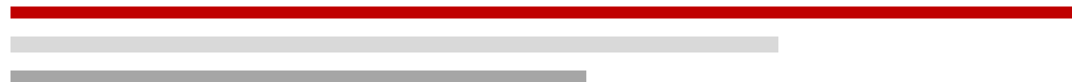
Everything Comes Down to This

Systems Linkages and Access to Care for Populations at High Risk for HIV Infection in New York State

Steven Sawicki, MHSA

Program Manager, NYS DOH, AIDS Institute, Office of the Medical Director, SPNS Lead

May, 2013



Cascades

CDC's National 'Cascade' (July, 2012)

OVERALL: Of the 1.1 million Americans living with HIV, only 25 percent are virally suppressed.

Percent of all People with HIV

100
80
60
40
20
0

Diagnosed	Linked to Care	Retained in Care	Prescribed ART	Virally Suppressed
82%	66%	37%	33%	25%

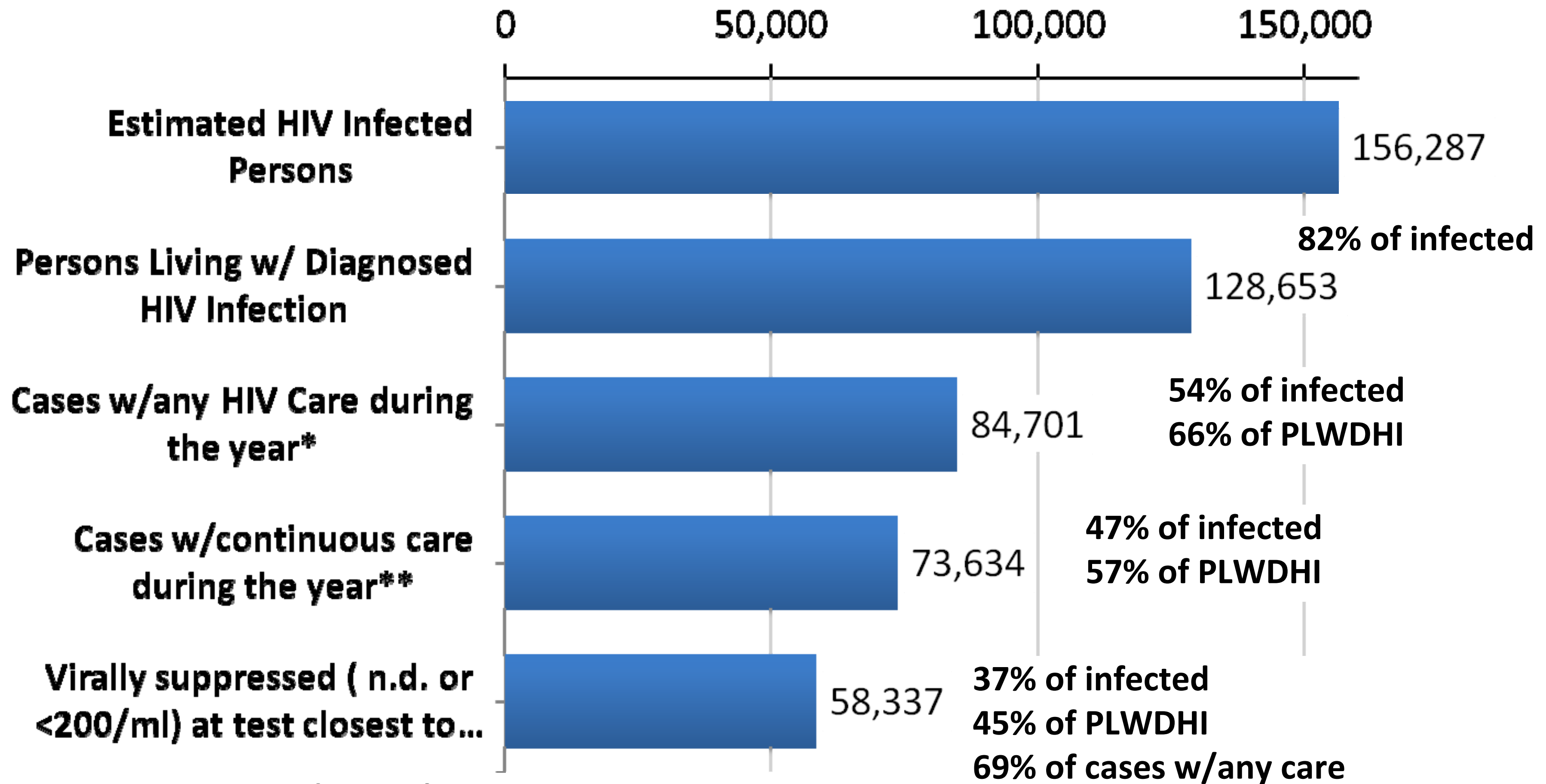
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

JULY 2012

NY Links

New York State Department of Health AIDS INSTITUTE

Cascade of HIV Care
New York State, 2010



* Any VL or CD4 test during the year

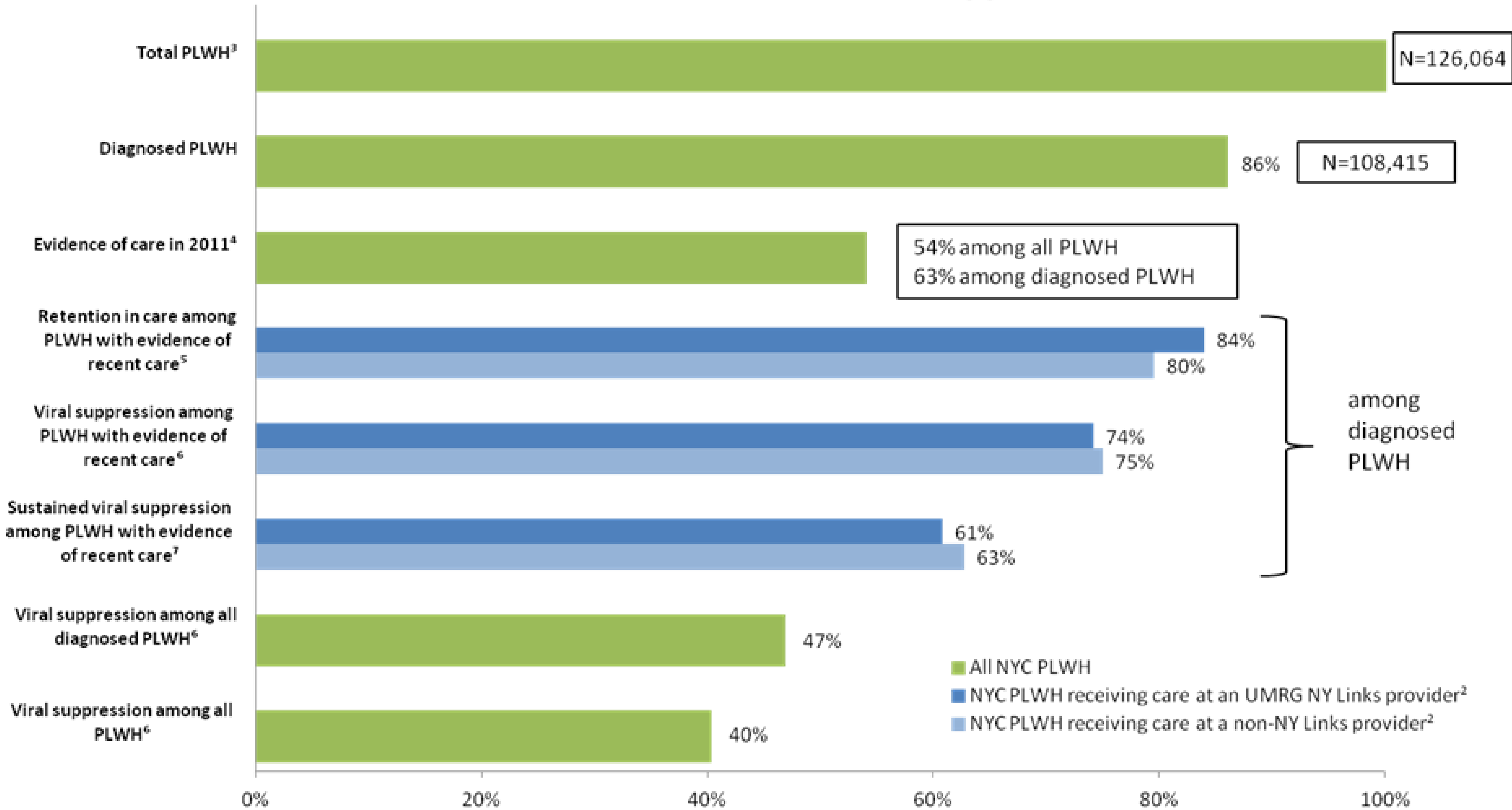
** At least 2 tests, at least 3 months apart

