VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Re-engagement into HIV Care: An Urban Communities Model

By: Jamie M. Roques, MPA, MPH, APRN and William Spatafora, MPA

Learning Objectives

At the end of this session participants will be able to:

- Accurately identify the HIV out of care cohort by utilizing data drill down approaches from multiple databases
- Collaborate with appropriate internal and external partners to develop a re-engagement into HIV care model
- Provide a comprehensive team approach for re-introducing patients back into HIV care
- Maintain re-engaged patients' HIV care

QI Project Background

- HIV Gaps in Care is a HAB measure that we have identified as an area needing improvement.
- The goal is <20% and when we began this project, we were at 22%.
- The team is testing several interventions with this cohort in addition to the BAAL sub-population.
- Viral load suppression is a key indicator of HIV healthcare, so we are tracking the VLS of those who have re-engaged into care.

Re-Engagement into HIV Care

Facility Name: Open Health Care Clinic

Location: 3801 North Blvd, Baton Rouge, LA 70806

Project Information

Project Start Date: April 2019

Completion Date: September 2019

Project Team

Team Lead

- Jamie Roques, MPA, MPH, APRN (Director of Nursing, Team Lead)

Data Team

- Jason Kraemer, RN, BSN (Nurse Manager, Quality Improvement)
- Suzanne Metoyer (Ryan White Program Manager)
- La-Shantlen Russ, MPA (Quality Manager)
- William Spatafora, MPA (Quality Data Analyst)
- Shelley Warrington, RN, BSN (RN Team Lead)

Re-Engagement Team

- Bettina Boone, MPH (Health Models Coordinator)
- Eugene Collins (Director of Community Services)
- Tasia Clayton, RN, BSN (PrEP/PEP Case Manager)
- Meta Smith-Davis (Asst Director of Community Services)
- Maranath Graugnard, RN, BSN (RN Community Services)
- Mary Heintz, RN, BSN (Behavioral Health RN Case Manager)

IMPROVEMENT OPPORTUNITY

Project Goal

- Reduce gap in care from 22% to below 10% by reducing:
  - The number of out of care PLWH from May 2019 to September 2019 by 50%.
  - Data source:
    - Number of OHCC *Out of Care* reconciled list received back from the Louisiana Dept of Health

