly acute through supportive services	
12/14-12/17	**Week 8 Quality Improvement**	
1 hour	*Subtopic: Starting and Planning a PDSA Cycle*	Quality Manager
Mo 9-10 am (Team D) Tu 1-2 pm (Team A) We 1-2 pm (Team C) Th 1-2 pm (Team B)	*Objectives:* • Discuss ideas for a QI project using data from eHIVQUAL and other baseline assessments • Practive developing AIM statements • At the end of the session, the team would reach consensus on the topic for the team QI project • Learn about how population health reports and workflows can help teams identify need for quality improvement interventions	
12/21-12/31	**Week 9 & 10 CCT Meeting Break for Holidays**	
1/4-1/7; 1/11-1/14	**Week 11 & 12 Population Health**	
1 hour	*Subtopic: Active Chronic Hepatitis*	Providers
Mo 9-10 am (Team D) Tu 1-2 pm (Team A) We 1-2 pm (Team C) Th 1-2 pm (Team B)	*Objectives:* • Describe current plans for workflows and roles of CHP staff currently supporting partnerships with community-based organizations • Develop plans/strategies to increase treatment of those identified with untreated HepC infection	
1/18-1/21; 1/25-1/28	**Week 13 & 14 Team-Based Care**	
1 hour	*Subtopic: Care Planning for Patients with Mental Health Needs*	Social Workers
Mo 9-10 am (Team D) Tu 1-2 pm (Team A) We 1-2 pm (Team C) Th 1-2 pm (Team B)	*Objectives* • Enlist social work team to help identify clients who have mental health needs and should be discussed at the weekly care planning meetings • Conduct case conference around selected patients who have seen Psychiatrist in the past year to identify care coordination needs or other support	
3/7-3/10; 3/14-3/17	**Week 15 & 16 Population Health**	
1 hour	*Subtopic: Newly Enrolled Clients (HIV and Non-HIV)*	STaR CCC
Mo 9-10 am (Team D) Tu 1-2 pm (Team A) We 1-2 pm (Team C) Th 1-2 pm (Team B)	*Objectives:* • Utilize CCT dashboard to identify patients new to the clinic • Present cases to the Clinical Care Team and make recommendations around care coordination support and next steps • Orient team on process for starting CCT meetings with brief case presentation of any new patients to the team	

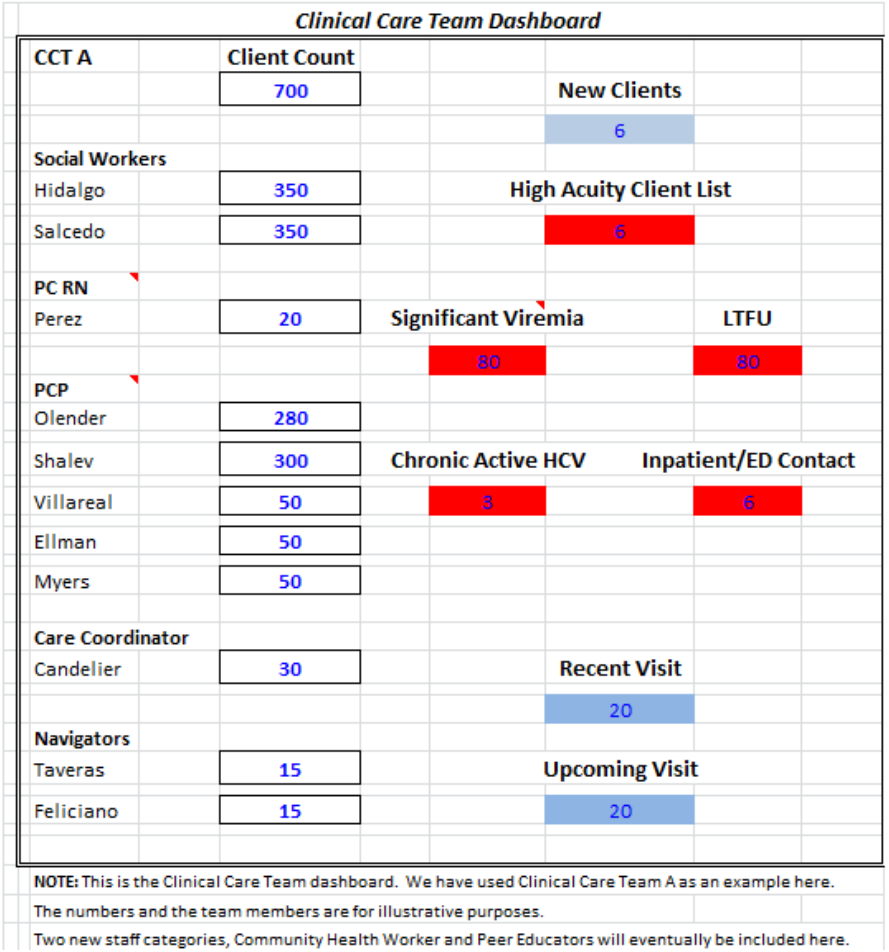
Patient Discussion Structure

Pre-Meeting Goals	Process	Comments
Team's Panel Management	• Nurse Care Coordinator(s) & CCT Social Worker review the patient lists available via the Dashboard or other Registries: o Recent ED/Hospitalization o Newly Enrolled in Care o High Risk o Significant Viremia o Active Chronic Hepatitis C (HCV) o Lost to Follow-Up (LTFU) o Primary Nursing/Treatment Adherence panel	Every week, we start the meeting by discussing: • ED/Hospitalized patients • Newly enrolled patients Depending on the team's goal for the meeting, a selection of these lists might be reviewed.
Meeting Goals	**Process**	**Comments**
Coordination of Patient Care	• Team prioritizes patients, discusses current care needs and/or challenges, brainstorms solutions, and coordinates patient care	All of the team members participate in the care planning discussion, and **action steps are documented in an interdisciplinary plan of care (IPOC) in Allscripts.**
Update Team on Patient's Care Plan Progress or Modifications	• Team members briefly share information on: o Care plan progress o Any changes in the ART regimen? If yes, why? o New care needs, barriers, and/or challenges that may need to be discussed as a Team ▪ What new appointments need to be scheduled?	**MCM selected for discussion from any of the lists should follow MCM Case Conference format (see below).**
MCM Case Conferencing	• Review patient's: o Most recent VL and CD4 lab results o # of hospitalizations since last conference o # of ED visits since last conference o # of missed PCP visits since last conference • Review patient's ART regimen and Adherence o Any changes in the ART regimen? If yes, why? o Missed doses? • Share information with Team about patient's progress in relation to Care Plan goals • Identify ongoing needs, barriers, and/or challenges that need to be discussed as a Team • Summarize patient's status in program o Stay in current track, change track, or graduate?	The MCM navigator will be responsible for presenting the case to the Team. The PCP is responsible for updating the Team on any changes in the ART regimen or care plan. Other team members will provide input on how to best address care needs, barriers, and/or challenges.
Follow-up on Action Items Identified in Prior Weeks	• If not discussed above, Team members share progress on action items from care planning discussions in prior weeks	Progress on action items will be recorded in a shared document (IPOC) in Allscripts.

2) HIT Development

Integration of Health Information Technology (HIT) for Population Health Management

- Updates to HIT to support team discussions (population health) and create efficiencies
- Collaboration with RDE Systems
- Dashboard design
- Adding additional key clinical indicators