BHAE, NYSDOH January, 2012

NY-Links

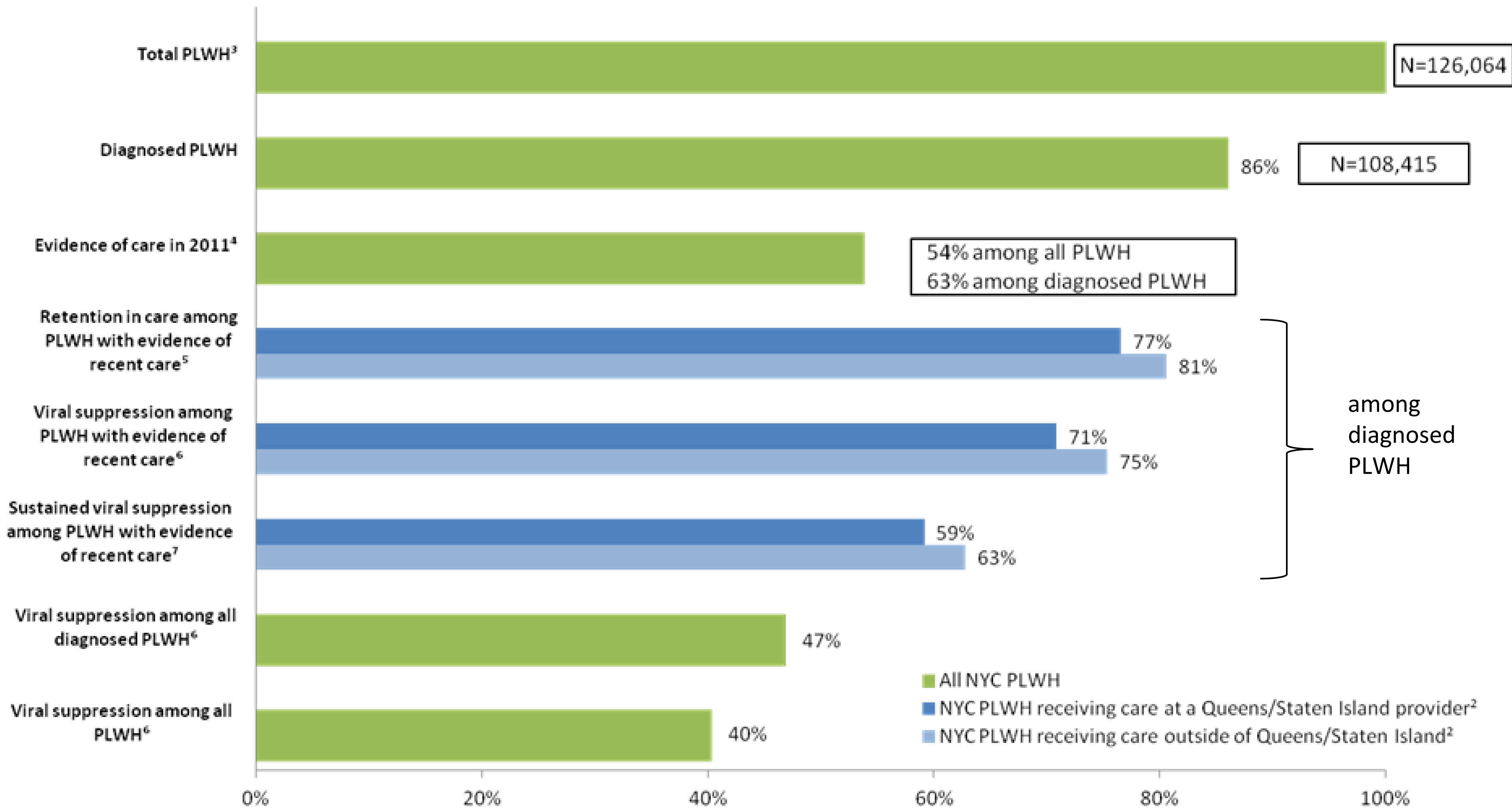
AIDS INSTITUTE New York State Department of Health

NY Links HIV care cascade: all PLWH in NYC and Upper Manhattan, 2011[1]



[1] Persons diagnosed with HIV on or before June 30, 2010 and living as of December 31, 2011. As reported to the New York City HIV Surveillance Registry (NYC HSR) as of September 30, 2012 [PROVISIONAL DATA]
[2] Receiving care at an UMRG NY Links provider or at a non-NY Links provider is determined by the ordering provider of the first CD4/VL reported to the NYC HSR January 1, 2011 - December 31, 2011
[3] NYC has a 14% undiagnosed HIV rate; for reference, see :Eavey JJ, Torian LV, Jablonsky A, Nickerson JE, Fettig JF, Leider J, Calderon Y. Undiagnosed HIV Infection in a New York City Emergency Room: Results of a Blinded Serosurvey, December 2009-January 2010. 19th International AIDS Conference, 2012, Washington, DC. Abstract# TUPE282
[4] Evidence of recent care is define as ≥1 CD4/VL reported to the NYC HSR January 1, 2011 - December 31, 2011
[5] Retained in care is defined as the percentage of PLWH with recent care who had ≥2 CD4/VL tests reported to the NYC HSR January 1, 2011 - December 31, 2011 that were at least 45 days but no more than 183 days apart
[6] Viral load suppression is defined as the % of PLWH with evidence of recent care whose most recent VL reported to the NYC HSR January 1, 2011 - December 31, 2011 was <400 copies/mL
[7] Sustained viral load suppression is defined as the % of PLWH with evidence of recent care whose VL tests reported to the NYC HSR January 1, 2011 - December 31, 2011 were ALL <400 copies/mL

NY Links HIV care cascade: all PLWH in NYC and Queens/Staten Island, 2011[1]



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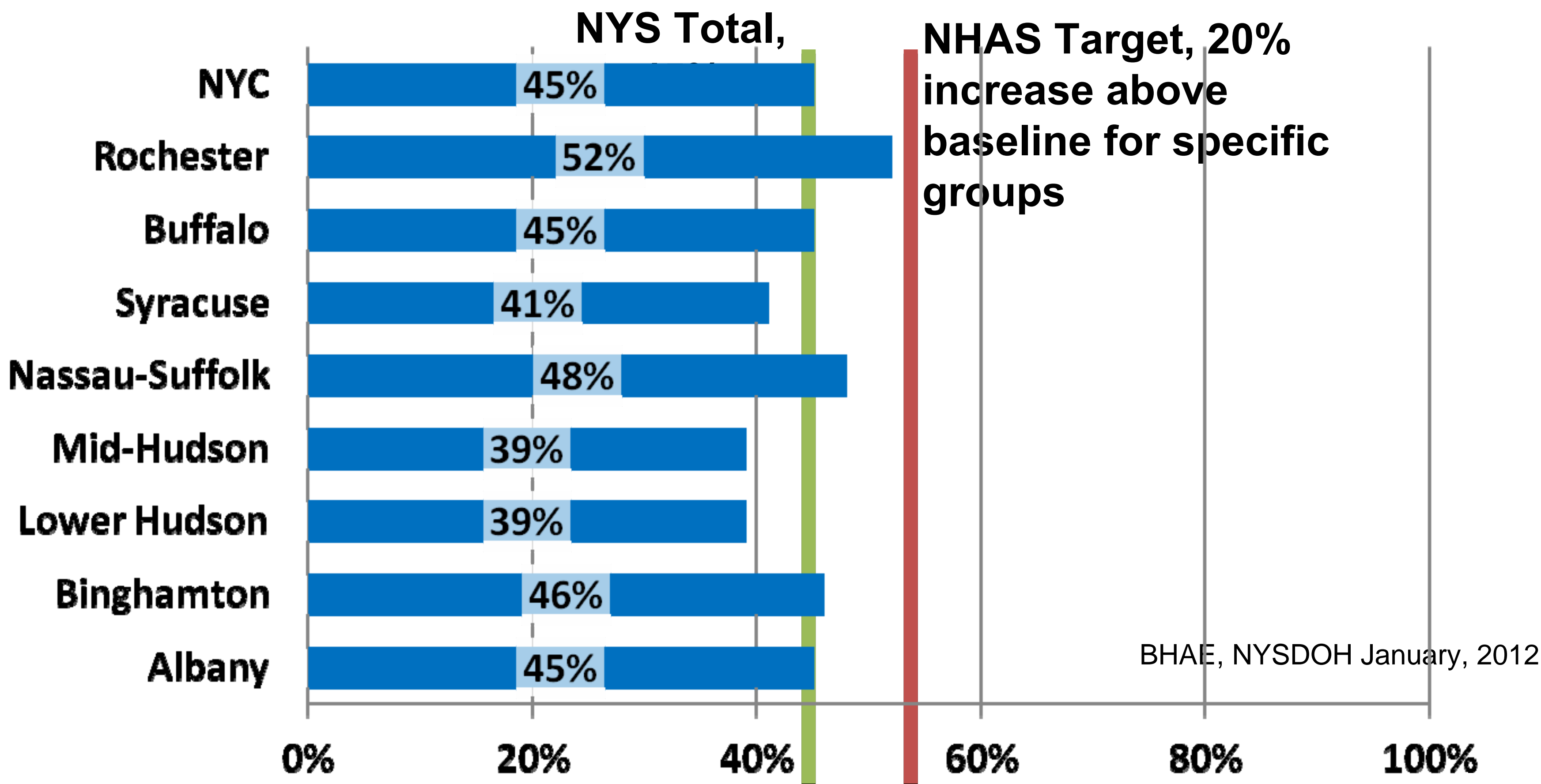
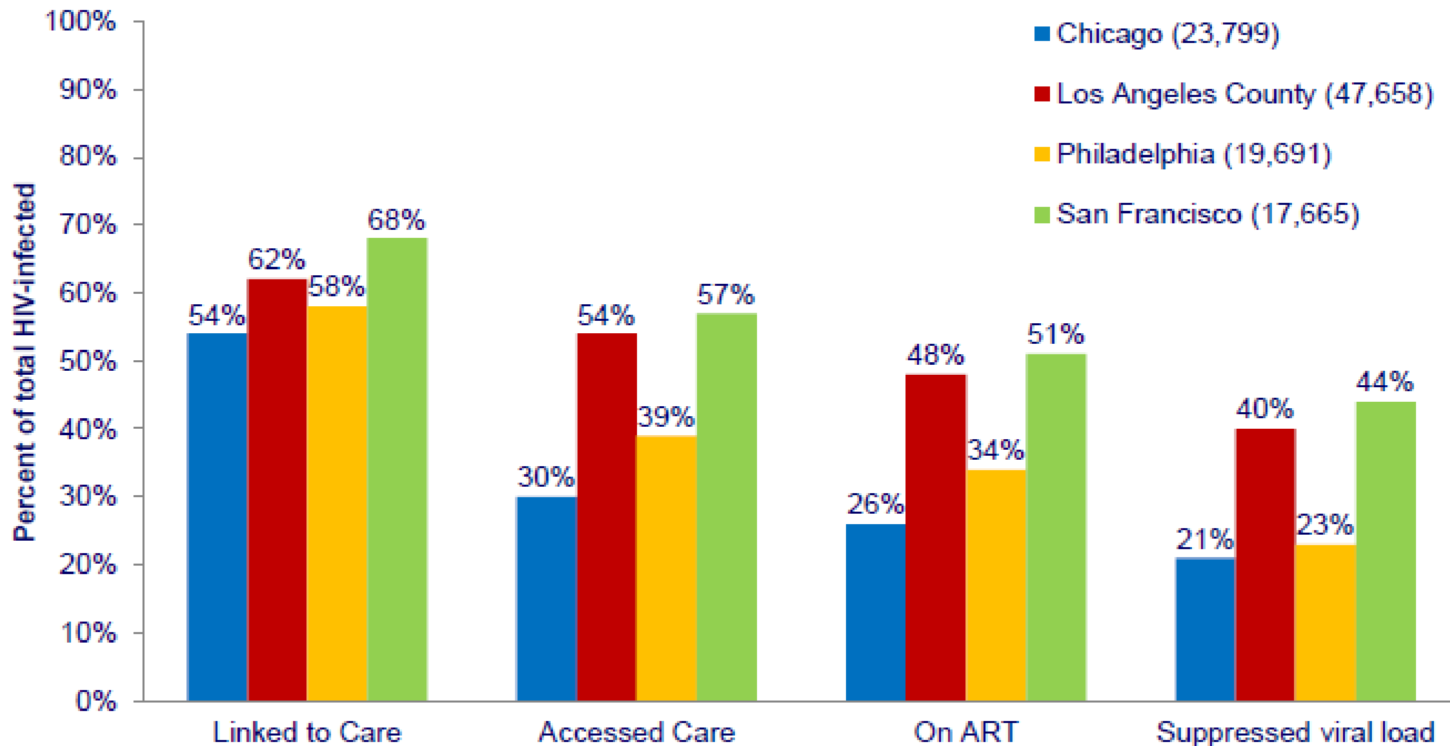
Viral Suppression Among All Persons Living with Diagnosed HIV Infection in 2010