- Overall increase:
  - The number of PLWH re-engaged in care by 50%

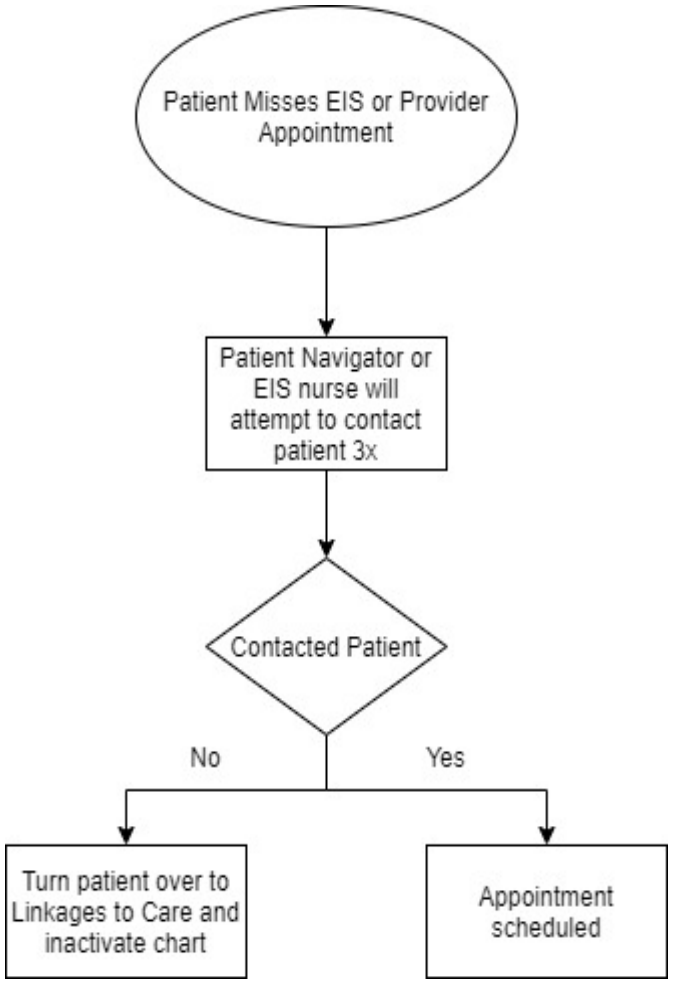
Scope of Re-engagement

To improve the following:

- Accurate out of care lists- generating list to verification
- List management by Multidisciplinary Team (MDT)- understanding individual patient barriers to creating and monitoring implementation of plans
- Re-engagement of out of care patients- implementation of targeted plans to locate patients, schedule them, and support them in keeping medical appointment

