2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

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Bridging the data (systems) divide! Integrating data systems for better HIV reporting and care coordination- Group session 11079

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Piper Duarte- Parkland Health & Hospital System;

Mari Millery, Jesse Thomas, Daisy Gely- Northeast/Caribbean AETC

Session Overview:

Whether building bridges across data silos or care silos, or responding to a disaster, information exchange is critical. Effective data exchange can address the problems of patient mobility, care coordination, and population data needs, and will help achieve the NHAS goals. But if left isolated and uncoordinated, data systems create duplication of efforts, reporting difficulties, and disconnected clinical care.

Three diverse regions and care landscapes bring their challenges and successes with integrating data systems to bridge the information divide. Boston enhanced their Electronic Health Records (EHRs) with additional reporting software; Dallas leveraged their EHR to its full breadth for comprehensive evaluation, while Puerto Rico prepared HIV care settings for the emerging policy trends and requirements of a Health Information Exchange (HIE), after the need was amplified in the aftermath of the devastating 2017 hurricanes. Bridging the data divide, providers are able to share data with external agencies, generate internal reports, improve data governance, and support communication between key stakeholders.

Join HIV care agencies who are maximizing data utilization to improve access and coordination of care at their own organizational level, while building infrastructure needed to move toward a national HIE, all implemented with the aim of benefitting the patient.

Session Objectives:

- Understand the process to implement an interface between Electronic Health Records (EHR) and HRSA reporting systems (CAREWare)
- Identify ways data consolidation can improve care coordination
- Identify methods to assess the need for health information exchange in HIV care settings

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From the field #2: Harnessing EPIC to ensure Standards of Care while optimizing Care Coordination

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Special thanks to the following stakeholders who allowed me to bring our work to you: Gwendolyn Martin, Case Management Manager; Tuula Persson, RN Case Manager; Sridhar Kandakuri, Applications IT; HIV Analytics Team

In a large, urban HIV clinic system, how can EPIC be harnessed to deliver valuable (and required) information?

Parkland HIV Services Department (PHSD) objectives: share experience to better

- Understand how EPIC can help ensure Standards of Care
- Identify ways data can be utilized for standardization
- Identify ways data consolidation can impact care coordination

Background

Clients entering care at Parkland HIV Services receive a comprehensive set of assessments, allowing them to be eligible to receive care and identify need.

Baseline audit highlighted the need for documentation to be migrated to EPIC to enable review alongside their clinical care. Though case management provided numerous referrals for partner agency services, clear documentation of referral tracking was absent.

- Issues:
  - *Dual Entry*
  - *Assessments could not be reviewed by clinic*
  - *Comparative and historical referrals unable to be viewed*
  - *Unable to track referral & follow up*
  - *Frequency of contact by MCM didn't match ACUITY of client*

Project AIM & GOALS:

AIM: Create Flowsheets within EPIC to meet

- Standards of Care
- Optimize Care Coordination
- Eliminate dual documentation
- Create Referral Tracking

- GOALS:
  - Increase clients initially assessed for ACUITY to 70%
  - Increase clients with updated Care Plans to 70%
  - Increase automated reporting *within* EPIC for Standards of Care

EPIC Migration: objectives to achieve goal

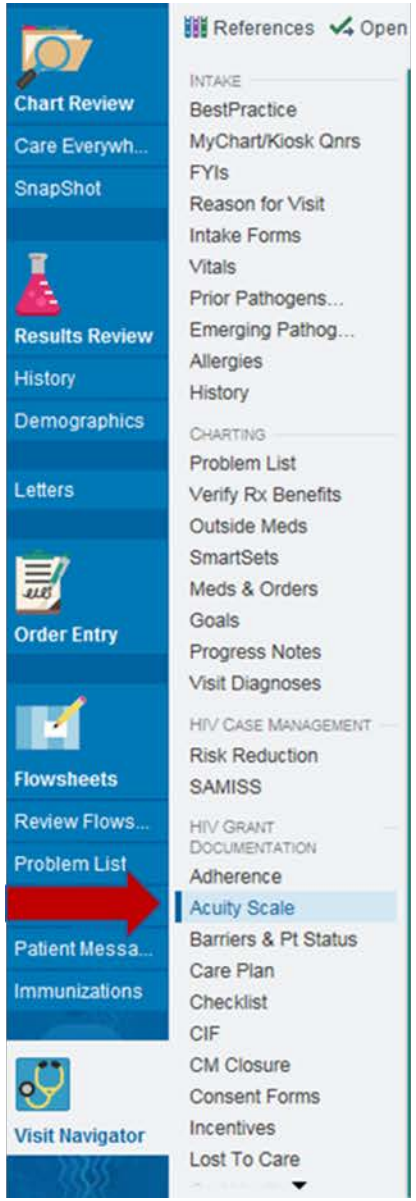
1. Use Standards of Care as Guide
2. Leverage Ambulatory IT to build CM Navigator within EPIC
3. Meet Weekly with Stakeholders
4. Create Flowsheets