% of living cases with viral load non-detectable or ≤ 200 copies/ml, test closest to mid-year

Cascades from Elsewhere



NY Links

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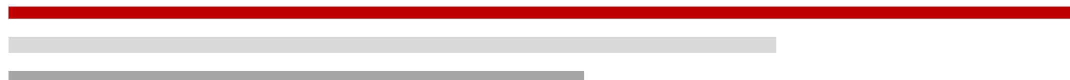
What Does This Mean?



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CDC's National 'Cascade' (July, 2012)

OVERALL: Of the 1.1 million Americans living with HIV, only 25 percent are virally suppressed.

Opportunities for Improvement

Percent of all People with HIV

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80
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Diagnosed	Linked to Care	Retained in Care	Prescribed ART	Virally Suppressed
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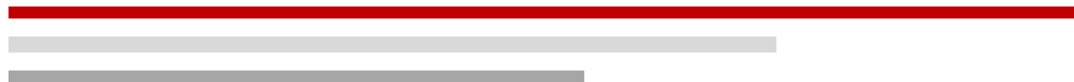
SPNS Overview



What are 'SPNS'?

- Special Projects of National Significance
  - Part of the Ryan White HIV/AIDS Program
  - Supports the development of innovative models of HIV care that respond to emerging needs of Ryan White clients
  - Topics for SPNS funding prioritized by HRSA
  - Strong evaluation/research component to assess the effectiveness of models, and then focus on the dissemination and replication of successes at a national level
  - Overall goals are consistent with National HIV/AIDS Strategy

NY Links Overview

NY Links Mission

Together, we

- identify innovative solutions for improving linkage to and retention in HIV care to support the delivery of routine, timely, and effective care for PLWHA in New York State; and

- bridge systemic gaps between HIV related services to achieve better outcomes for PLWHA through improving systems for monitoring, recording, and accessing information about HIV care in NYS.

NY Links

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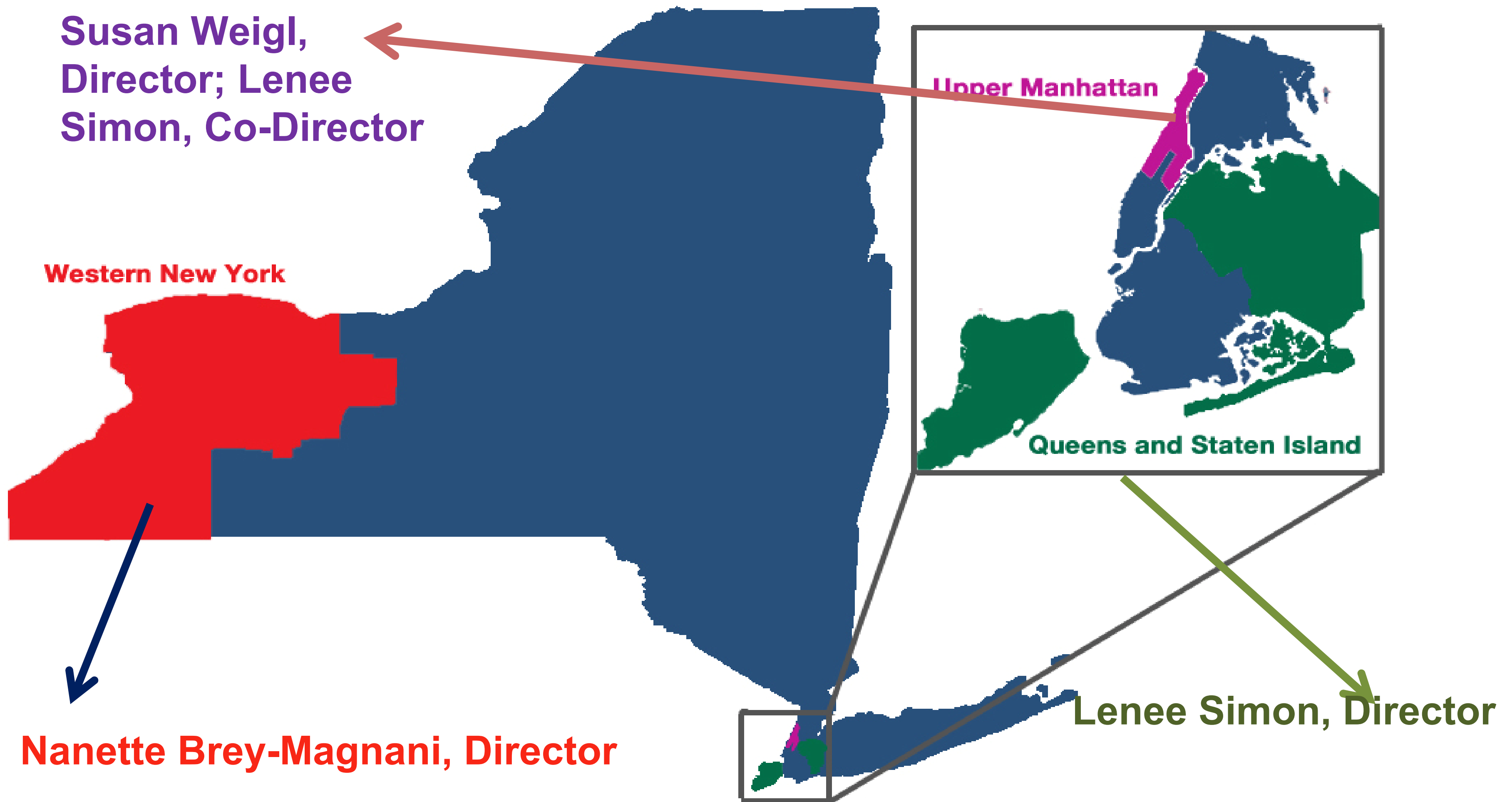
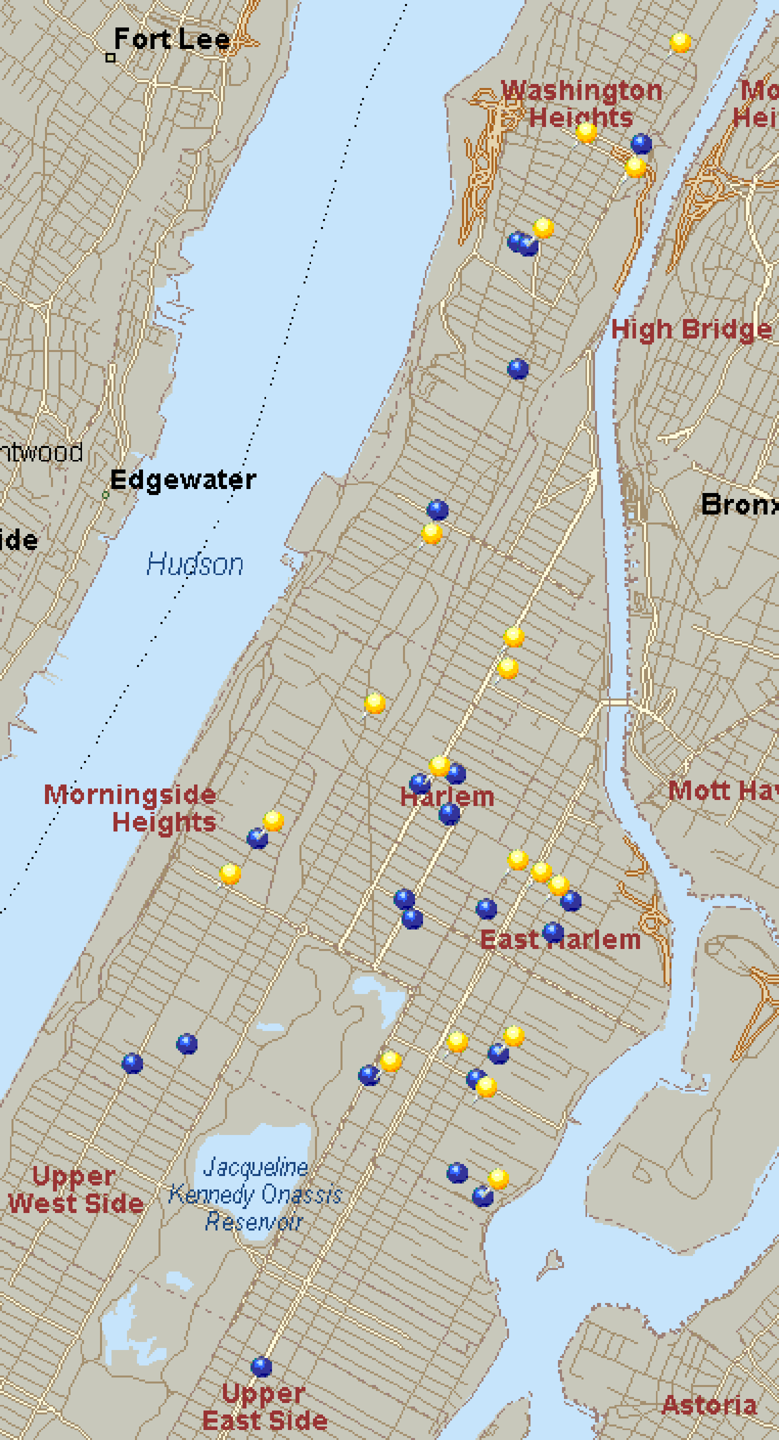
Existing collaborative locations in New York State