Processes

Initial Re-engagement Process Map

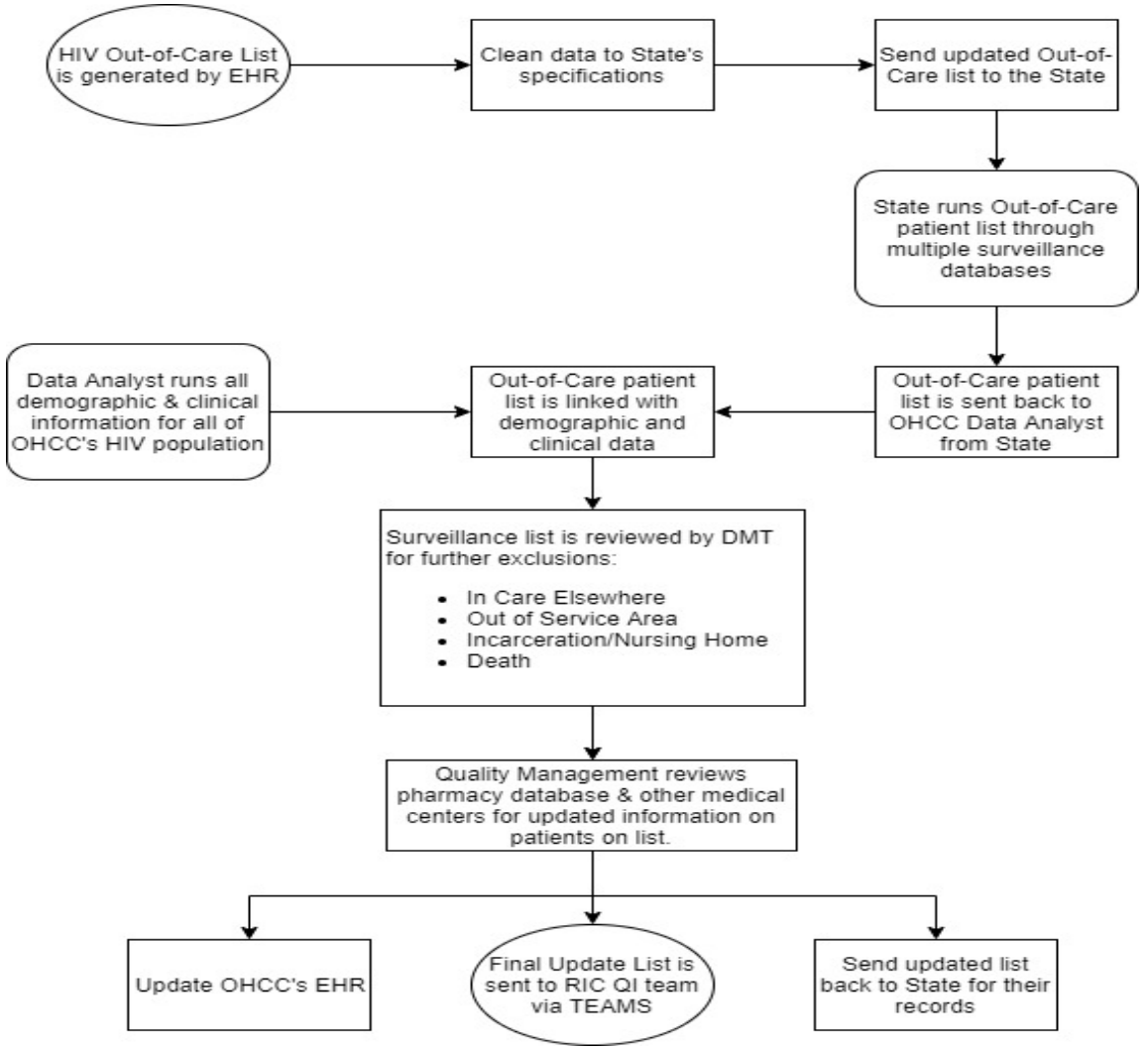


Improvement Opportunity

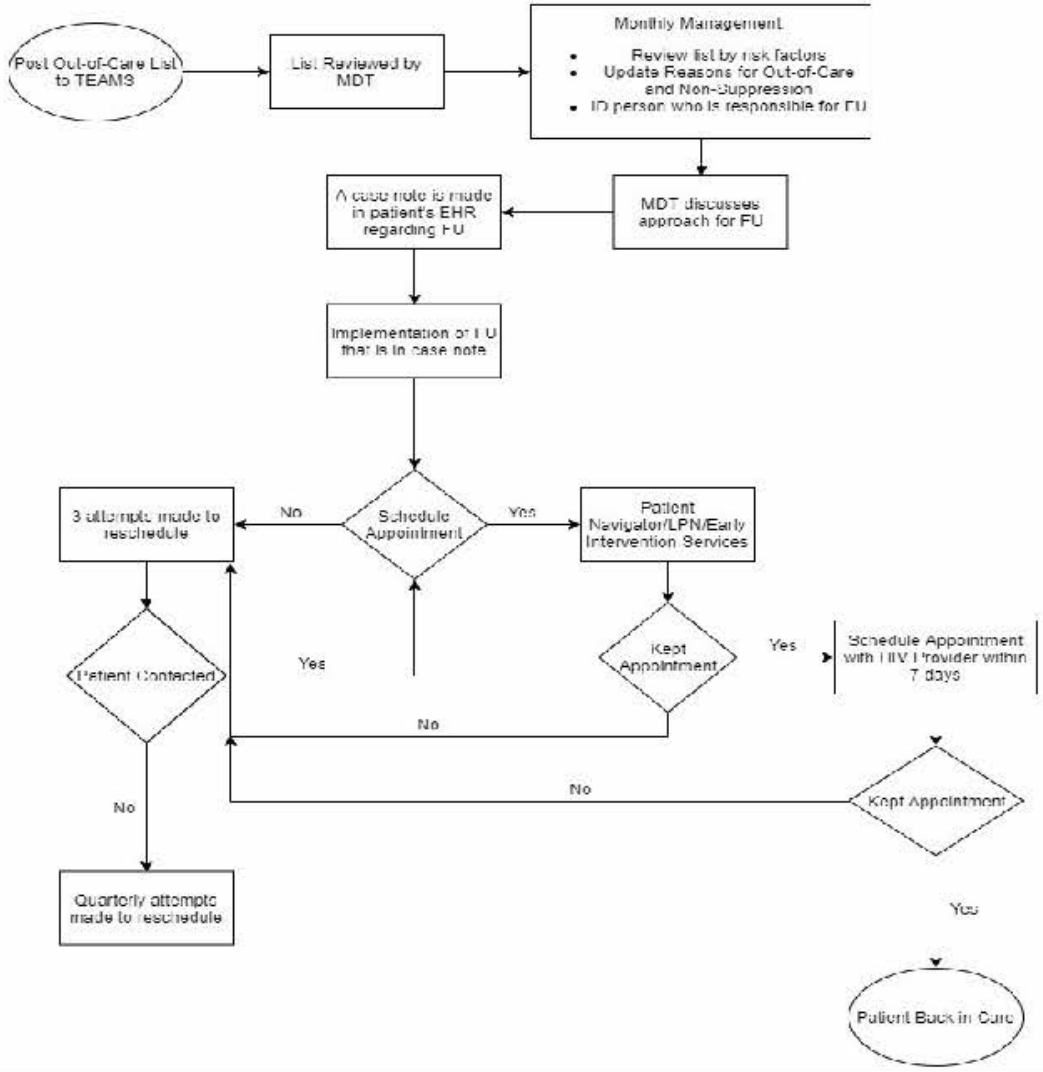
- Coordinating with the state to better identify OHCC's "true" number of HIV patients that have been out of care for >6 months.