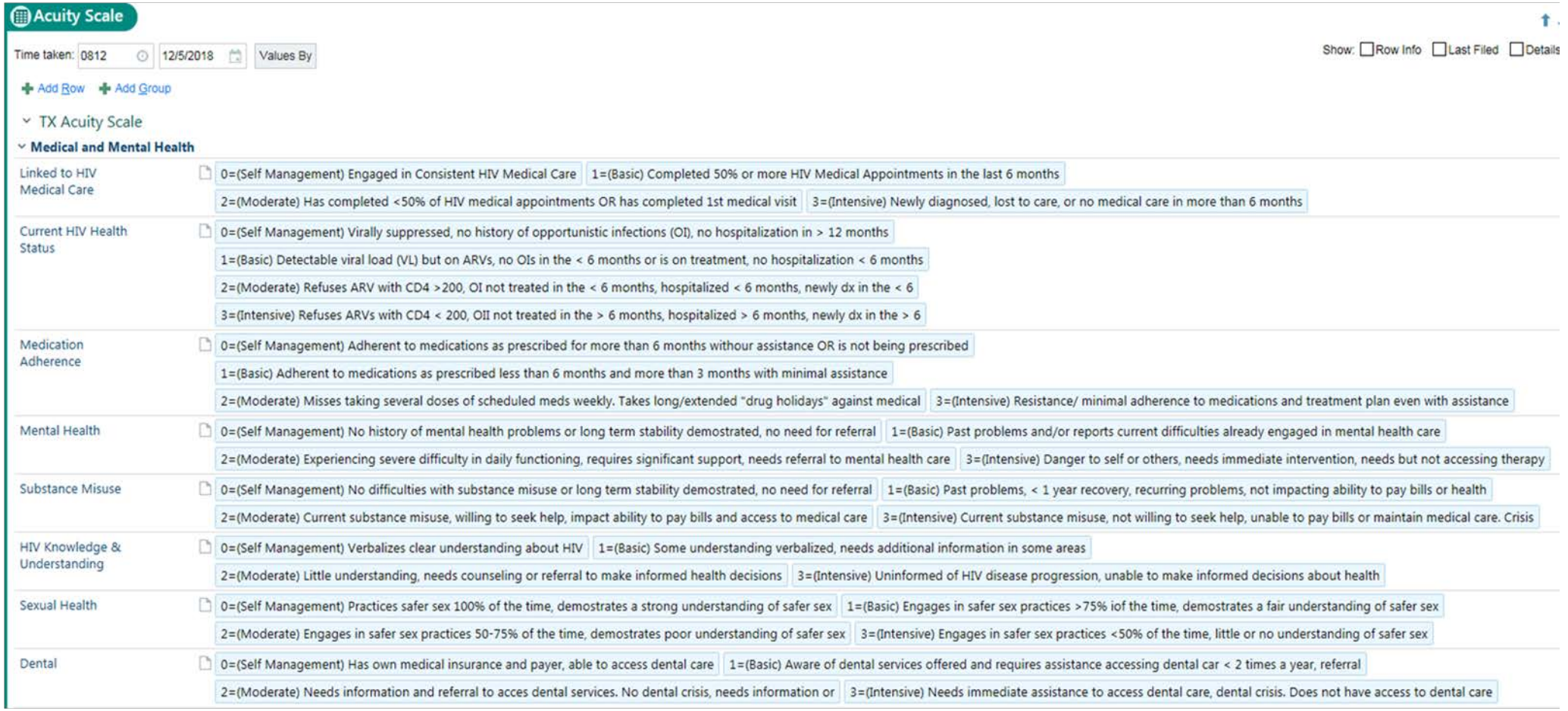
- Evaluating processes informed IT to assist the Flowsheet build
- Standards of Care could be ‘mimicked’ to reflect all data capture needs
- Distinct fields allows for reports to ensure fidelity & show progress
- Remove dual entry!