Upper Manhattan Regional Group

- **Engagement of all medical and non-medical providers in the Upper Manhattan geographic area to improve linkage to and retention in HIV care. Initiated 11/11.**
- **Current Progress:**
  - 5th Learning Session: January 23, 2013, Next Session, June 21
  - Provider driven interventions currently being tested and evaluated.
  - * Patient/Peer Navigation
  - *Notification Systems
  - *Linkage to Care handoffs
  - *System Modification

- Blue-Clinical Program Participating in the Upper Manhattan Regional Group
- Yellow-Supportive Service Program Participating in Upper Manhattan Regional Group

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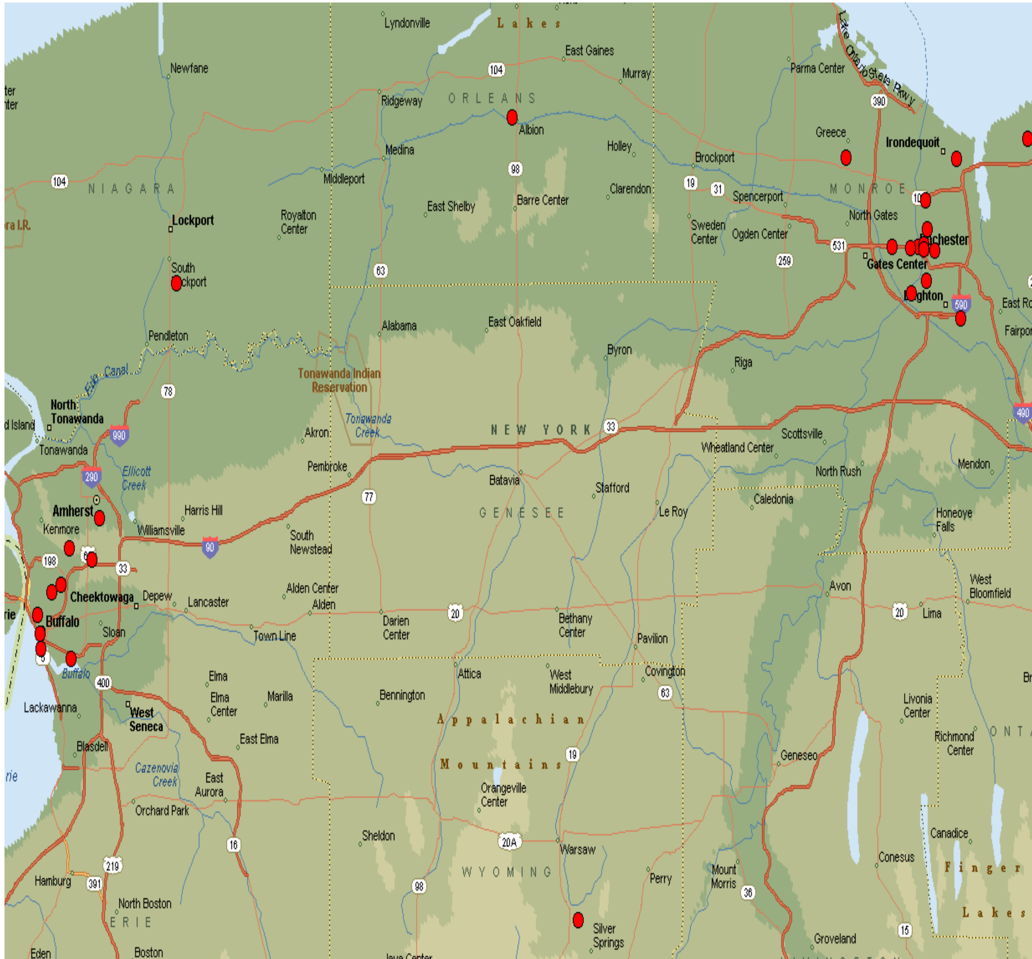
Western New York State Collaborative (WNYS)



- **Red**-Programs Participating in the WNYS Regional Collaborative

- **Engagement of all HIV medical and non-medical providers in the Western NY geographic area (Rochester and Buffalo) to improve linkage to and retention in HIV care. Initiated 6/12**

- **Current Progress:**
  - 4th Learning session scheduled for June 26th
  - Providers working on utilizing data, as a system and individually, to locate areas where interventions would have the most impact.

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Queens-Staten Island Collaborative

Engagement of all HIV medical and non-medical providers in the Queens and Staten Island geographic area to improve linkage to and retention in HIV care. Initiated 2/13

Current progress:

- Kick Off Learning Session on February 22, 2013. Next Session June 18.
- Introduce providers to the goals and objectives of this Collaborative
- Generate momentum to jointly work on linkage and retention interventions

NY Links

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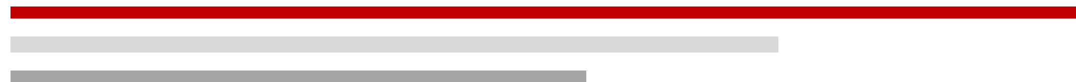
Mid and Lower Hudson Collaborative

- Working with providers in the 7 counties north of NYC: Westchester, Rockland, Putnam, Orange, Sullivan, Ulster, and Duchess.
- First Learning Session targeted for September, 2013.

NY Links Performance Measures

Because Data Drives Quality



NY Links

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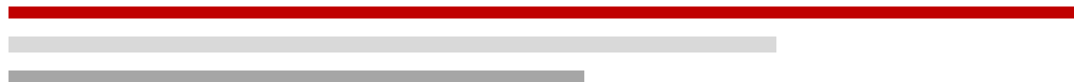
Brief Overview of NYS Links Measures

Measure	Agency Type
Linkage	All Programs that Conduct HIV Testing
Retention	HIV Clinical Care
New Patient Retention	
Clinical Engagement	Supportive Services & General Medical Assistance*
New Client Clinical Engagement	

in +care

QI and QI Project Steps



Quality Improvement Projects Should Look Inside and Out

Internal Processes – Drilled down data, team review, determination of interventions, testing of interventions, results

- Retention
- New Patient
- Clinical Engagement

External Processes – Identification of Gap, Partnering, testing of approach or intervention, results

- Retention
- New Patient
- Clinical engagement

Quality Improvement Project Steps

A Problem Solving Process

Test of process change:

Drilling down Data to identify patients; interventions to address specific patients' needs; documentation and reporting of results (track individually and group)

Step 1: Review, Collect and Analyze Baseline Data

Step 2: Form a Team, Develop a Work Plan

Step 3: Investigate the Process/Problem

Step 4. Plan and Test Changes – PDSA Cycles

Step 5: Evaluate Results with Key Stakeholders

Step 6: Systematize Change

“Every system is perfectly designed to achieve exactly the results it achieves.”

The System

(Before New York Links)

Rochester

Rochester

Monroe Co. STD/HIV Prevention + Control Program

Monroe Co. STD/HIV Prevention + Control Program

AJHC

AJHC

AJHC

Strong ID

NYSDOH

Green

AIDS CARE TRANS.

AIDS CARE Housing

AIDS Care

AIDS Care

AIDS CARE C.M.