- Re-work our own process of introducing HIV patients back into care.

New Data Process Map



Revised Re-engagement Process Map



Measures and Data

Measure Definitions

Gap in Care- Percentage of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year

Out of Care- HIV+ patients with no HIV clinical encounter (includes medical visit & labs) in the last 6 months

Returned to Care- Patient with first returning medical visit with an HIV provider

Viral Load Suppression- less than 200 copies/mL

Exclusion Criteria

Patients living with HIV that meet the following criteria:

- Moved out of service area
- In care elsewhere
- Death
- Other (incarceration, nursing home, etc)

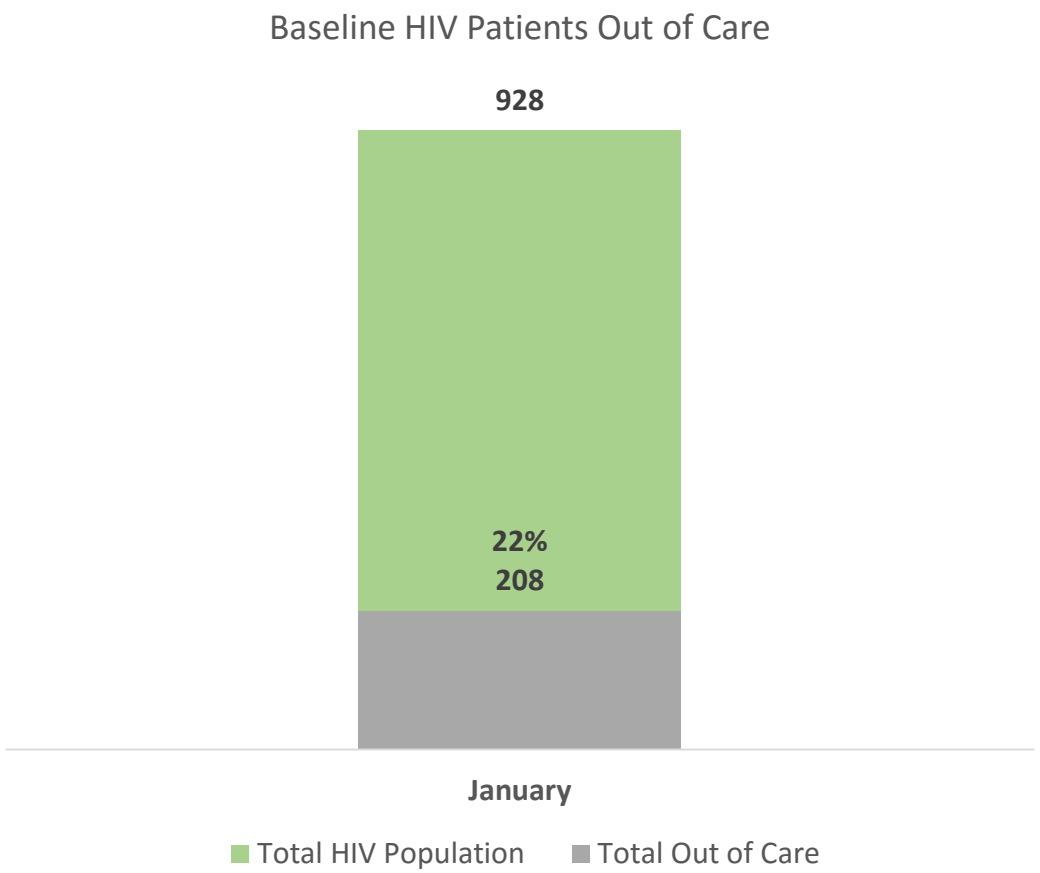
OHCC HIV Out of Care Population Characteristics as of January 2019