Care Coordination Impact: an example

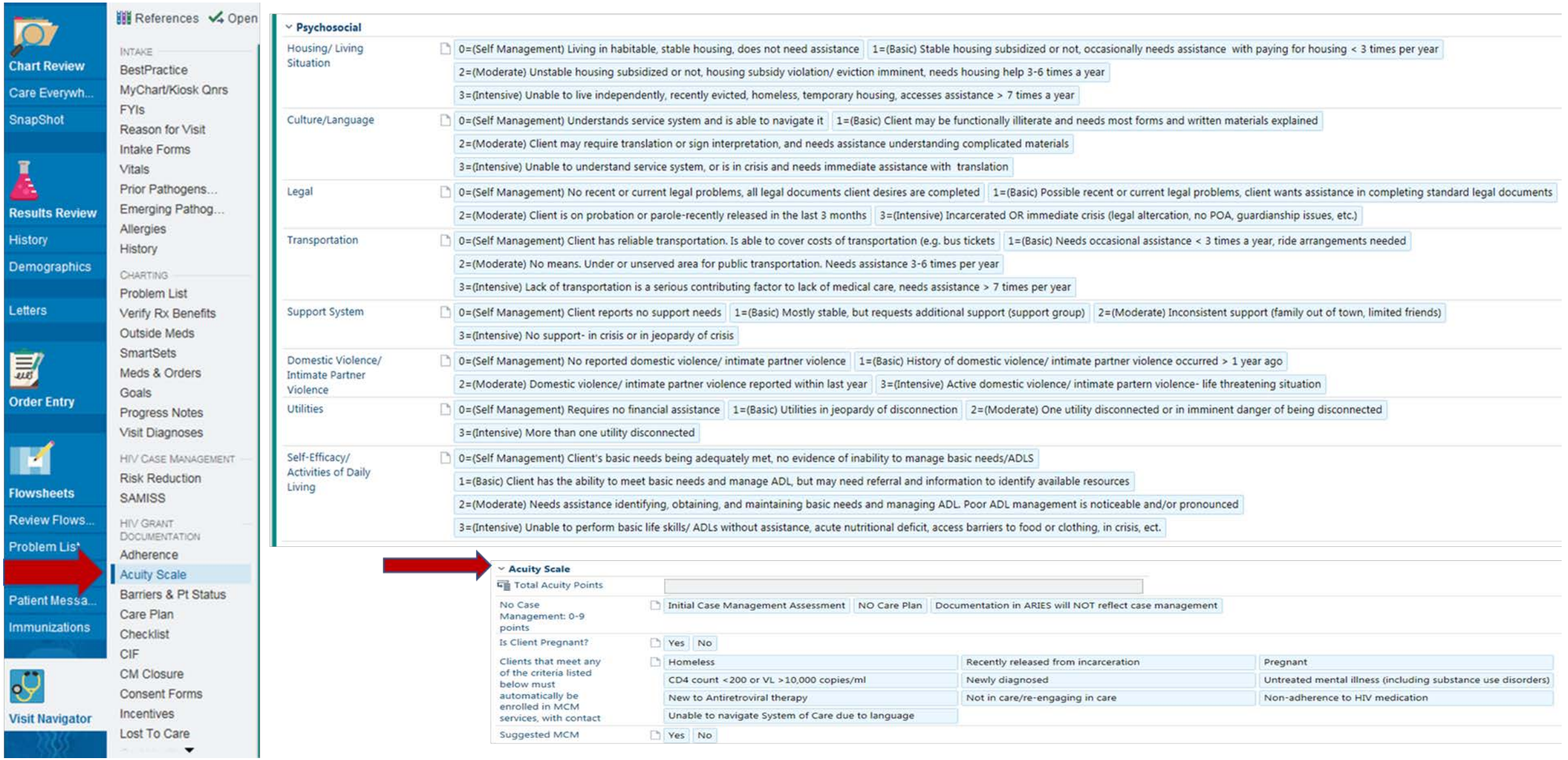
Eligibility needs, referral history and comparative assessments are now accessible to all staff coordinating care