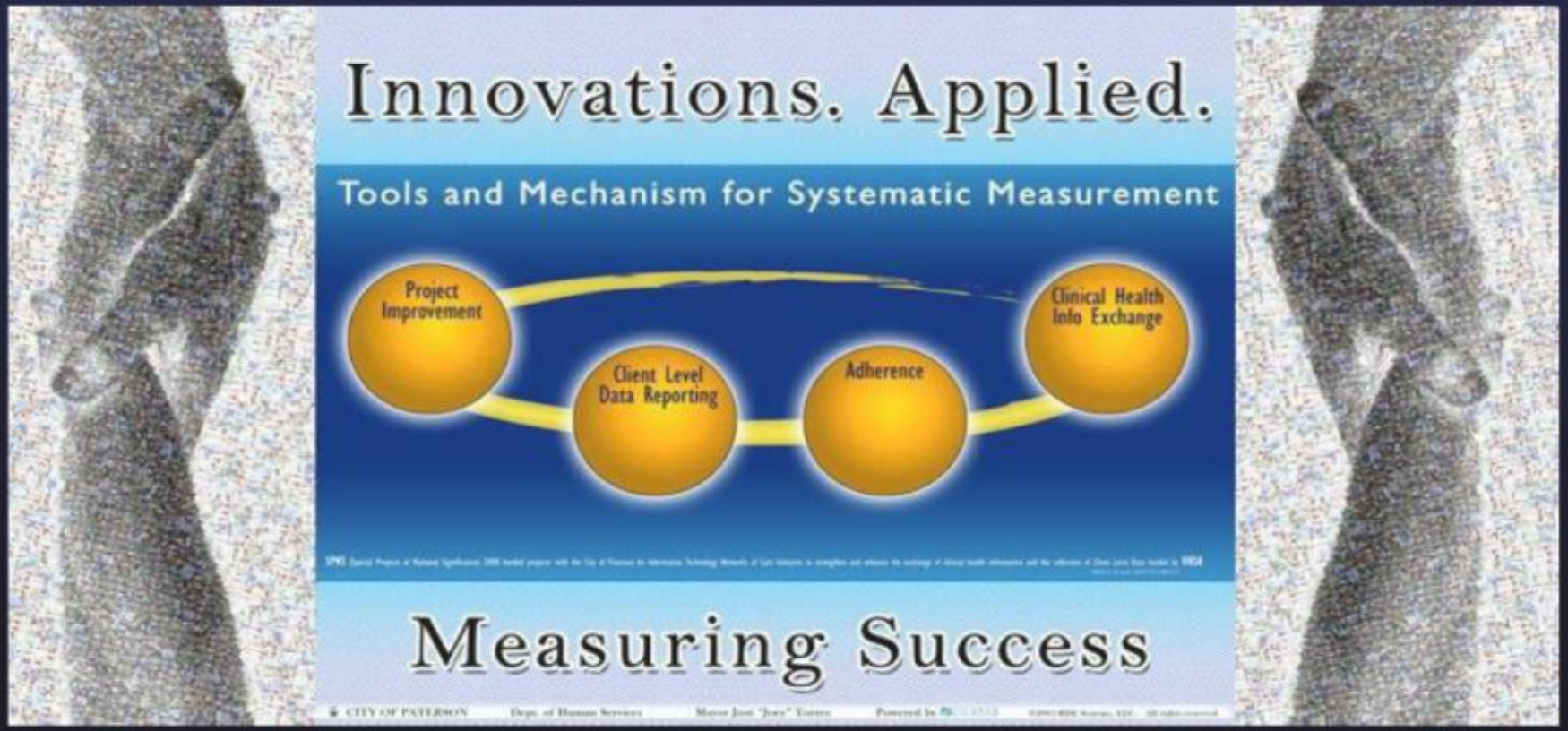
Clinical Care Team Dashboard

CCT A	Client Count		
	700	New Clients	
		6	
Social Workers			
Hidalgo	350	High Acuity Client List	
Salcedo	350	6	
PC RN			
Perez	20	Significant Viremia	LTFU
		80	80
PCP			
Olender	280		
Shalev	300	Chronic Active HCV	Inpatient/ED Contact
Villareal	50	8	6
Ellman	50		
Myers	50		
Care Coordinator			
Candelier	30	Recent Visit	
		20	
Navigators			
Taveras	15	Upcoming Visit	
Feliciano	15	20	

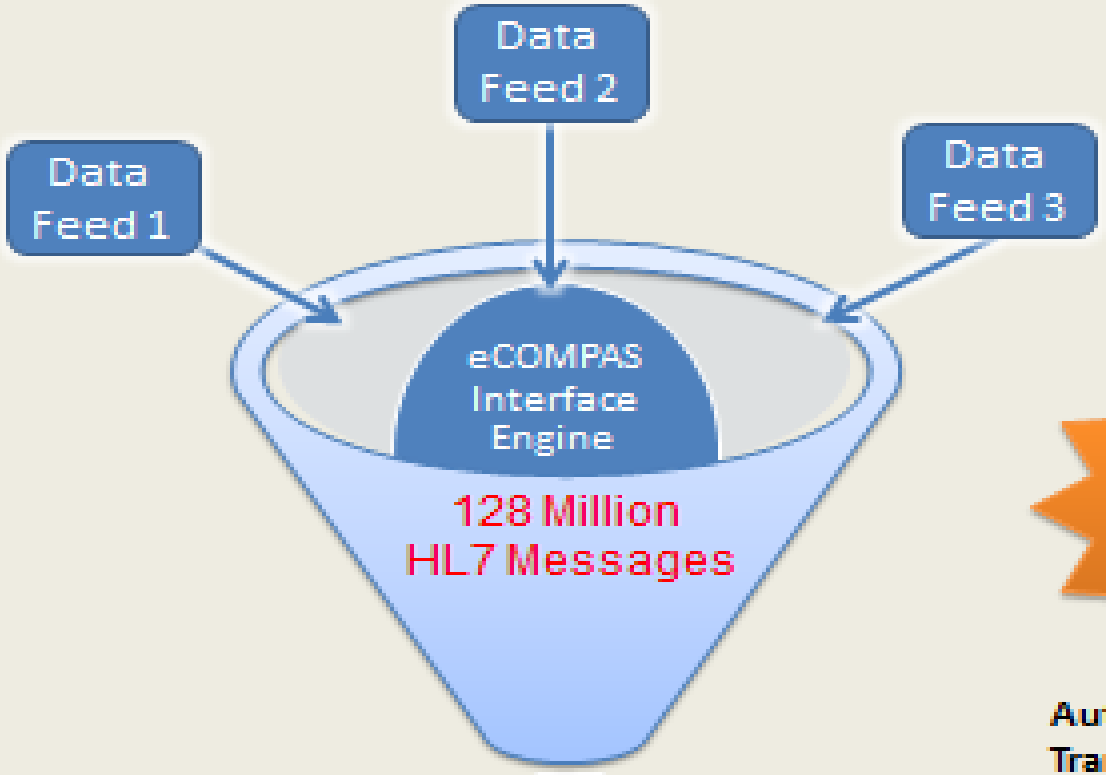
NOTE: This is the Clinical Care Team dashboard. We have used Clinical Care Team A as an example here.
The numbers and the team members are for illustrative purposes.
Two new staff categories, Community Health Worker and Peer Educators will eventually be included here.

RDE Systems

How We Met:
HRSA Special Projections of National Significance



"Electronic Health Information Exchange: A Process of improved operations and measurement of Client health outcomes"



1,000 est. hours saved each year!

Automated Data Transformation

- PCP and Care Coordinator Assignment
- Care Engagement and Population Management

