System-level Workforce Capacity Building for Integrating HIV Primary Care in Community Health Care Settings

Practice Transformation Model (PTM)

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Disclaimer

Presentation Outline

- Overview
- Capacity
- Implementation
- Sustainability
- Lessons Learned & Recommendations
- Resources

- For over 25 years, Brightpoint Health has effectively responded to the evolving health needs of New Yorkers.
  - Federally Qualified Health Center (FQHC)
  - 23 Operational Sites located in all five boroughs, 7 patient-centered medical homes (PCMH) recognized
  - Serving homeless population, mental illness, formerly incarcerated and low income families
  - Providing care and services to 33,919 patients annually (2017)
    - PLWHA: 1453 patients (2017)

- Services include:
    - Primary Care
    - Maternal Health
    - Behavioral Health
    - Dental Services
    - Outpatient Substance Abuse Services
    - Onsite Pharmacy
    - Medical Case Management
    - Health Homes
    - HIV Adult Day Treatment
    - Grant Funded Health/Care Management Services
- On December 13, 2018 Brightpoint Health officially became a member of Hudson River Health Care.
- As a combined new entity, will serve 225,000 people throughout the Hudson Valley, NYC, and Long Island regions.

- PTM goal:
  - Improve care coordination between primary care (PC) and behavioral health (BH) and empower patients who are not virally suppressed, have multiple chronic conditions, and are at risk for falling out of care
- PTM site:
  - Inwood Health Center, located in the Bronx (Highbridge neighborhood)
  - One-stop PC clinic that is co-located with BH and other services
  - Services ±4,000 clients annually; just over 500 PLWH
- PTM key components:
  - Standardized systems for identifying and engaging high-risk PLWH
  - Formalized communication among PC and BH providers
  - Enhanced Health Information Technology (HIT) Infrastructure
  - Client self-management program

Capacity

- Staffing
    - Program Director
    - Quality Improvement Coordinator
    - Patient Navigator
    - Peer Educator
- Buy-in
    - Provider Champion
    - Staff Training
    - Evaluation and Dissemination
- Location
    - EHR
    - Co-location of clinical and wrap-around services
    - Physical space to hold self-management groups

Standardized systems for identifying and engaging high-risk HIV-positive patients.

- The patient registries identified clients with three consecutive months of unsuppressed viral loads and those patients medically unstable as defined by clients with multiple co-morbidities and who have upcoming PC and BH appts

- The patient registries also allowed the Registered Nurse, Patient Navigator and Peer Educators to flag patient charts on appointment dates, such that the patient can be referred to the team for engagement and intervention

- PT team facilitated warm-hand offs to engage clients that were typically lost to care

- Formalized communication among primary care and behavioral health providers
  - Retrospective huddles were a better mode to conducting pre-visit planning
  - Operational changes to the Inwood PC clinic morning meeting schedule, such that huddles, case-conferences and training times were carved into the provider and staff schedules
  - The use of Plan Do Study Act cycles (PDSAs)

- Enhanced Health Information Technology (HIT) Infrastructure
  - To maintain communication, PT sticky notes, telephone encounters, and uploading client care plans and case conferencing notes were used as methods to coordinate care and share important patient clinical information.

Client self-management program:

- Results from the pre and post assessments showed participant improvement with regards to general health, confidence doing things, cognitive symptom management and use of medical care

- The peer led groups were effective in the HIV treatment cascade as it promotes self-efficacy, health literacy, motivation and shared experiences

- PLWHA peers play an especially important role in a patient's multidisciplinary care team, as medication-adherent role models with lived shared experience

Sustainability and Integration

- Incorporate additional groups for patients with multiple comorbidities within clinic setting

- Develop organizational capacity for Direct Observation Therapy (DOT)

- Continue with an integrated model of care to address social determinants of health

- Create an agency-wide culture around ending the AIDS Epidemic

- Expand capacity through additional grant funds

- Early communication with ancillary staff highlighted opportunities for improvement in patient flow

- Staff training included that the proper documentation was entered in eCW by the call center to facilitate efficient communication between clinic staff and patients at the time of visit. The use of Plan Do Study Act cycles (PDSAs) to attain staff buy-in for the PTM

- Retrospective huddles were a better mode to conducting pre-visit planning

- PLWHA peers play an especially important role in a patient's multidisciplinary care team, as medication-adherent role models living with a shared experience
- The formulated self-management workshop incorporated well received aspects of the PSMP and WHAM workshops and similar peer groups
  - Action planning activities
  - Shorter Group Sessions (clinic setting)
  - Comprehensive group materials to facilitate activities that discuss barriers for treatment adherence, for instance:
    - Problem-solving
    - Symptom cycle
    - Decision making
    - Purpose of medication usage

Contact Information

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