Patient Sex	N	%
F	64	30.77%
M	144	69.23%
Grand Total	208	100.00%

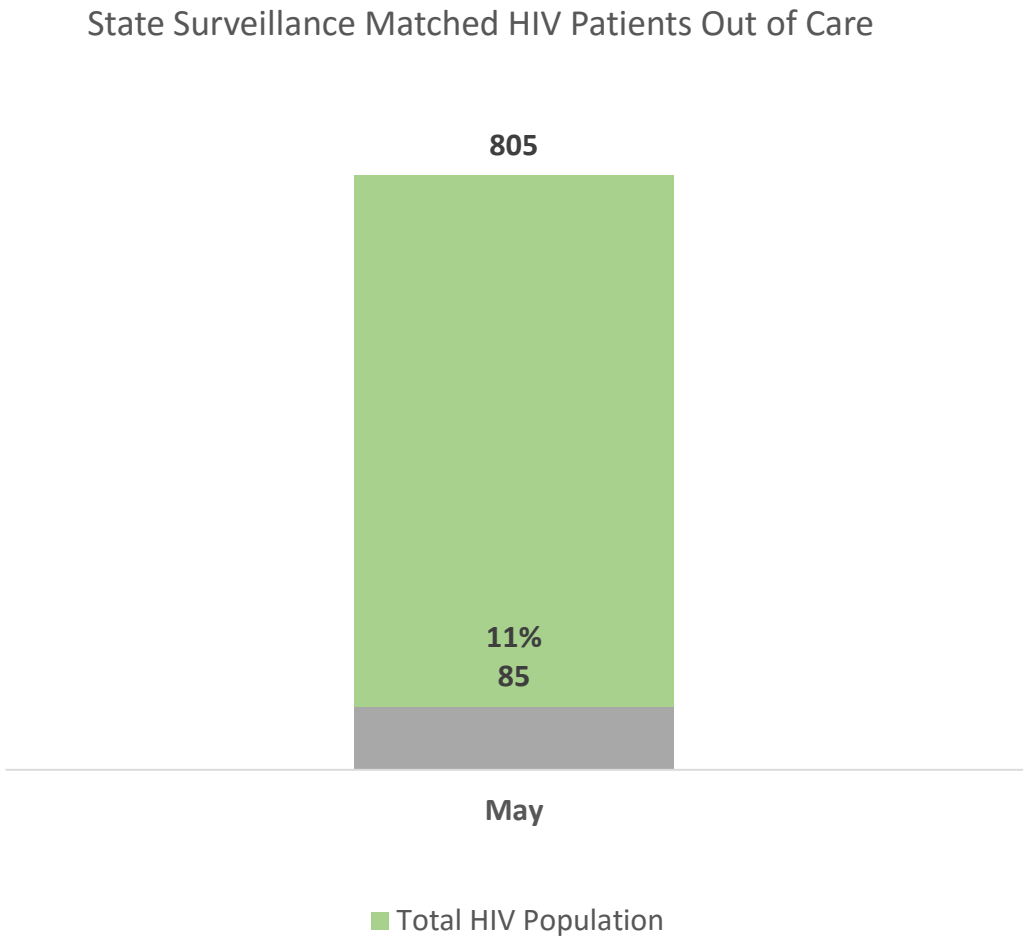
Race	N	%
Female		
Black or African American	52	25.00%
White	12	5.77%
Male		6
Black or African American	103	49.52%
White	41	19.71%
Grand Total	208	100.00%