- Direct Data Integration

188,000 Data Elements

Automated Data Transformation Engine

eCOMPAS Master Database

215.5 Million data points


NY Presbyterian eCOMPAS
Page
Safety
Tools
eCOMPAS
"An interactive approach to measuring success"
Main
Reports
Logout
[?] Help
18 : 02
Client Summary
Name
DOB
Gender
Male
MRN
Staff
HIV/PCP Provider: Peter Gordon
Social Worker: Angel Cruz
Active Program Enrollments
CHP Clinic
Insurance
A - Self Pay - $10 Flat Clinic: 5% Other
A01 - Medicaid
Notes
View or Edit Notes
less
Registry
Demographics
Insurance
Programs
Medical
Services
Contact Information
Primary Language
English
Other Language
Home Phone
(347)780-0210
Work Phone
(347)780-0210
Cell Phone
e.g. 123-659-7451 more
Email Address
Permanent / Mailing Address
Secondary Address (if different)
Same as Mailing Addr.
Country or Other Areas
United States
Address Line 1
2538 VALENTINE AVE
Address Line 2
3B
City
BRONX
State/Province/Region
NY
County
BRON
Zip/Postal Code
10459
Country or Other Areas
- Please Select -
Address Line 1
2538 VALENTINE AVE
Address Line 2
3B
City
BRONX
State/Province/Region
NY
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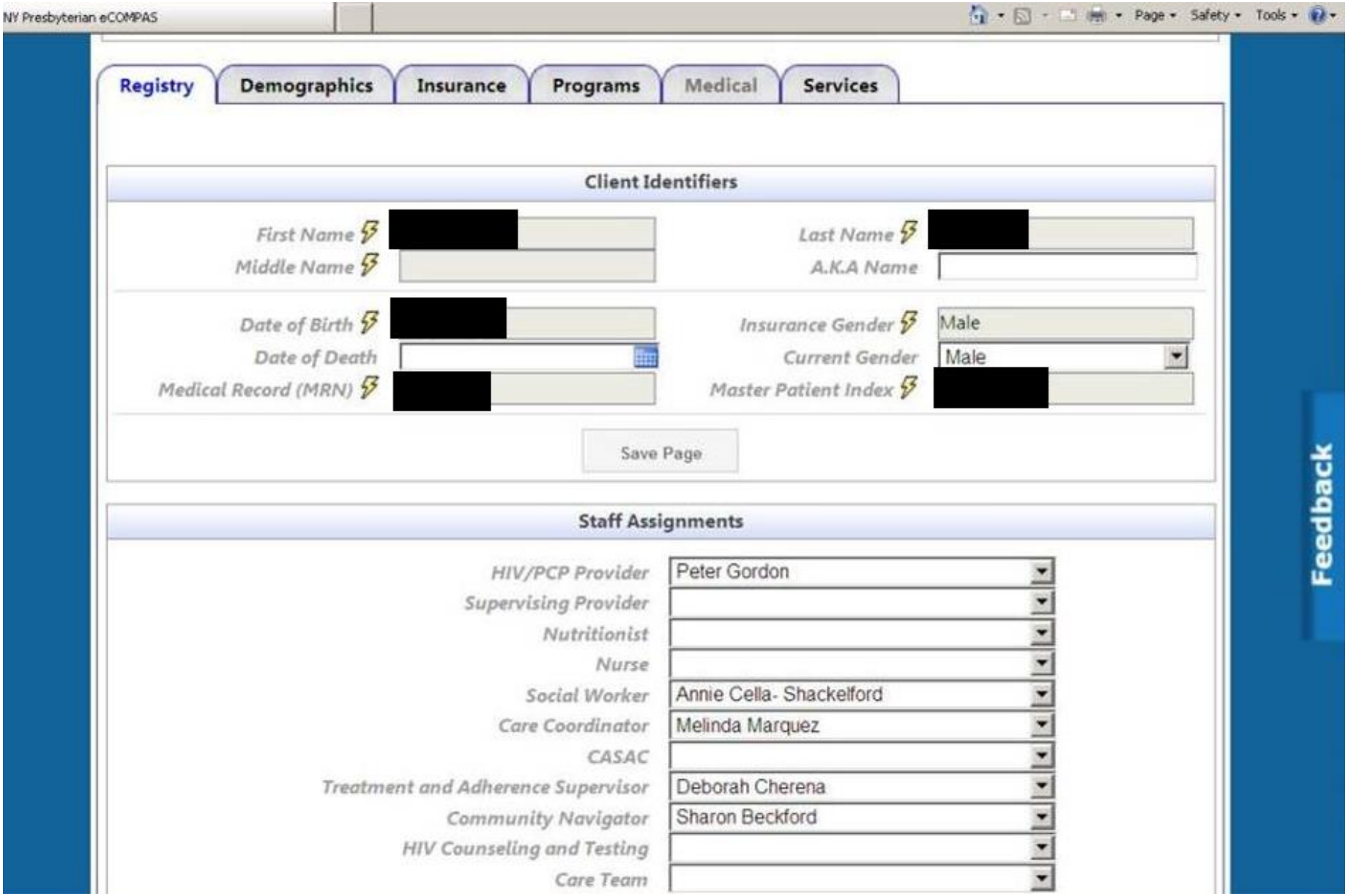
Zip/Postal Code
10459
Alternative Contact Information / Hang out Location
Feedback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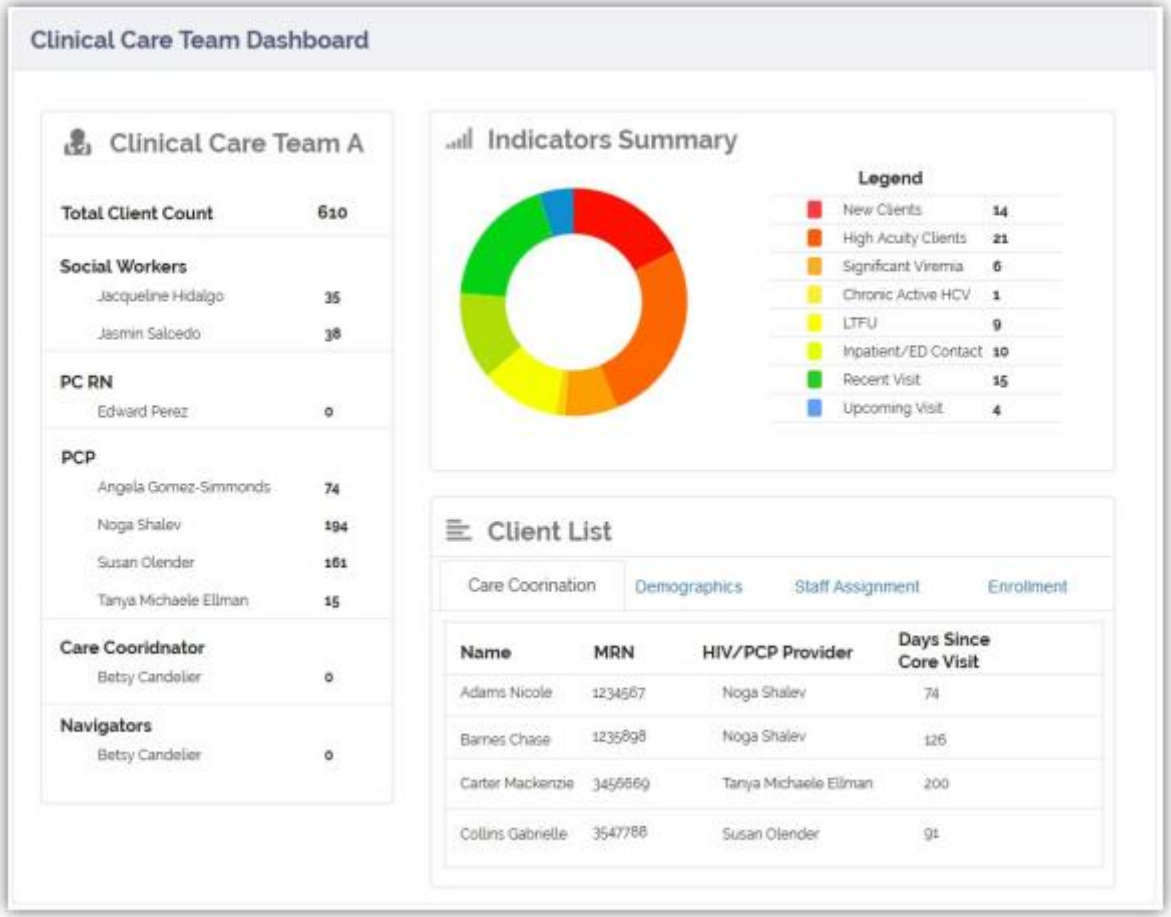
Client Identifiers
First Name
Middle Name
Last Name
A.K.A Name
Date of Birth
Date of Death
Medical Record (MRN)
Insurance Gender
Male
Current Gender
Male
Master Patient Index
Save Page
Staff Assignments
HIV/PCP Provider
Peter Gordon
Supervising Provider
Nutritionist
Nurse
Social Worker
Annie Cella- Shackelford
Care Coordinator
Melinda Marquez
CASAC
Treatment and Adherence Supervisor
Deborah Cherena
Community Navigator
Sharon Beckford
HIV Counseling and Testing
Care Team
Feedback

Creating Efficiencies – including Primary Care Nursing as Part of the CCT Dashboard



How does this transformation occur in the clinic and how can stakeholders drive the process?

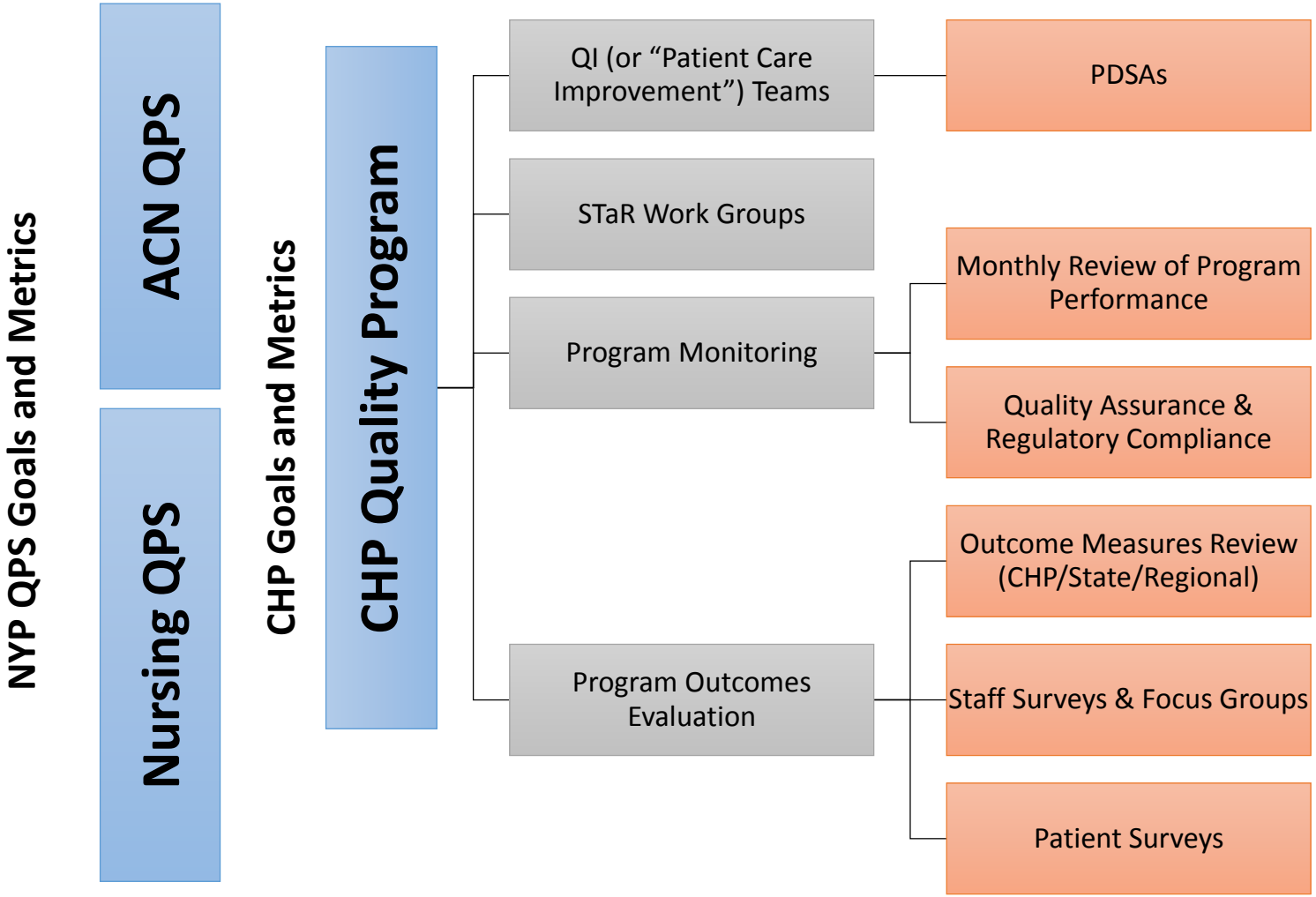
3) Practice Transformation and Quality Improvement

"If we want safer, higher-quality care, we will need to have redesigned systems of care, including the use of information technology to support clinical and administrative processes."