AIDS CARE FOOD

AIDS CARE MENTAL HEALTH

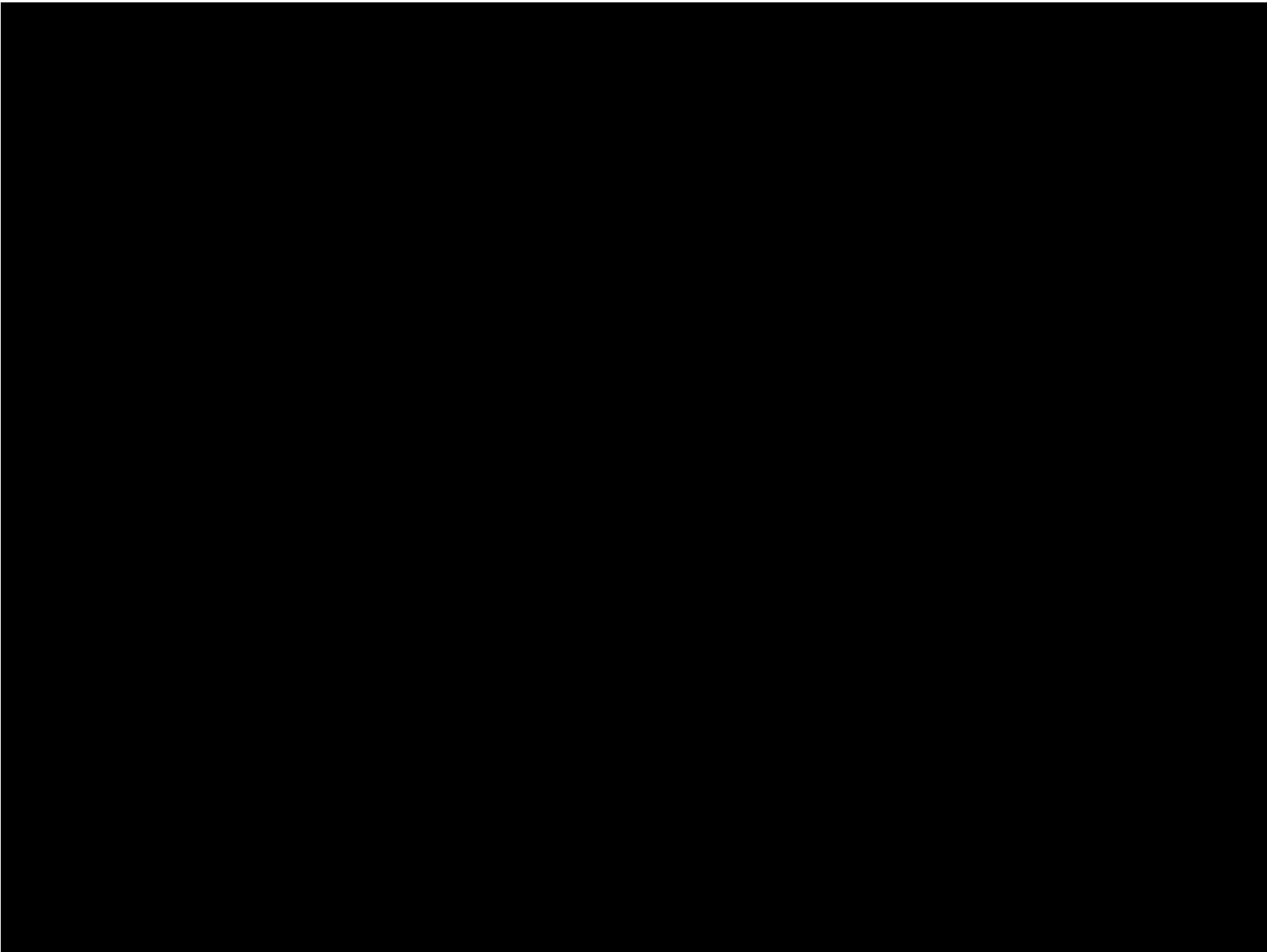
ABC, ACTION FRONT CENTER

Unity

IVY

Dept of Social Svcs

Bath VA



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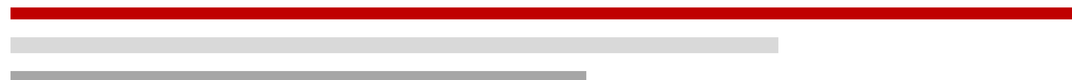
Interventions

Act locally:

- Linkage and retention activities and improvements are unique in the context of:
  - each organization, its patient population and its community
  - each Collaborative, its patient population and its community.

Drilling Down Data



ECMC Patient Retention
1075--# of Patients

118—Excluded (transfers, moves, deceased, incarcerated.

957 pts in pool:
Retained: 823 (86.4%)
Not Retained: 134

Reason	Number of Patients Total: 134	Average VL
Returned to clinic at the end of the reporting period, working with staff on past barriers	40	7336
Unknown – can't reach them due to changed contact information	18	7833
Medically stable – feel well; doing well on treatment, generally state desire to come in as needed; counseled on continued need for monitoring	13	21
Employment – cite difficulties coming to appts due to work schedule	6	258
Disclosure/confidentiality issues – report difficulty coming to clinic due to concerns about who they will see and who will see them	1	20
Ongoing alcohol/substance use- Continued use creates barrier to attendance to medical and other obligations	14	32194
Mental Health- Continued mental health issues create a barrier to attendance to medical and other obligations	8	15044
Insurance instability Since resolved, created temporary issue	1	20
Disengaged/lack of buy-in Staff has successfully contacted the patient but pt does not express understanding of importance medical follow up	13	27436
Family obligations Cite obligations to family, generally care of young children and elderly patients	1	20
Hospitalized off site Long admission to another local health facility	0	
Incarcerated <90 days Not incarcerated long enough to meet exclusion criteria, but did miss appointments as result	2	2210
Refuses treatment Patient expresses they do not wish to continue treatment/medical follow up	3	4942
Dually located:	1	20
Transportation	1	415211
Ongoing Utility/financial	1	272
Other medical issues	1	20
Plans to relocate/transfer	5	26
Housing instability	1	20

Evergreen Medical Group
NY Links SPNS
New Patient Retention 2B

June 2011-May 2012 10/13 retained = 77%	
Reason	Number of Patients
Insurance Issues	2
Incarcerated <90 days, did not meet exclusion requirement, but did miss appointments	1
	Total Patients: 3

August 2011-July 2012 8/11 retained = 73%	
Reason	Number of Patients
Insurance Issues (still in care)	2
Language Barrier/ Lack of available interpreter (still in care)	1
Transferred HIV care back to PCP	1
	Total Patients: 4

NY Links

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The American Red Cross

3. Retention and engagement into HIV Primary Care for supportive services and general medical services

3a. Clinical Engagement Measure

Results: May/June – 77.23% of 101 patients

Reason	Number of Patients 78 yes/23 no
Could not reach	11
None scheduled, good health	4
None scheduled, but should have	2
No primary visit, but went to a specialist	6

4 Guiding Principles of Improvement

- Understanding work in terms of processes and systems
- Developing solutions by teams of providers and patients
- Focusing on patient needs
- Testing and measuring effects of changes

Most problems are found in processes not in people.

NY Links

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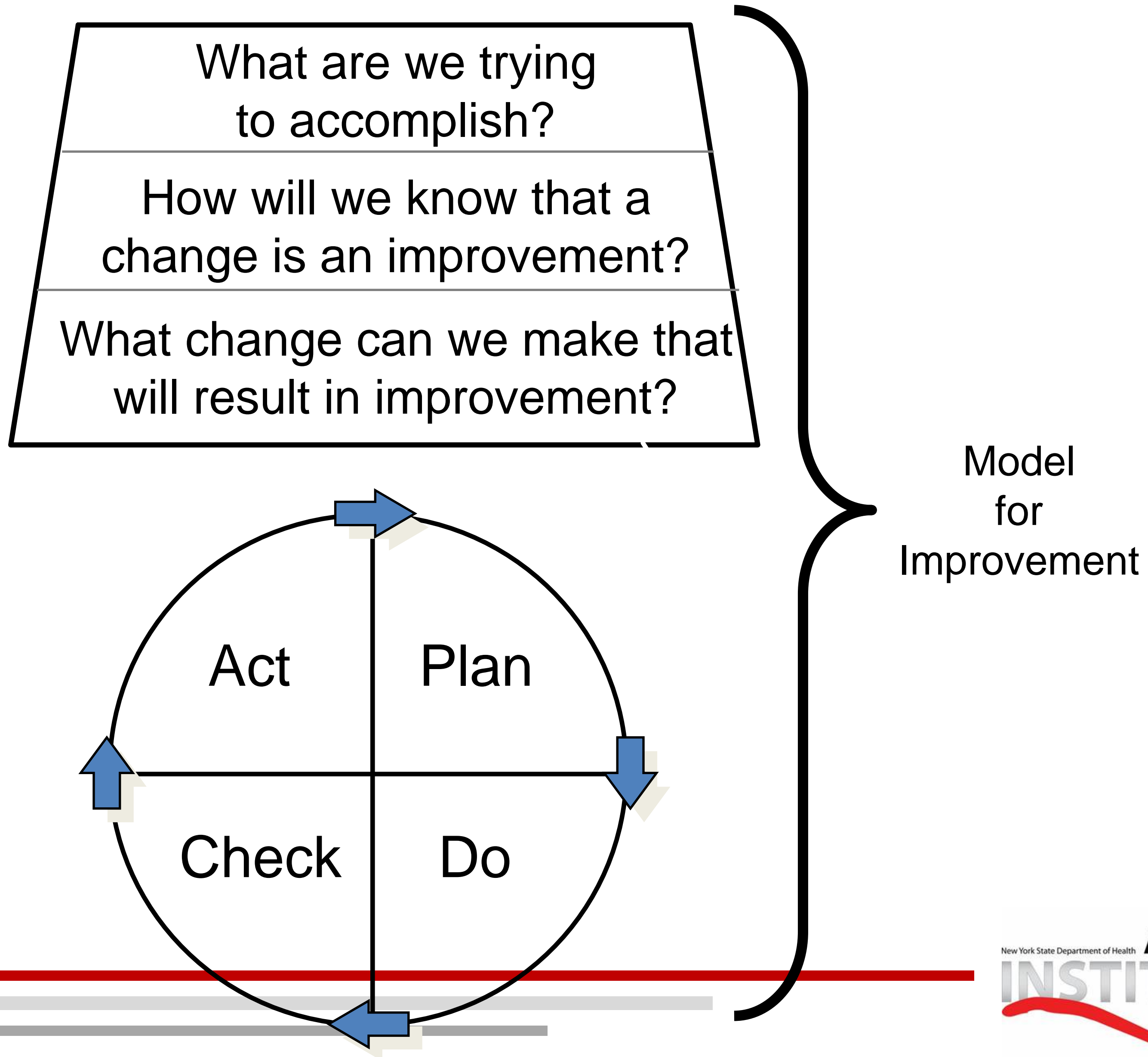
Overview
Why develop a process diagram?