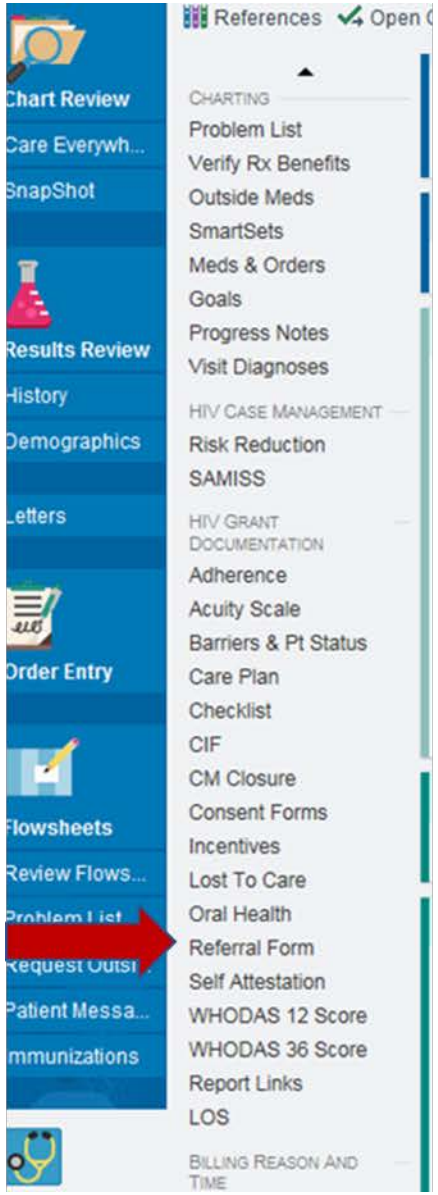
1. Acuity
2. Identify need
3. Discuss resources
4. Provide referrals
5. Develop a mutually agreed upon care plan