Committee on the Quality of Health Care in America

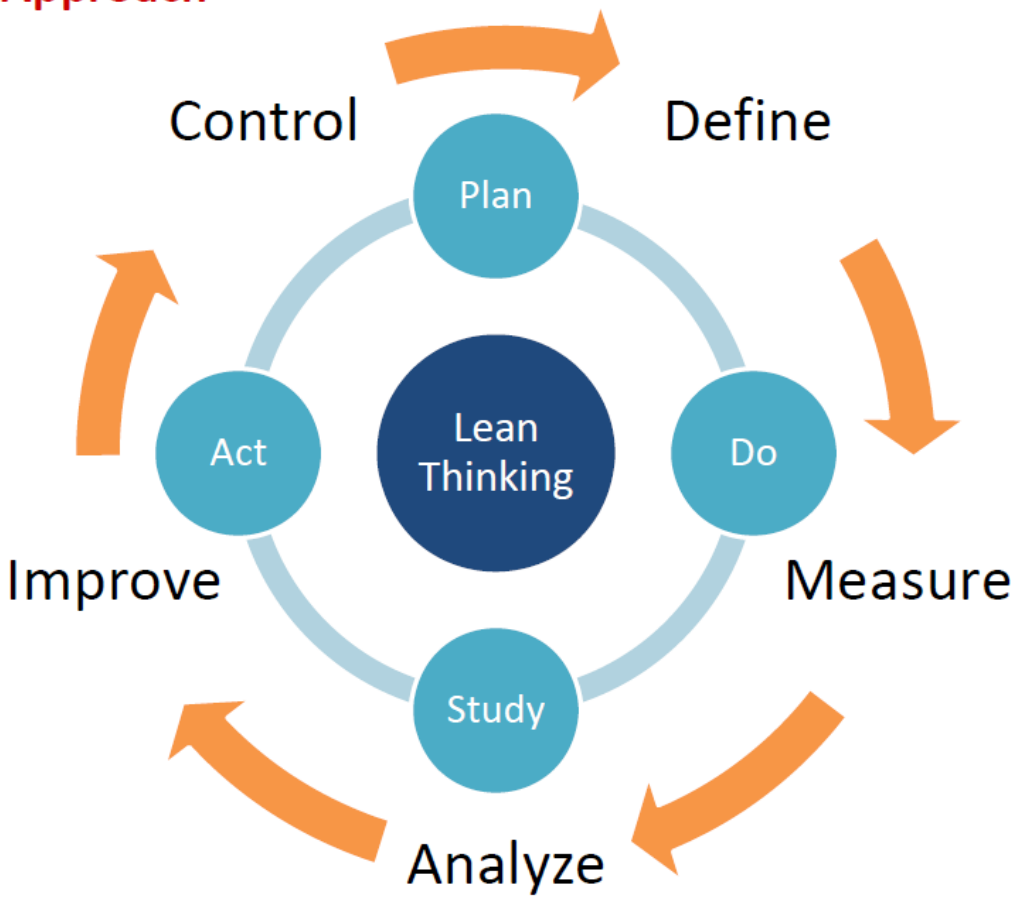
(Institute of Medicine, *Crossing the Quality Chasm*, 2001)