Patient Sexual Orientation	N	%
Bisexual	5	2.40%
Don't know	53	25.48%
Lesbian, gay or homosexual	53	25.48%
Straight or heterosexual	97	46.63%
Grand Total	208	100.00%

1st Data Set Submitted: OHCC Out of Care Distribution



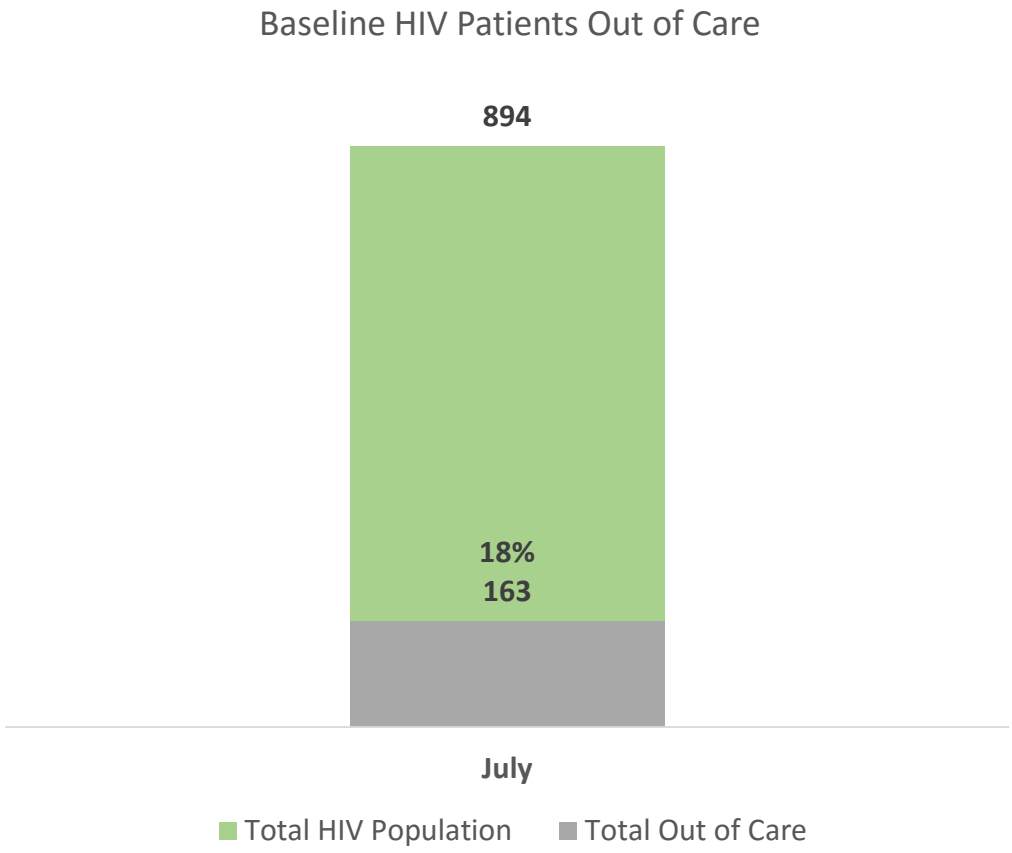
State Surveillance Data Received: Out of Care Baseline Data