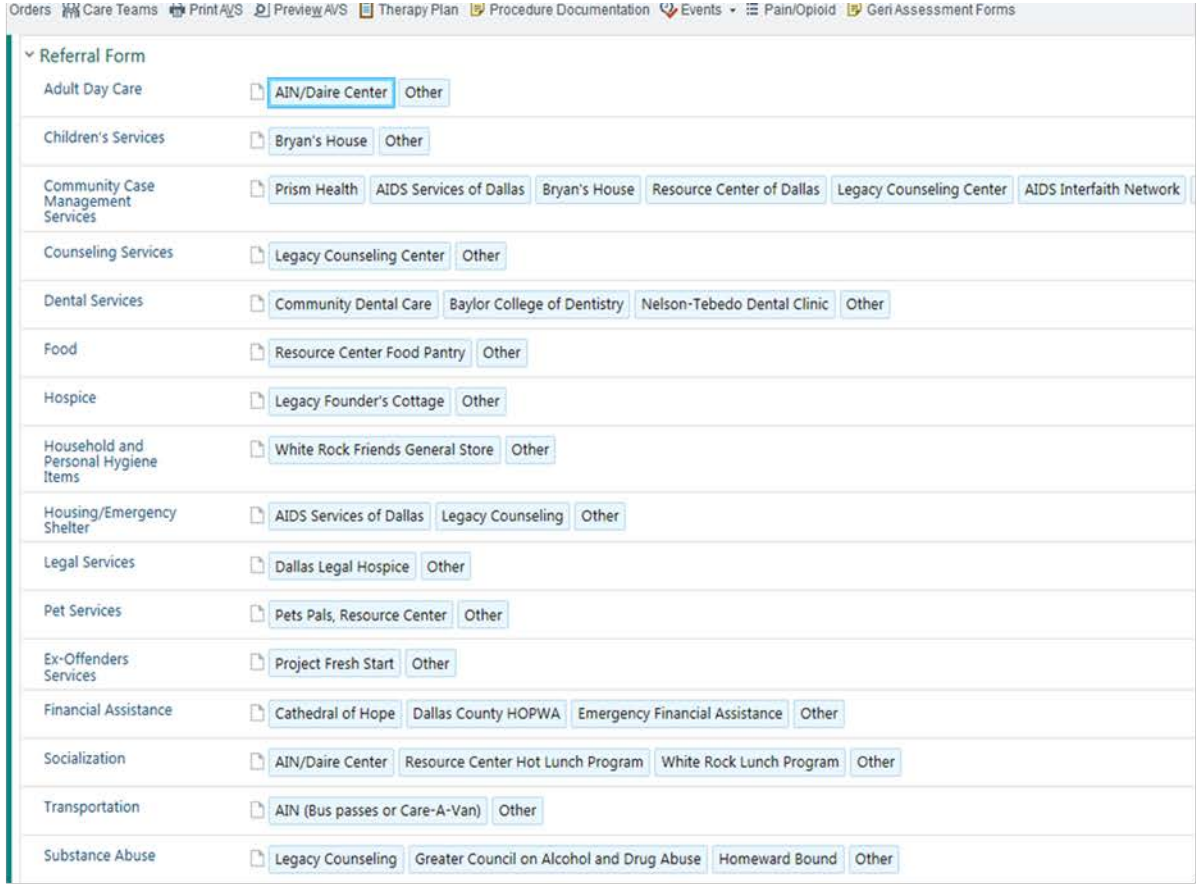


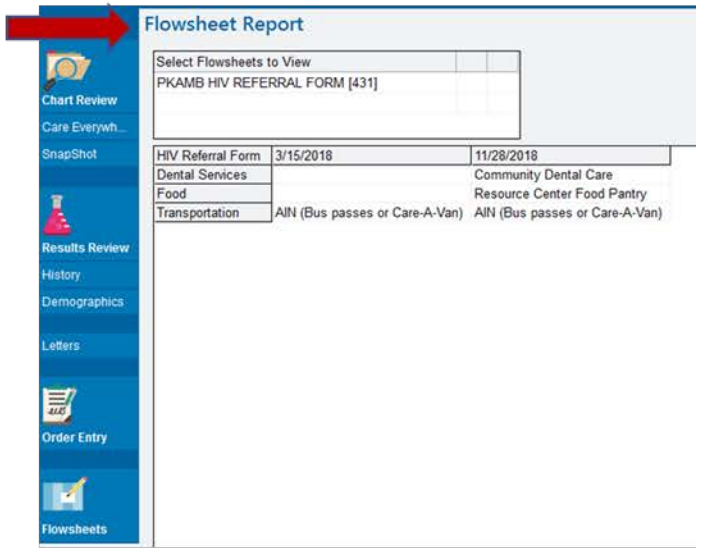


Our final product! EPIC migration allowed for our case managers to have dedicated, standardized flowsheets to document the clients' assessments and care plans.