Implementing Practice Transformation through a Quality Framework



Quality Improvement Model

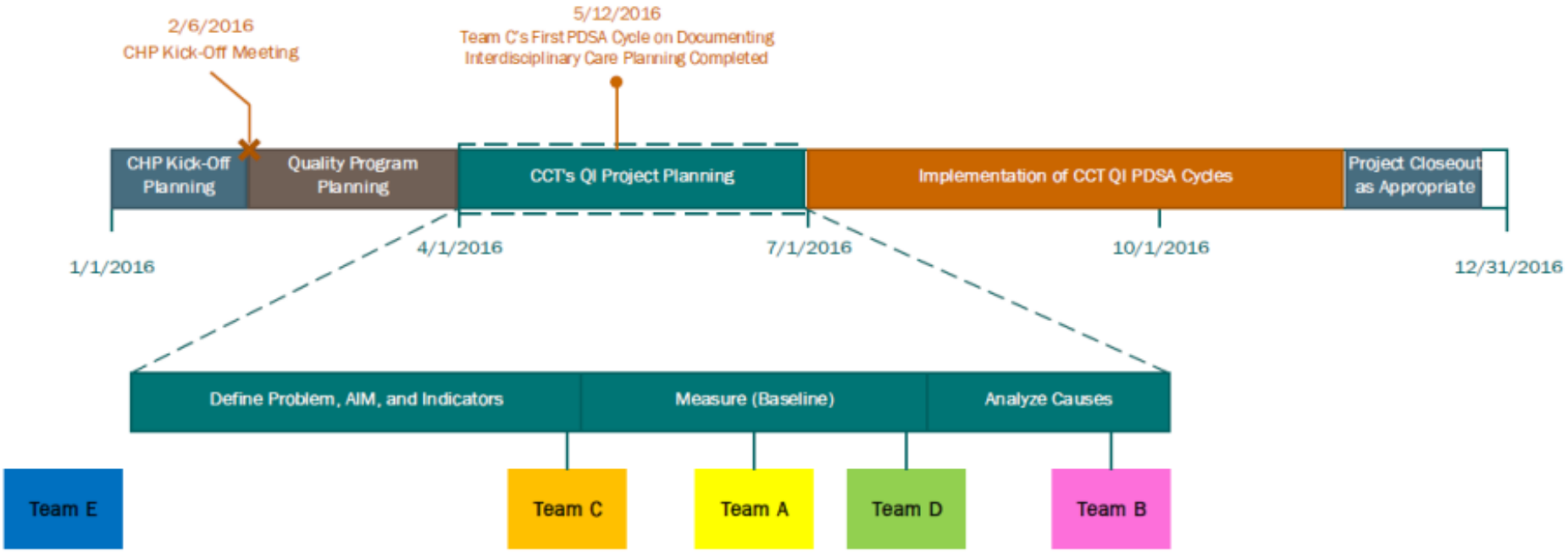
A Blended Approach



AMAZING THINGS ARE HAPPENING HERE

NewYork-Presbyterian
Quality and Patient Safety

Care Teams QI Projects Timeline



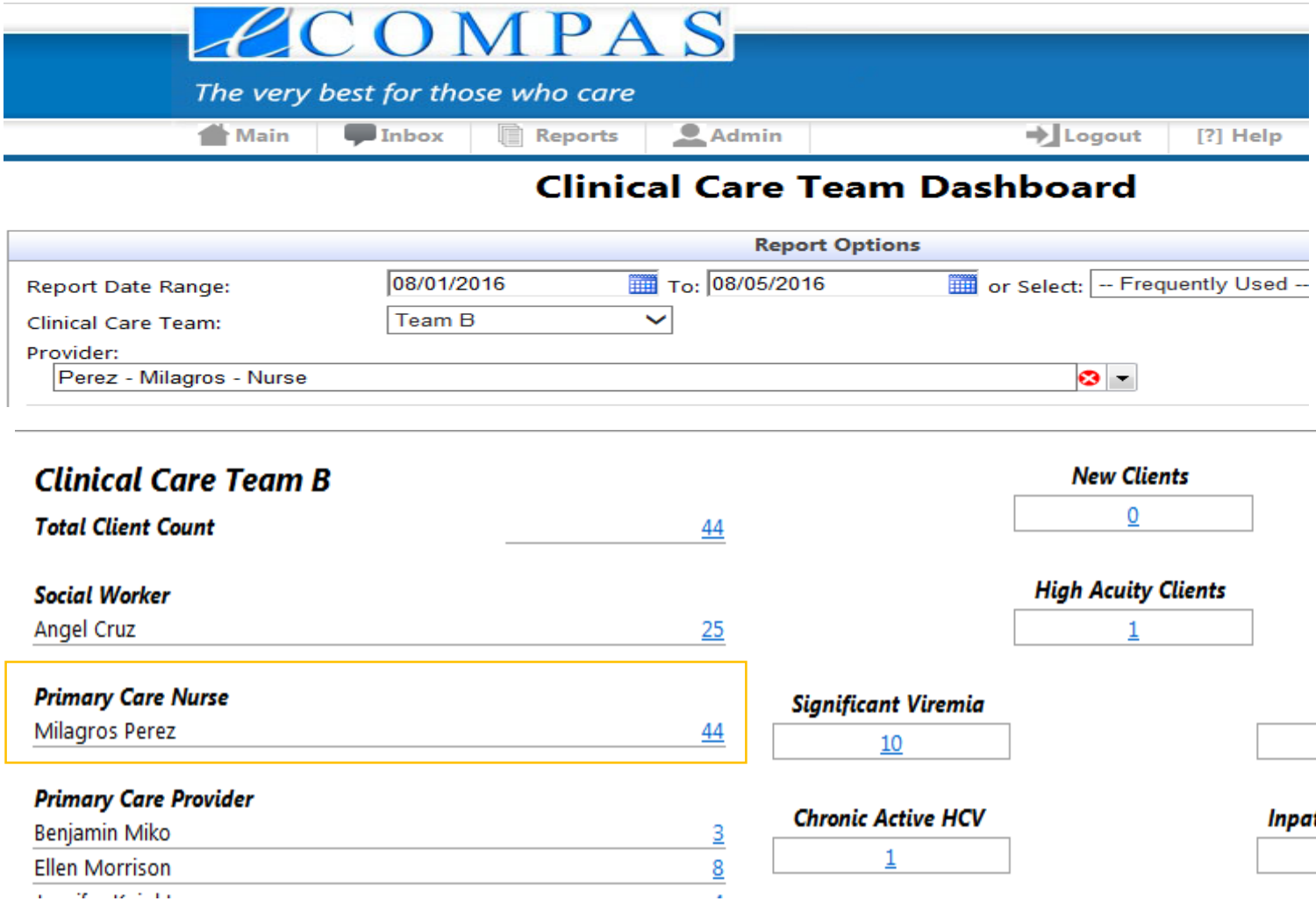
Facilitating Transformation: Updating the Treatment Adherence Program

- "Jumpstart" Adherence Program defunded
- Pre-poured pillboxes paired with education are essential adherence support intervention for patients
- Opportunities to use Nursing expertise in medications and patient education
  - Prevention of Medication errors
- Nurses as an integral part of the Clinical Care Teams

Nurses Working at the Top of License

- Medication distribution & reconciliation and adherence support through Primary Care Nursing

CCT Dashboard: Primary Care Nursing



STaR Working Group on Medication Distribution & Adherence Support

- Working Group consisted of representatives from each of the stakeholder groups with interest:
  - Registered Nurses
  - Nurse Administrator
  - Physicians
  - Adherence Supervisor
  - Operations Manager
- STaR Team facilitated the creation of the Working Group and participated in the meetings

Building on a Strength and Engaging Stakeholders for Transformation

Planning Implementation of New Treatment Adherence Program

- Review the old process and policies with the following goals:
  - Identify issues
    - Medical errors
    - Reconciliation issues
    - Large number of patients pick-up medication (~200 patients)
  - Identify opportunities for transformation
    - Nursing expertise in medication and education
    - Nursing now committed to dedicated Clinical Care Team (CCT)
  - Solutions
    - Shrink pick-up list
    - Move medication reconciliation and adherence pick-up under Nursing
    - Nursing will be able to guide CCT meetings with up to date knowledge

Updating Protocol & Workflows

NewYork-Presbyterian
Ambulatory Care Network

NewYork-Presbyterian Hospital
Comprehensive Health Program
Policy Number: PC 56 A
Page 1 of 5
May, 2015

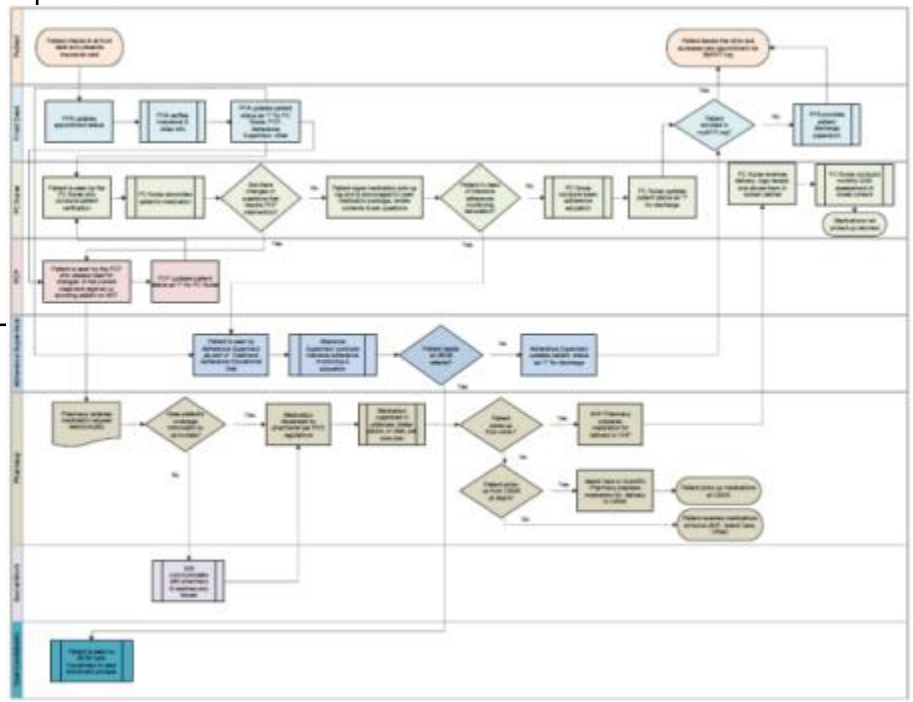
TITLE:
Medication distribution and reconciliation, and treatment adherence support in the comprehensive health program (CHP).

PURPOSE:
To outline all components of the medication distribution and reconciliation process and referrals to intensive adherence support services.

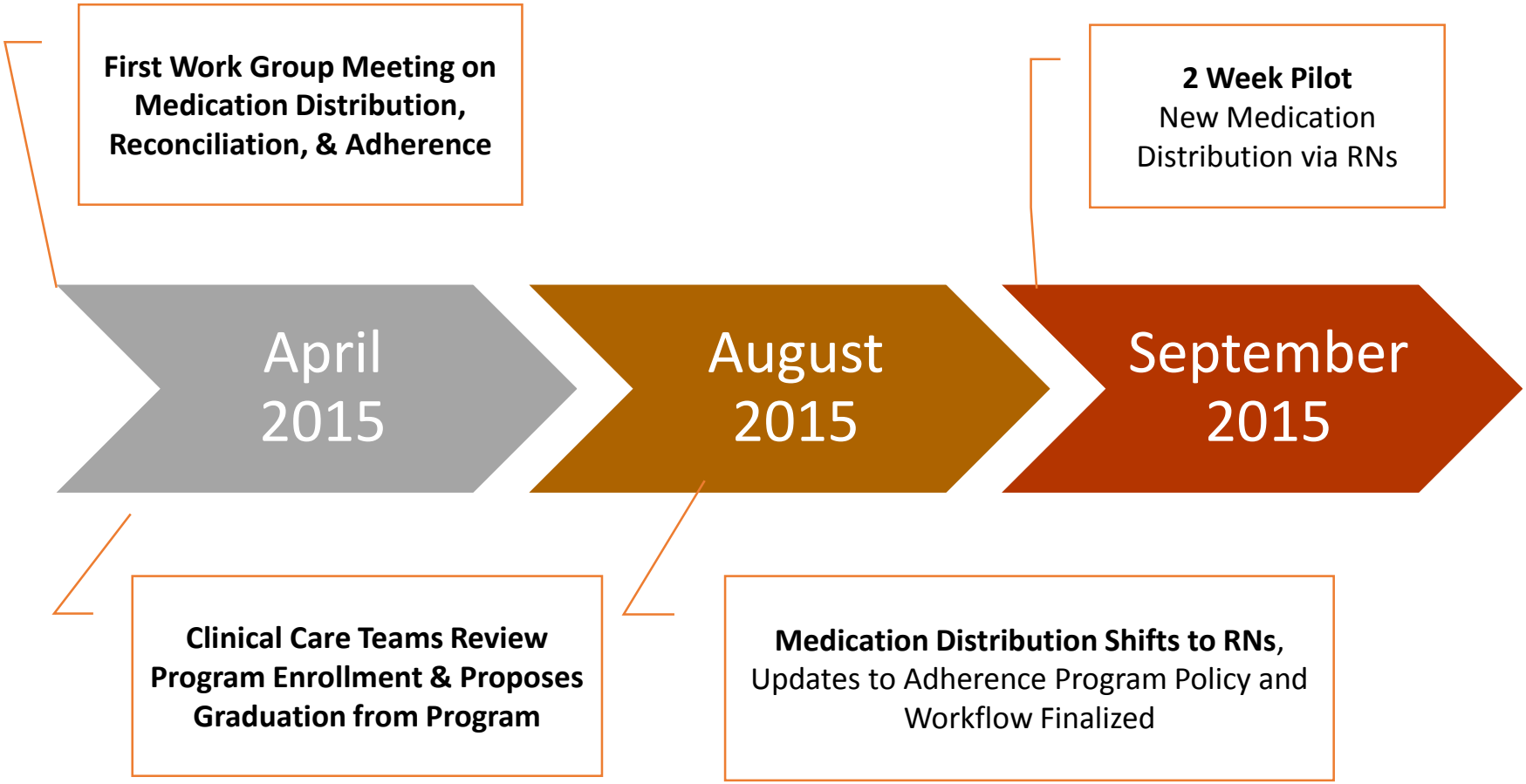
POLICY:
Distribution at CHP of medications that have been pre-poured into pillboxes or into sealed cellophane packages (blister packs) is one of a variety of interventions designed to facilitate long-term medication adherence to antiretroviral medications. This intervention is often coupled with other interventions (treatment adherence education visits or Medical Case Management [MCM] support) as part of the patient's comprehensive interdisciplinary plan of care.