- Rationale:
  - More deeply understand process improvement
    - PDSA – Discern whether change is isolated vs clearly connected to process
  - Promotes better decision making
    - Helps you to see your work as a system, a whole
    - Gathers team thinking
    - Creates buy-in and consensus
    - Functions as a procedure and thus can be used to create protocols and evaluate current ones
    - Promotes wider understanding of process

Resources : HIVQUAL Workbook – flow chart
NQC: National Quality Academy Tutorials – flow chart

Model for Improvement



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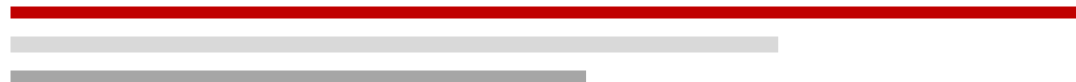
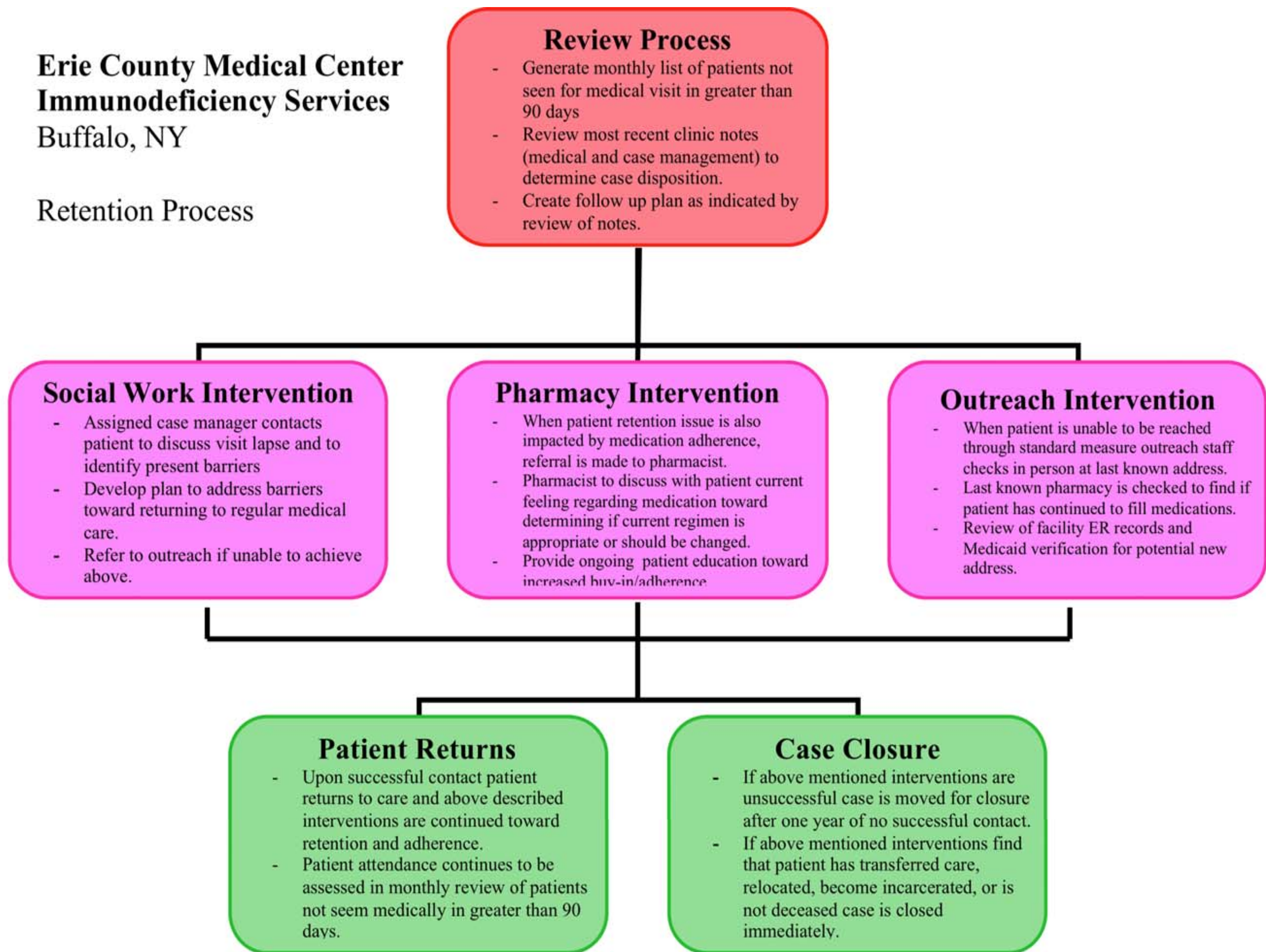
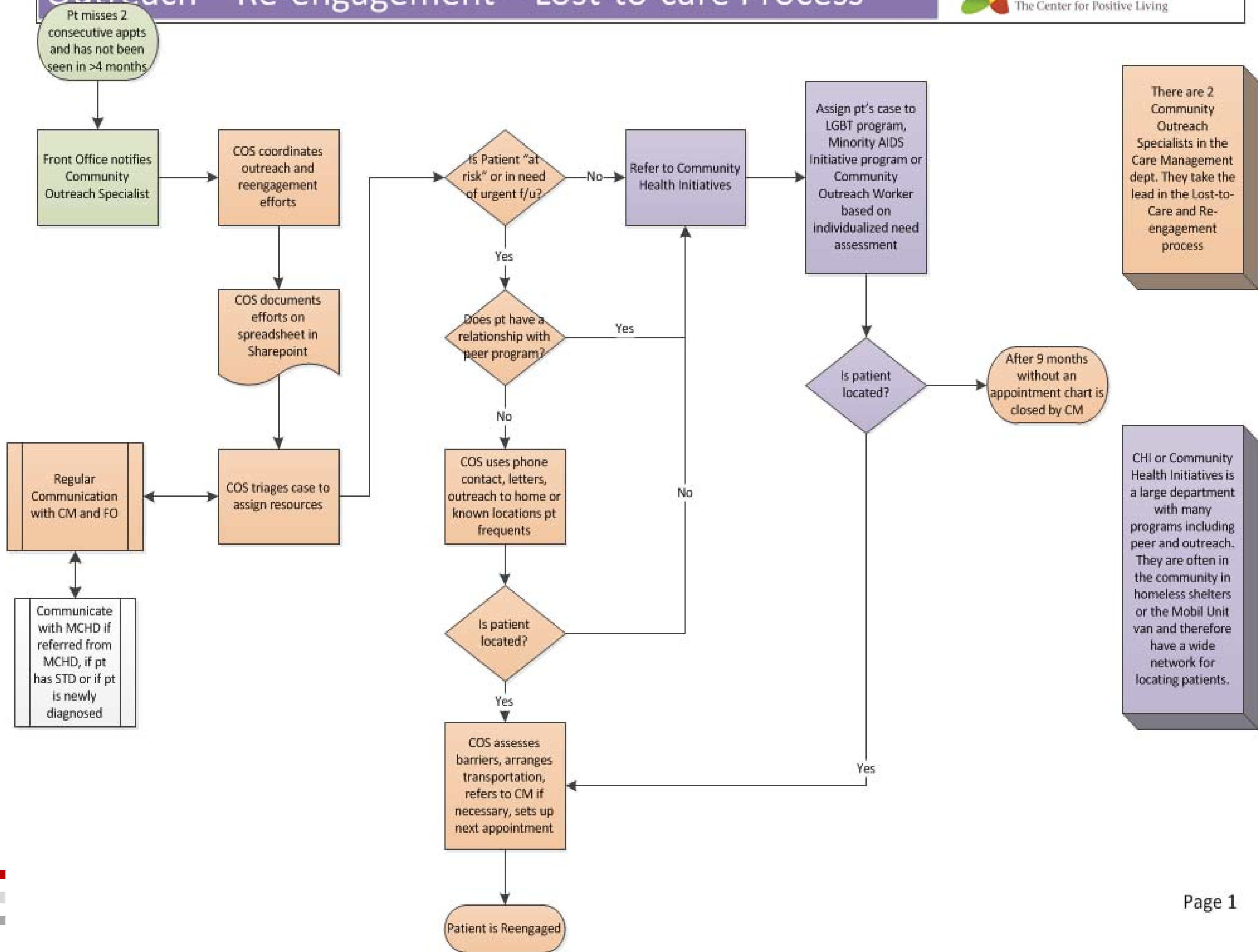
The System

(Under Improvement)





Erie County Medical Center
Immunodeficiency Services
Buffalo, NY
Retention Process
Review Process
- Generate monthly list of patients not seen for medical visit in greater than 90 days
- Review most recent clinic notes (medical and case management) to determine case disposition.
- Create follow up plan as indicated by review of notes.
Social Work Intervention
- Assigned case manager contacts patient to discuss visit lapse and to identify present barriers
- Develop plan to address barriers toward returning to regular medical care.
- Refer to outreach if unable to achieve above.
Pharmacy Intervention
- When patient retention issue is also impacted by medication adherence, referral is made to pharmacist.
- Pharmacist to discuss with patient current feeling regarding medication toward determining if current regimen is appropriate or should be changed.
- Provide ongoing patient education toward increased buy-in/adherence
Outreach Intervention
- When patient is unable to be reached through standard measure outreach staff checks in person at last known address.
- Last known pharmacy is checked to find if patient has continued to fill medications.
- Review of facility ER records and Medicaid verification for potential new address.
Patient Returns
- Upon successful contact patient returns to care and above described interventions are continued toward retention and adherence.
- Patient attendance continues to be assessed in monthly review of patients not seem medically in greater than 90 days.
Case Closure
- If above mentioned interventions are unsuccessful case is moved for closure after one year of no successful contact.
- If above mentioned interventions find that patient has transferred care, relocated, become incarcerated, or is not deceased case is closed immediately.