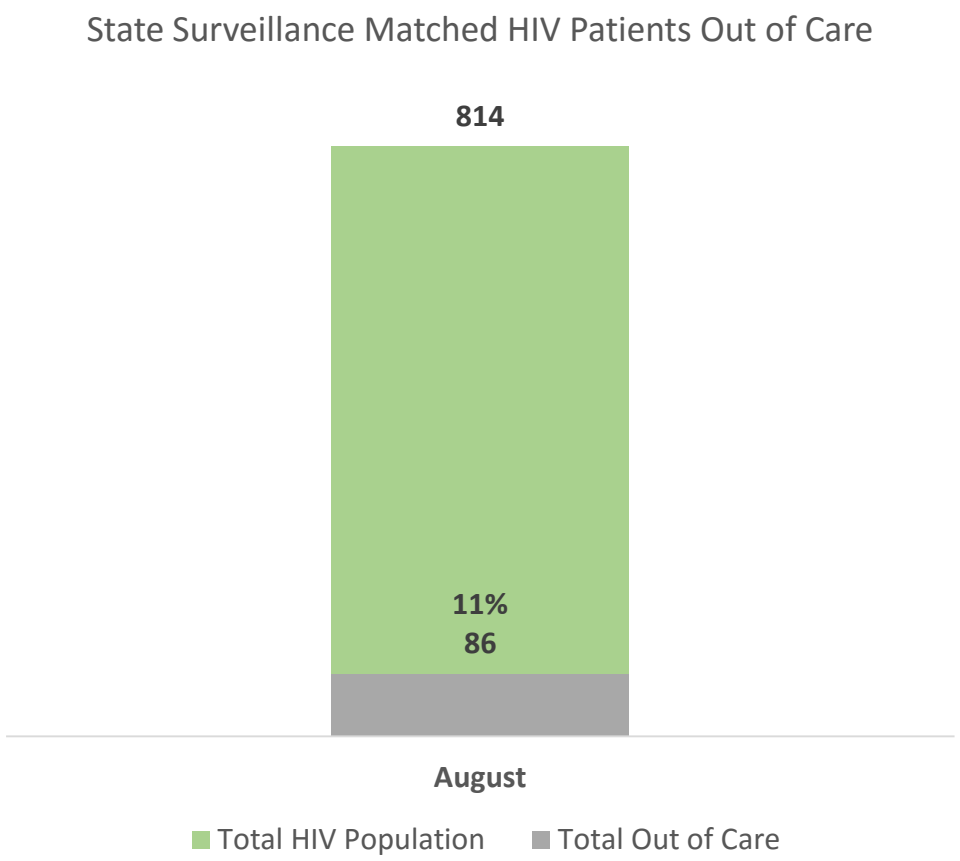
Outcomes of New Processes #1

Patient Status	N	%
Back In Care	10	11.76%
Moved Out of Service Area	9	10.59%
In Care Elsewhere	7	8.24%
Other	3	3.53%
Out of Care	56	65.88%
Grand Total	85	100.00%

2nd Data Set Submitted: OHCC Out of Care Distribution



State Surveillance Out of Care Baseline Data



Outcomes of New Processes #2

Patient Status	N	%
Back In Care	29	33.72%
Moved Out of Service Area	13	15.12%
In Care Elsewhere	11	12.79%
Other	5	5.81%
Out of Care	28	32.56%
Grand Total	86	100.00%

Overall Outcomes

- New Processes #1:
  - **206** Out of Care in January
  - **85** Out of Care in May
  - **56** Out of Care in June
- % Out of Care decreased in January – June by **73%**

- New Processes #2:
  - **164** Out of Care in July
  - **86** Out of Care in August
  - **28** Out of Care in September
- % Out of Care decreased in July – September by **83%**

In summary

- **Our 2 goals were to:**
  - Decrease gaps in Care to below 10%
  - Increase the number of patients back into care by 50%
- **Findings**:
  - Gaps in Care = 3.5%
  - Patients returned to care = 67%

Lessons Learned

- Having a multi-disciplinary team approach is the way to go.
- Having a provider actively participate in the re-engagement initiative is vital (monthly meetings).
- We revised workflow for patients returning to care by tag teaming the EIS Nurse with the Patient Navigator to work with the patient in hopes of maintaining them in care.
- We realized that it was necessary to flag out of care patient's electronic health record so that we could ensure that when they returned to our clinic for any service their HIV needs would be addressed.
- We identified alternative sources to obtain current patient contact information such as contact info from patient's last known pharmacy.
- Having the Health Dept reconcile our out of care data set with their surveillance data set helped us not spend time and energy on patients that were truly no longer ours:
  - in the 1st data set submitted we sent in 208 patients to the state and received 85 back (60% reduction)
  - in the 2nd data set submitted we sent in 168 patients to the state and received 86 back (48% reduction).

Contact Information:

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Questions ?