PROCEDURE:

Treatment Adherence Support Plan

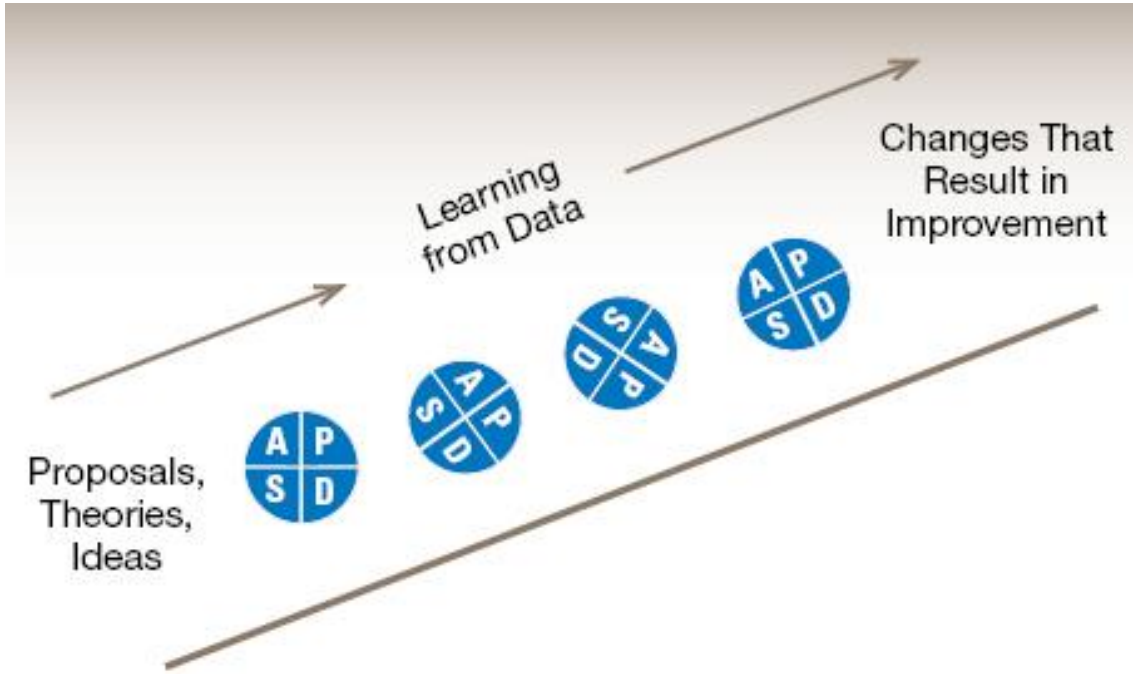


Changes to the Medication Distribution & Adherence Program Workflow



Implementation Mid-Course Corrections: Plan, Do, Study, Act Cycles

- Small changes
- Iterative process
- Data-driven



Treatment Adherence Program QI Team

- ❑ **Clinical Care Team A**
- ❑ **Treatment Adherence Supervisor**
- ❑ **All RNs (4)**
- ❑ **STaR Project Director /Quality Manager**

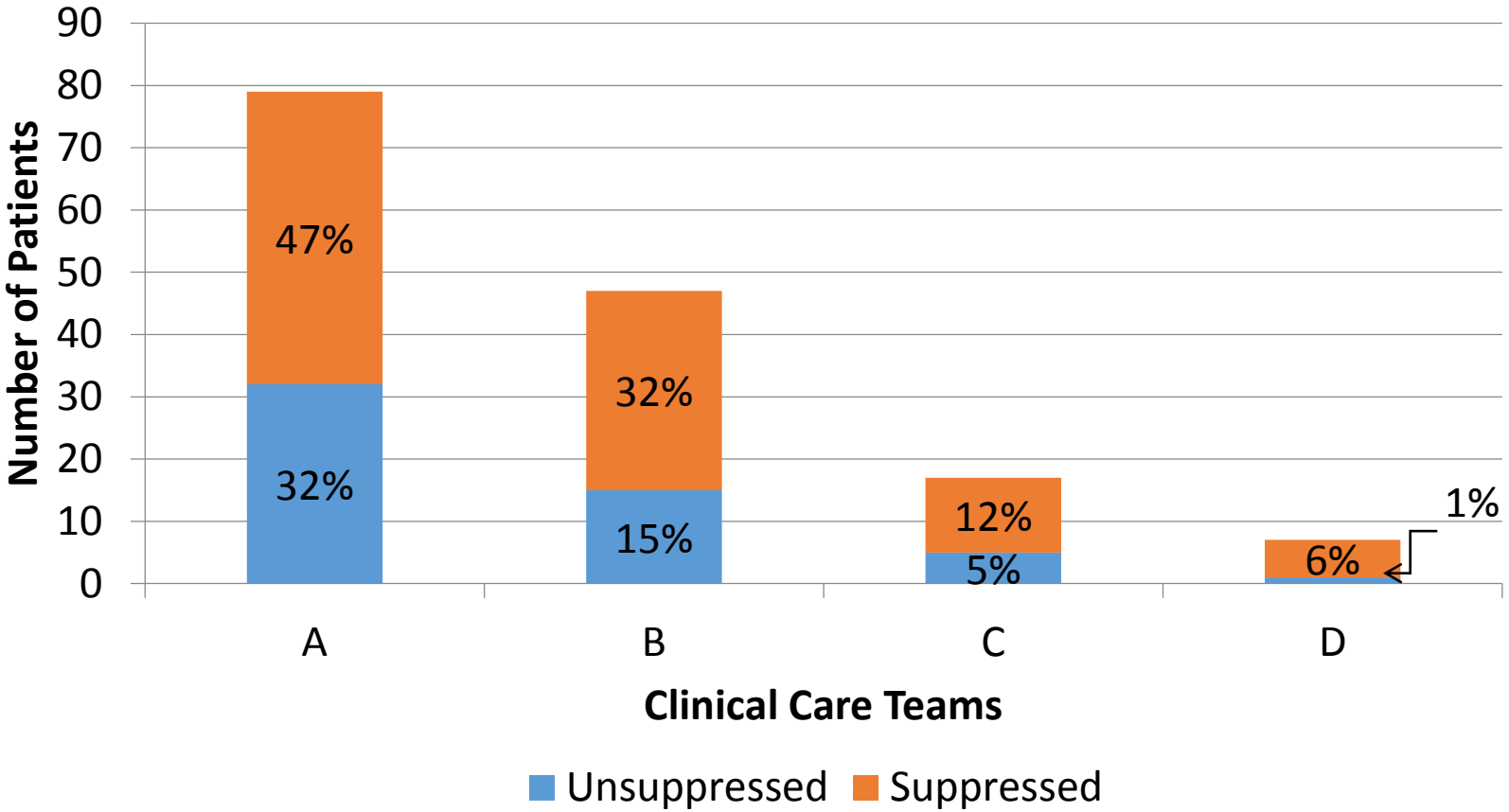
QI Project AIM

- Increase, over a period of three months initially, the proportion of patients outreached, re-engaged and/or referred to other internal resources (e.g., Treatment adherence educator, Medical Case Management, or peer education) by those directly involved in implementing adherence support for CHP clients out of those patients enrolled in the program and who are failing to pick-up their medication or need additional adherence support.