Outreach – Re-engagement – Lost-to-care Process
AIDS CARE
The Center for Positive Living
Pt misses 2 consecutive appts and has not been seen in >4 months
Front Office notifies Community Outreach Specialist
COS coordinates outreach and reengagement efforts
COS documents efforts on spreadsheet in Sharepoint
COS triages case to assign resources
Regular Communication with CM and FO
Communicate with MCHD if referred from MCHD, if pt has STD or if pt is newly diagnosed
Is Patient "at risk" or in need of urgent f/u?
No
Yes
Does pt have a relationship with peer program?
Yes
No
COS uses phone contact, letters, outreach to home or known locations pt frequents
Is patient located?
No
Yes
COS assesses barriers, arranges transportation, refers to CM if necessary, sets up next appointment
Patient is Reengaged
Refer to Community Health Initiatives
Assign pt's case to LGBT program, Minority AIDS Initiative program or Community Outreach Worker based on individualized need assessment
Is patient located?
Yes
After 9 months without an appointment chart is closed by CM
There are 2 Community Outreach Specialists in the Care Management dept. They take the lead in the Lost-to-Care and Re-engagement process
CHI or Community Health Initiatives is a large department with many programs including peer and outreach. They are often in the community in homeless shelters or the Mobil Unit van and therefore have a wide network for locating patients.

DATE	PATIENT NAME	Referral Made By:	Level of engagement- Re-engagement/ Lost-to care	Language	CHI Grant	PROVIDER	Outreach Completion Date	1=complete 0=incomplete	COS working with Patient	Notes GREEN = APPOINTED SCHEDULED GRAY= APPOINTMENT ATTENDED YELLOW= MISSED FOLLOW UP APPOINTMENT RED = CANCELLED/ CLOSED/ REFERRAL COMPl
7/1/12		Front Office	Re-engagement			Mancenido		1	Lilly	Patient continues to no show- LF 10/30/12 8/15: t/c
7/1/12		Honnick	Re-engagement			Mancenido		1	Lilly	Missed appointment on 9/27/2012, scheduled to meet
9/6/12		Honnick	Re-engagement			Mancenido		1		COS Lilly provided escort to agency and complet
9/7/12		Brown	Re-engagement			Mancenido		0		Home visit on 9/16 a note was left to call CM julian or
10/17/12		Front Office	Re-engagement					1		attended appointment on 11/14/2012
10/25/12		Front Office	Re-engagement							
10/24/12		Front Office	Re-engagement							
10/19/12		Front Office	Re-engagement							
10/15/12		Front Office	Re-engagement							
10/15/12		Front Office	Re-engagement	English	MSM					
10/9/12		Front Office	Re-engagement							
9/18/12		Front Office	Re-engagement							
9/12/12		Front Office	Re-engagement							
9/24/12		Jackson	Re-engagement	English	an					
9/6/12		Front Office	Re-engagement							
		Front Office	Re-engagement	English	MSM					
10/30/12		COS	Re-engagement			Mancenido				
10/30/12		COS	Re-engagement	English	o	Mancenido				
10/30/12		COS	Re-engagement			Mancenido				
10/30/12		COS	Re-engagement			Corales				
9/18/12		Front Office	Re-engagement			Corales				
10/30/12		COS	Re-engagement			Mancenido				
9/8/12		Seffens	Re-engagement							
		Front Office	Re-engagement			Mancenido				
9/13/12		Front Office	Re-engagement			Corales				
		Front Office	Re-engagement			Schaefer				
6/19/12		Madison	Re-engagement			Corales				
11/8/12		CM Tanya	Re-engagement			Corales				
11/14/12		CM Abby	Re-engagement		ro					
11/14/12		CM Devin	Re-engagement	English/ spanish	Hetero					
11/30/12		CM Julian	Re-engagement	English	o	Valenti			Lilly	Left contact information via phone call with patient's v
11/30/12		CM Tanya	Re-engagement	English	an	Mancenido				Scheduled CM appointment for 12/13 @ 2:00 pm
12/10/12		CM Julian	Re-engagement	English	MSM	Mancenido				
12/17/12		CM Tanya	Re-engagement	English	o	Schaefer				
							Total	18		

AIDS Care. This is the spreadsheet Community Outreach Specialists use to track referrals for patient follow-up, language barriers, connection to Community Health Initiative programs and and progress with re-engagement.

AIDS Care use of EMR log notes to communicate interventions taken by Front Office, Community Outreach and Care Management

Telephone, Log and Prescription Notes

- 02/20/2013 NO SHOW
  Truong, Yen
- **02/20/2013 Medical**
  Quinones, Abigail
- **02/13/2013 Face To Face**
  Quinones, Abigail
- **02/06/2013 Face to Face**
  Quinones, Abigail
- **02/05/2013 MHT**
  Quinones, Abigail
- 02/05/2013 Serrano, Alma
- **02/01/2013 Face to Face**
  Quinones, Abigail
- **01/28/2013 Reassessment and Service Plan Goals**
  Quinones, Abigail
- **01/25/2013 R/A and Service Plan Goals**
  Quinones, Abigail
- **01/23/2013 Follow Up**
  Quinones, Abigail
- 01/14/2013 NO SHOW
  Truong, Yen
- 01/07/2013 Transportation/Bus Passes
  Brown, Julian
- **01/04/2013 Medical**
  Quinones, Abigail
- **11/30/2012 Medical**
  Quinones, Abigail
- **11/29/2012 Medical, Referral**
  Quinones, Abigail
- 11/29/2012 Referral to Outreach
  Flores, Lilly
- **11/15/2012 FOLLOW UP**
  Quinones, Abigail
- **11/14/2012 Medical**
  Quinones, Abigail
- 11/08/2012 NO SHOW
  Truong, Yen

Frequent CM contact to engage in MH and Substance use treatment

Re-engaged with CM

Patient returned to care with provider on 1/7/2013 after 6 months

Assistance with barriers

Referral to Community Outreach

Front Office documentation

UNIVERSITY of ROCHESTER MEDICAL CENTER

Strong Memorial Hospital
Infectious Diseases Clinic

PDSA:

PI Indicator (Important Function): No-Show Rate

Why was this indicator selected? To attain viral load suppression of HIV positive patients through improved retention of patients in HIV care. NYLinks reports have identified that patient retention needs improvement.

Plan

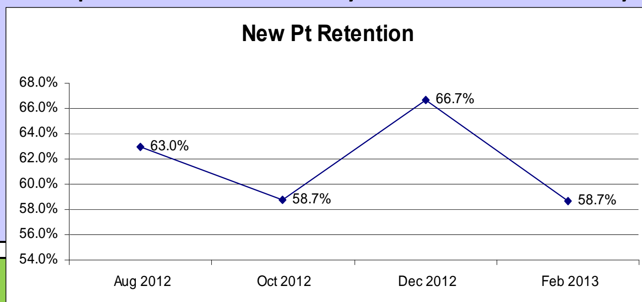
- Improve patient retention rates, reduce number of patient "no-shows".

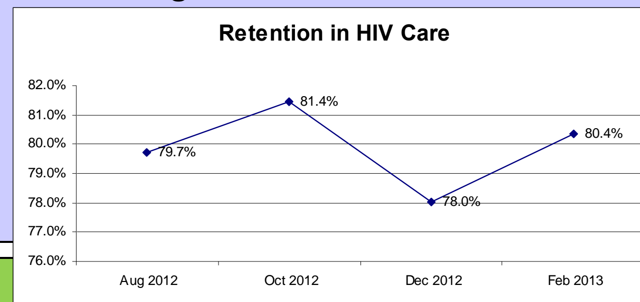
Do

- Nursing and social workers are meeting every other week after case management to review the HIV patient "no show" list from the prior week. The staff discuss reasons why patients are missing appointments and social workers are following up with patients and/or their case managers re these missed appointments. This information is being transferred to an intranet data sharing program.

Study

- The HIV Clinic SPNS Committee reviews the intranet data monthly to identify trends and other systemic issues. The SPNS Committee presents this analysis to the monthly HIV Clinic staff meeting.





Act

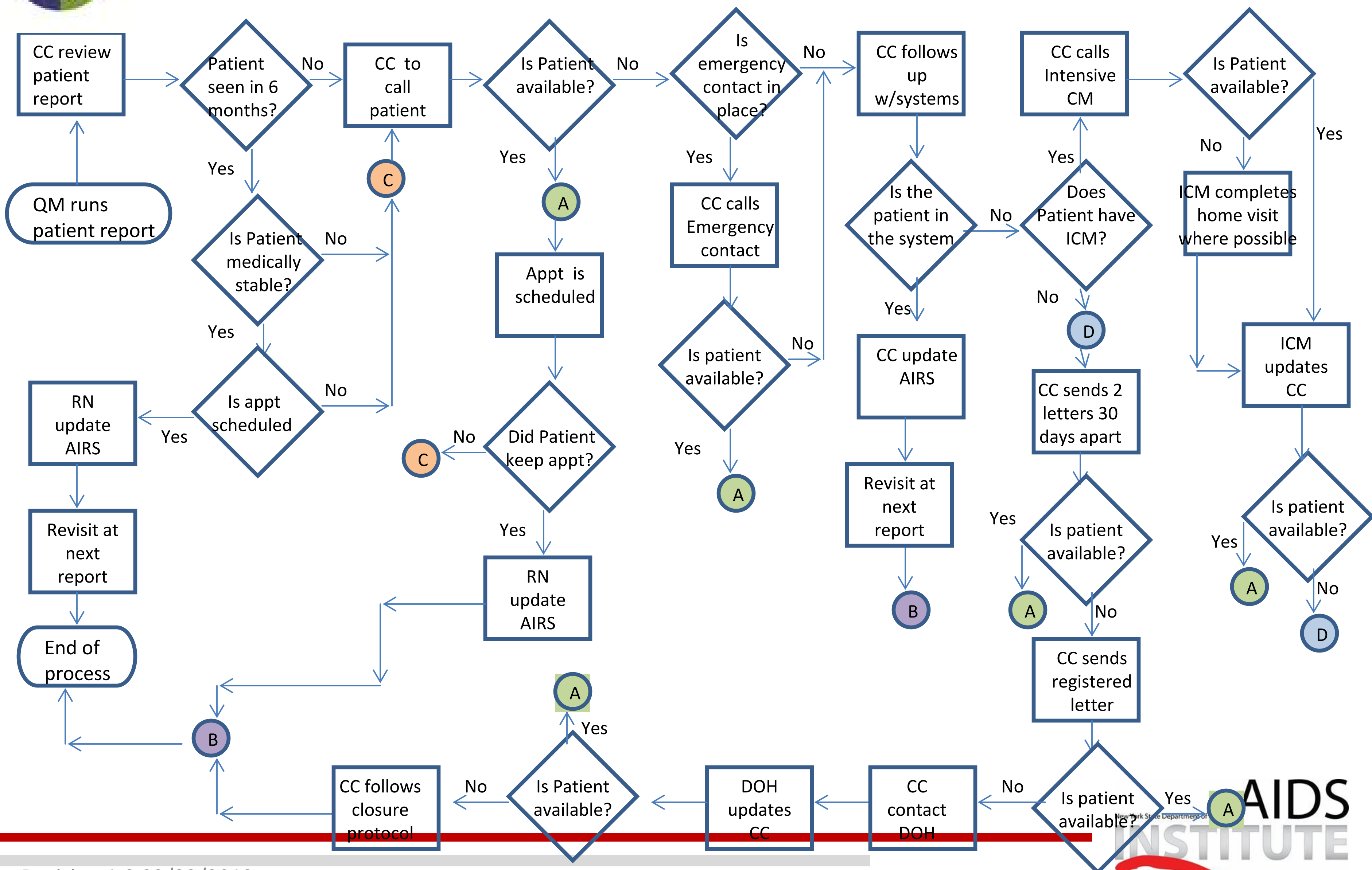
- Staff members discuss results/analyses and provide recommendations to improve outcomes.