References
Open
Chart Review
Care Everywh...
SnapShot
Results Review
History
Demographics
Letters
Order Entry
Flowsheets
Review Flows...
Problem List
Patient Messa...
Immunizations
Visit Navigator
INTAKE
BestPractice
MyChart/Kiosk Qnrs
FYIs
Reason for Visit
Intake Forms
Vitals
Prior Pathogens...
Emerging Pathog...
Allergies
History
CHARTING
Problem List
Verify Rx Benefits
Outside Meds
SmartSets
Meds & Orders
Goals
Progress Notes
Visit Diagnoses
HIV CASE MANAGEMENT
Risk Reduction
SAMISS
HIV GRANT DOCUMENTATION
Adherence
Acuity Scale
Barriers & Pt Status
Care Plan
Checklist
CIF
CM Closure
Consent Forms
Incentives
Lost To Care
Psychosocial
Housing/ Living Situation
0=(Self Management) Living in habitable, stable housing, does not need assistance
1=(Basic) Stable housing subsidized or not, occasionally needs assistance with paying for housing < 3 times per year
2=(Moderate) Unstable housing subsidized or not, housing subsidy violation/ eviction imminent, needs housing help 3-6 times a year
3=(Intensive) Unable to live independently, recently evicted, homeless, temporary housing, accesses assistance > 7 times a year
Culture/Language
0=(Self Management) Understands service system and is able to navigate it
1=(Basic) Client may be functionally illiterate and needs most forms and written materials explained
2=(Moderate) Client may require translation or sign interpretation, and needs assistance understanding complicated materials
3=(Intensive) Unable to understand service system, or is in crisis and needs immediate assistance with translation
Legal
0=(Self Management) No recent or current legal problems, all legal documents client desires are completed
1=(Basic) Possible recent or current legal problems, client wants assistance in completing standard legal documents
2=(Moderate) Client is on probation or parole-recently released in the last 3 months
3=(Intensive) Incarcerated OR immediate crisis (legal altercation, no POA, guardianship issues, etc.)
Transportation
0=(Self Management) Client has reliable transportation. Is able to cover costs of transportation (e.g. bus tickets
1=(Basic) Needs occasional assistance < 3 times a year, ride arrangements needed
2=(Moderate) No means. Under or unserved area for public transportation. Needs assistance 3-6 times per year
3=(Intensive) Lack of transportation is a serious contributing factor to lack of medical care, needs assistance > 7 times per year
Support System
0=(Self Management) Client reports no support needs
1=(Basic) Mostly stable, but requests additional support (support group)
2=(Moderate) Inconsistent support (family out of town, limited friends)
3=(Intensive) No support- in crisis or in jeopardy of crisis
Domestic Violence/ Intimate Partner Violence
0=(Self Management) No reported domestic violence/ intimate partner violence
1=(Basic) History of domestic violence/ intimate partner violence occurred > 1 year ago
2=(Moderate) Domestic violence/ intimate partner violence reported within last year
3=(Intensive) Active domestic violence/ intimate partern violence- life threatening situation
Utilities
0=(Self Management) Requires no financial assistance
1=(Basic) Utilities in jeopardy of disconnection
2=(Moderate) One utility disconnected or in imminent danger of being disconnected
3=(Intensive) More than one utility disconnected
Self-Efficacy/ Activities of Daily Living
0=(Self Management) Client's basic needs being adequately met, no evidence of inability to manage basic needs/ADLS
1=(Basic) Client has the ability to meet basic needs and manage ADL, but may need referral and information to identify available resources
2=(Moderate) Needs assistance identifying, obtaining, and maintaining basic needs and managing ADL. Poor ADL management is noticeable and/or pronounced
3=(Intensive) Unable to perform basic life skills/ ADLs without assistance, acute nutritional deficit, access barriers to food or clothing, in crisis, ect.
Acuity Scale
Total Acuity Points
No Case Management: 0-9 points
Initial Case Management Assessment
NO Care Plan
Documentation in ARIES will NOT reflect case management
Is Client Pregnant?
Yes
No
Clients that meet any of the criteria listed below must automatically be enrolled in MCM services, with contact
Homeless
Recently released from incarceration
Pregnant
CD4 count <200 or VL >10,000 copies/ml
Newly diagnosed
Untreated mental illness (including substance use disorders)
New to Antiretroviral therapy
Not in care/re-engaging in care
Non-adherence to HIV medication
Unable to navigate System of Care due to language
Suggested MCM
Yes
No







ALL GRANT DOCUMENTATION AVAILABLE within EPIC EHR– inclusive of historical assessments & referrals

Care Coordination Impact

- Providers can now see:
  - ACUITY
  - Referral closure
  - Documented barriers to care
  - Eligibility status

- Flowsheets provide streamlined, structured data entry, allowing better assessment of patients need for medical case management and shared view of progress to achieve clinic outcomes.
- Upon project completion, Case Management encounters ***doubled***.

EPIC Migration Results

With completion of case management documentation migration to EPIC, reports can now be run to monitor:

- ✓ ACUITY Screening
- ✓ SAMISS Screening
- ✓ RISK REDUCTION Screening
- ✓ ELIGIBILITY Checklist
- ✓ CARE PLAN Updates
- ✓ BARRIERS TO CARE
- ✓ ORAL HEALTH Screening
- ✓ MEDICATION ADHERENCE

- Succinct tracking of patients through medical case management and their readiness to graduate from medical case management - through the build of the ACUITY flowsheet- facilitated productivity and retention of clients in care.

Results (cont'd)

- AUDIT REVIEW COMPARISON 2016-2018
  - ACUITY: improved from 0% to *87%*
  - Frequency of contact matches ACUITY: improved from 0% to *76%*
  - Referral tracking: improved from 0% to *92%*

Audit Accolades- Recent State and Federal monitoring of the program determined that this EPIC Grant Documentation Project set the team as 'trailblazers' in establishing *best practice*.

Reporting created now validates capacity and prioritization.

Documentation efforts have allowed more robust 'deep dives' when analyzing why clients are not achieving outcomes (ACUITY, Barriers to Care, Referral Closure)

Using EPIC to its full breadth improved data governance and report consolidation, while incorporating grant metrics and requirements through novel, seamless utilization.

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