Intermediate AIMS

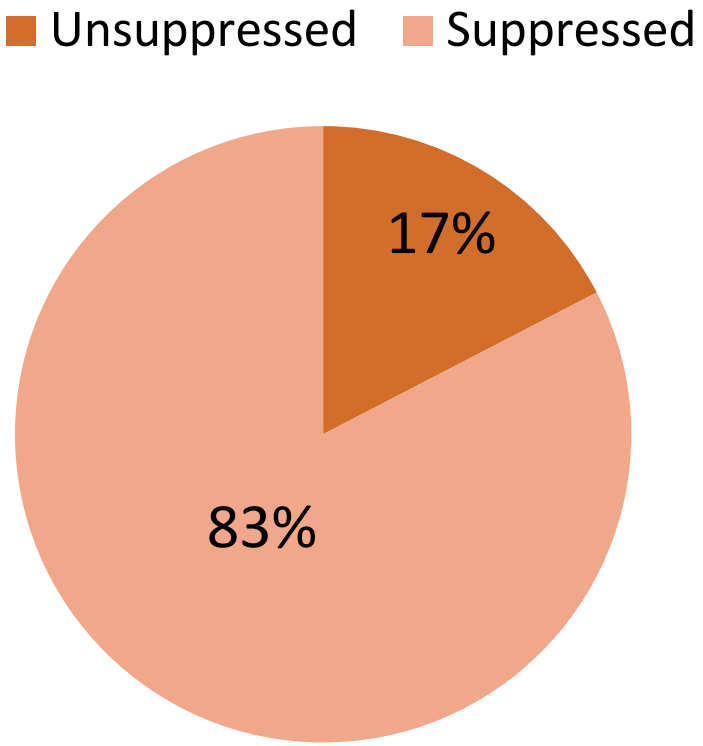
- Regulatory
  - Decrease number of medications returned to Pharmacy.
- Intervention Monitoring
  - Achieve real-time monitoring of missed medication pick-ups
- Improve care coordination among those involved in treatment adherence monitoring and support
  - Care Teams at Clinic, Community Partner Staff, Nursing Team

CHP Adherence Program Population (February 2016): Viral Suppression (<200copies/mL) Rates by Teams N=150



Overall, 64% viral suppression rate.

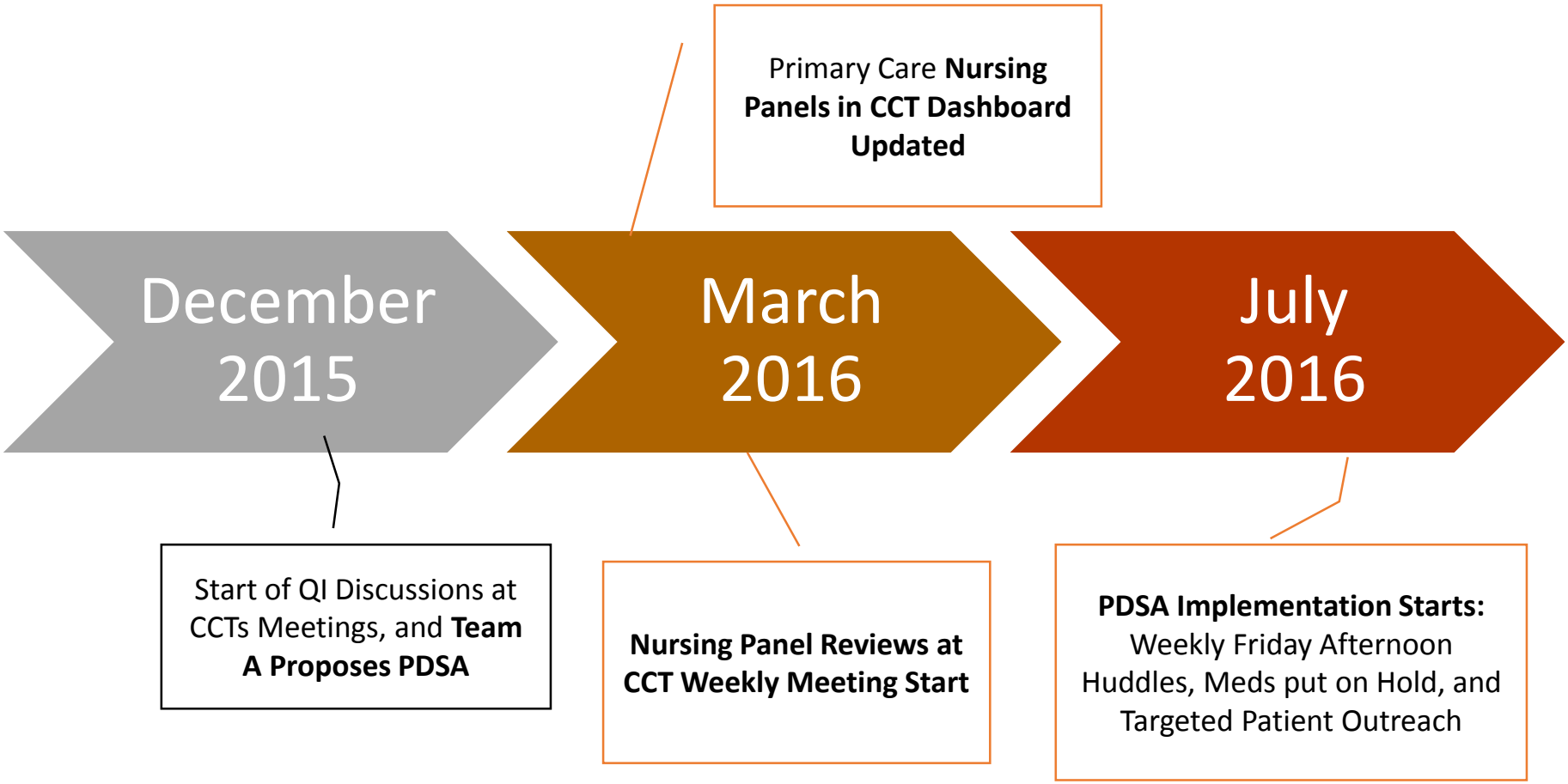
CHP Adherence Program Population (February 2016): Last Viral Load > 6 month N=23



PDSA Work Plan

Action Step	Details	When	Who
1) Develop and maintain Adherence Program population report through eCOMPAS	Get an updated list from AHF of patients picking-up at CHP; and Enroll patients in the Program in eCOMPAS and maintain list so it is up-to-date	Ongoing	STaR Data Coordinator
2) Develop med pick-up tracking system	Develop medication pick-up patient list and tables for monitoring missed medication pick-ups	End of May	Treatment Adherence Supervisor (TAS)
3) Medication pick-up weekly afternoon huddle	Implement Friday afternoon huddle with RN and TAS to further refine weekly reports of missed medication pick-ups and protocol; identify patients to be outreached and discussed at CCT meetings	Beginning of July	RNs, TAS, and other team members as needed
4) Identify patients for CCT meeting discussion	Patient discussion might result in an intervention including but not limited to: 1) referral to peer program, 2) referral to TAS, 3) referral to MCM, 4) need to be outreached and scheduled for PC visit.	Beginning of July	RNs, TAS, and other team members as needed

Changes to the Medication Distribution & Adherence Program Workflow

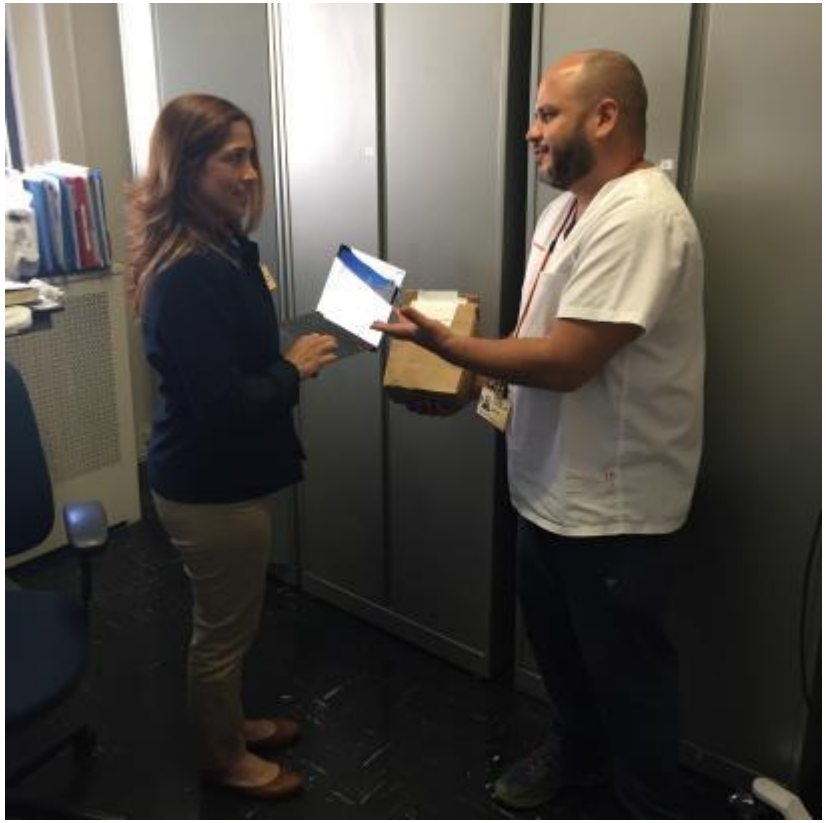


Team QI PDSA Progress (What We Have Accomplished)