Goal: New Patient Retention of 65%; Current Patient Retention of 85%

ANTHONY JORDAN

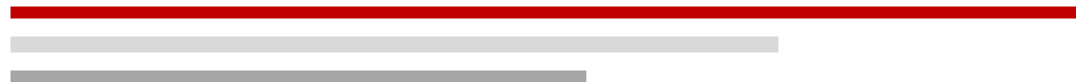
PPC- Primary Care

Patient Retention Complete Process

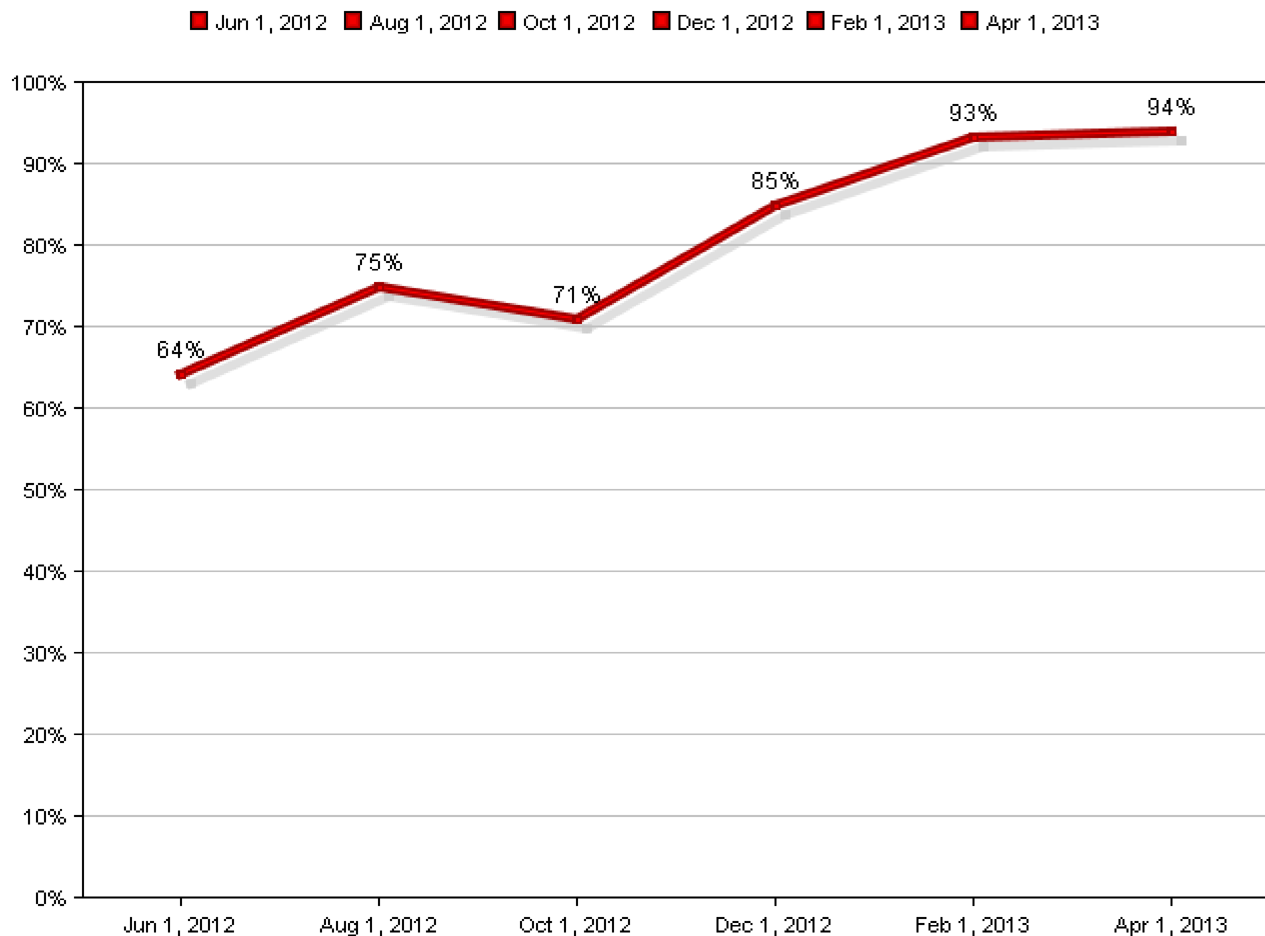


The System

(Initial Results)



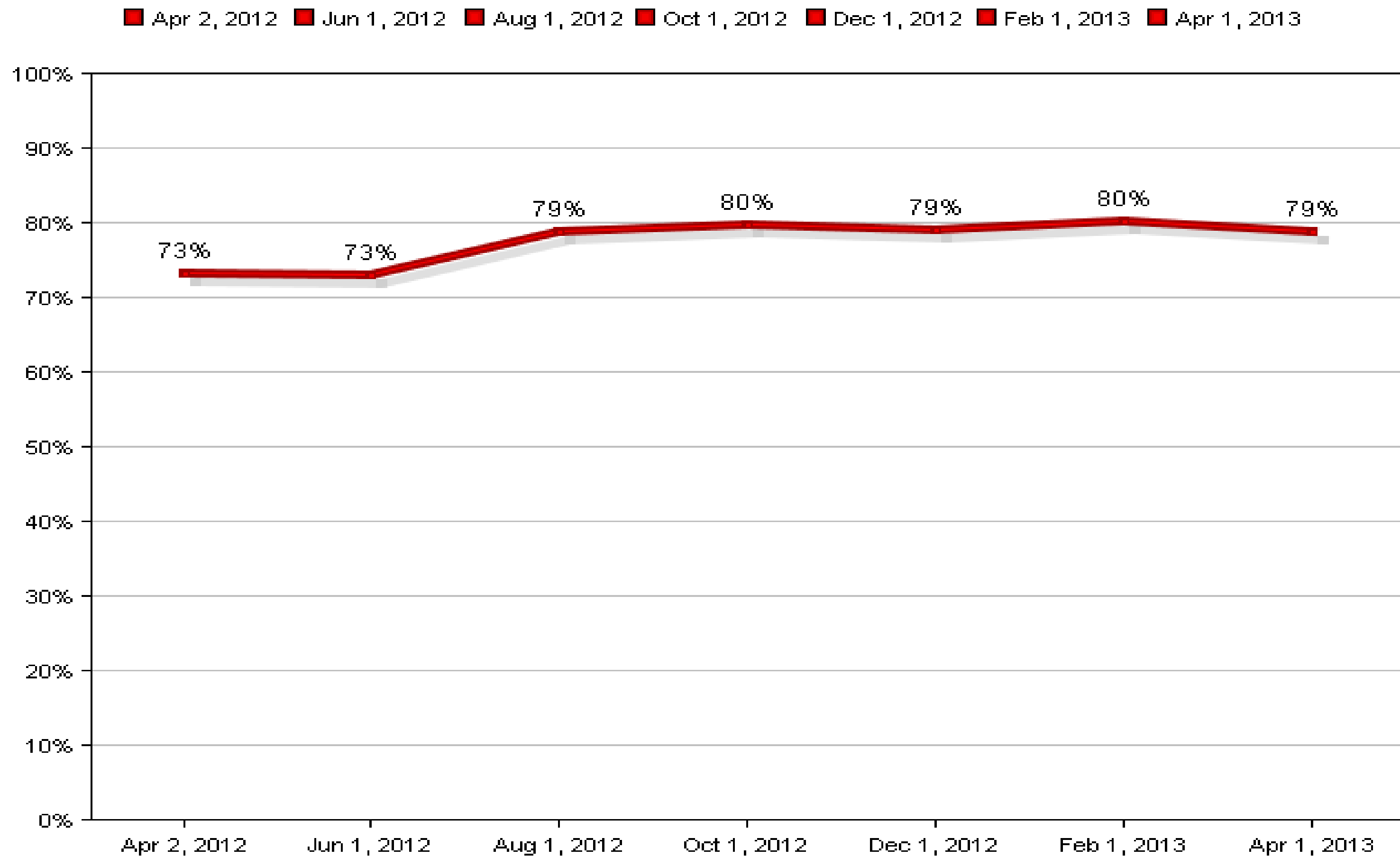
Linkage to Care: % of newly diagnosed patients who had their first HIV primary care visit within 30 days of the date of their confirmatory HIV test result



NY Links

New York State Department of Health AIDS INSTITUTE

Retention: % of HIV pts, regardless of age, who had at least one medical visit with a provider with prescribing privileges in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits



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The Goal