- ✓Coordinated with AHF Pharmacy to receive an accurate master list of patients picking up meds at CHP
- ✓Reviewed Master Medication Delivery logs and Medication Pick-Up logs for all teams
- ✓Conducted four afternoon huddles in July with RNs, TAS, and Quality Manager
- ✓Created an Adherence Program patient tracking list

Team QI PDSA Progress (What We Have Accomplished)

- ✓TAS coordinating with AHF Pharmacy for reducing the # of meds returned (because patients not picking up)
- ✓Through weekly Friday afternoon huddles, ensuring that all meds are returned per Hospital regulations
- ✓Identified patients in need of additional support and conducted outreach through the TAS



Meds Missed Pick-up & Viral Load Suppression Tracking Tool Tables

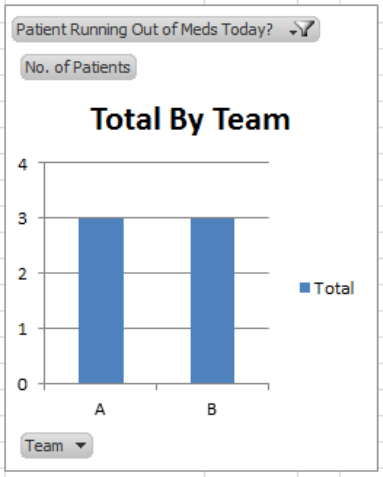
Patient Running Out of Meds Today?	1

Team	No. of Patients
A	3
B	3
Grand Total	6

Patient Running Out of Meds Today?	1

Patients by Team

A

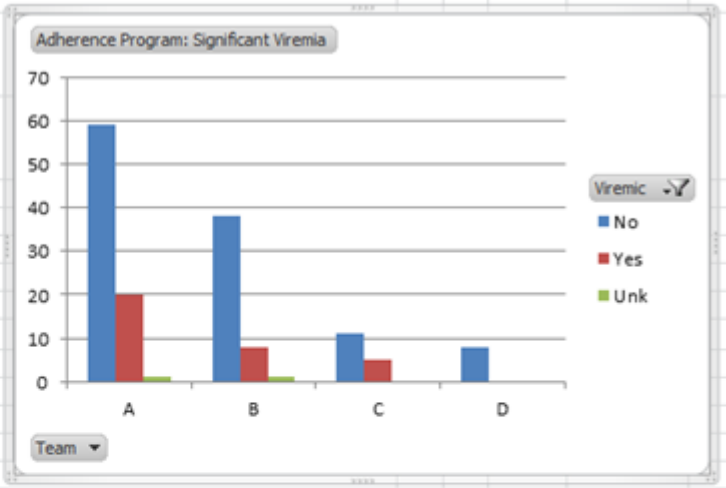


Adherence Program: Significant Viremia				
Team	No	Yes	Unk	Grand Total
A	59	20	1	80
B	38	8	1	47
C	11	5		16
D	8			8
Grand Total	116	33	2	151

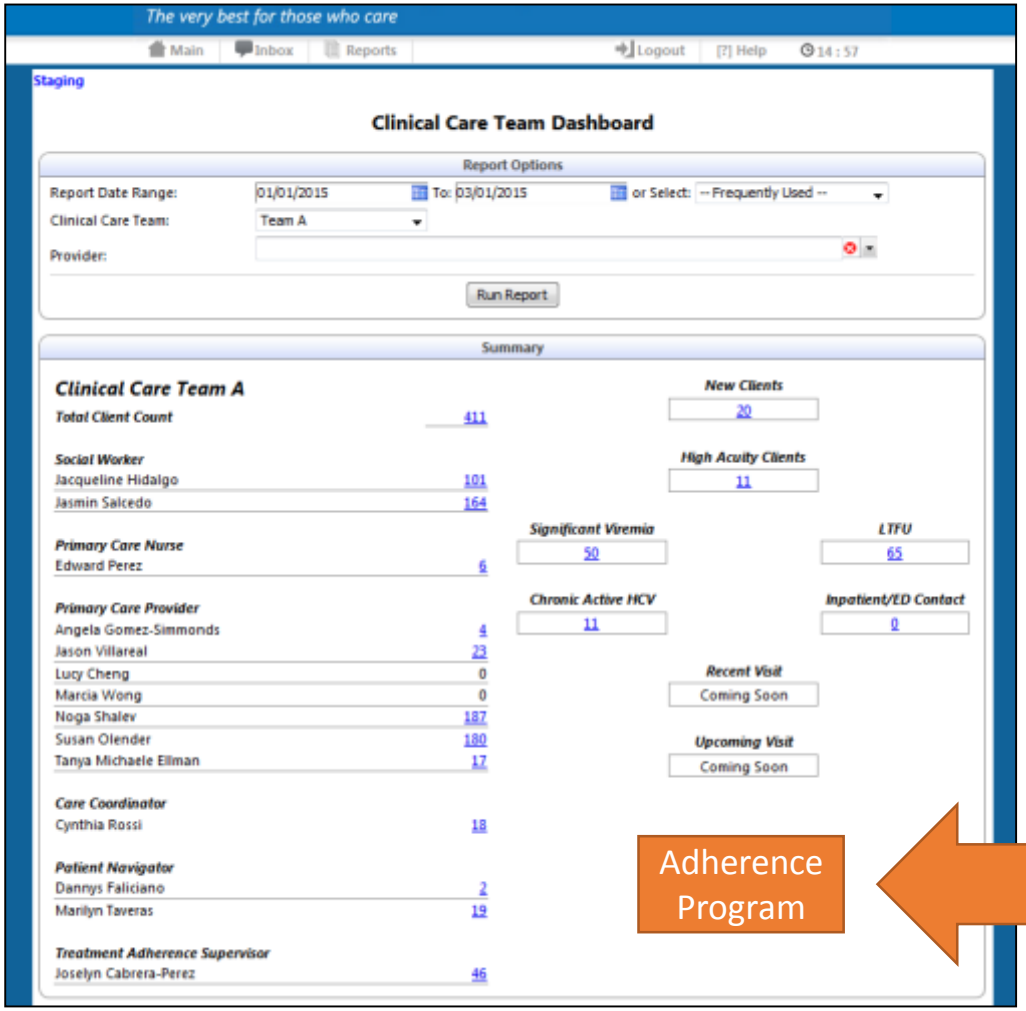
Viremic	Yes

Patients By Team

A



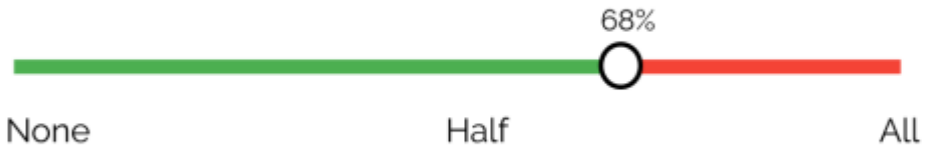
Creating Efficiencies –Adherence Program Indicators in the CCT Dashboard




The ACN-CnP Staff
Welcomes You

STAR **Adherence Survey**

How many retroviral pills have you taken in the last month?



Question **4** of 7

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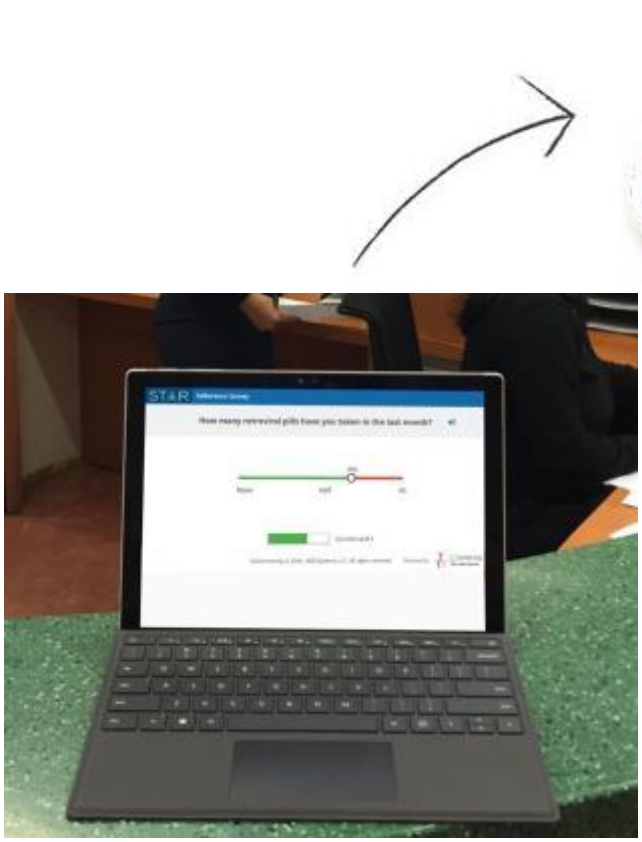
Secure Data Transfer



Summary

- ❑ Involving stakeholders in all the stages of process improvement and transformation
- ❑ Building trust
- ❑ Using HIT solutions to achieve efficiencies and enhance communication
- ❑ Employing QI approaches or tools allow for systematic assessment of changes
- ❑ Leveraging Clinical Care Team to support continuous quality improvement

Questions