Effective Strategies for Engaging and Retaining Clients in HIV Care and Treatment

Lessons Learned from Teams in Primary Care Settings
Effective Strategies for Engaging and Retaining Clients in HIV Care and Treatment

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- Cindy Lewis, CMA (Care Team MA)
- Steve Bromer, MD (facilitator)
Objectives

• Name 4 foundational Building Blocks of Primary Care and explain how they relate to the HIV Care Continuum
• Describe 2 workflows used with people living with HIV in a primary care setting that support retention in care
Questions

• What can we learn about team-based care from innovations in primary care to support retention in care?
• What have we learned from the RW model of care that can be shared with Primary Care?
California’s Integrated Plan

Laying a Foundation for Getting to Zero:

1. Reducing New HIV Infections in California;
2. Increasing Access to Care and Improving Health Outcomes for PLWH in California;
3. Reducing HIV-Related Disparities and Health Inequities in California; and

- Population management as a retention tool
- Effective Care Teams in Primary Care
- Increasing access and reducing health disparities
Russian River Health Center
1973
“The notion of a Health Care Team is as rarely challenged in principle as it is achieved in practice.”

Learning from 23 bright-spot practices

Bodenheimer et al, Ann Fam Med 2014:12:166
Sinsky et al, Ann Fam Med 2013:11:272
10 Building Blocks of High-Performing Primary Care

1. Engaged leadership
2. Data-driven improvement
3. Empanelment
4. Team-based care
5. Patient-team partnership
6. Population management
7. Continuity of care
8. Prompt access to care
9. Comprehensive-ness and Care Coordination
10. Template of the future
Building Block Model and the Care Continuum

The U.S. HIV Care Continuum

- 100% HIV-Infected
- 87% HIV-Diagnosed
- 75% Linked to HIV Care
- 57% Retained in HIV Care
- 55% Undetectable Viral Load

40,000 new infections per year

The National Alliance for HIV Education and Workforce Development (NAHEWD) represents the national network of AIDS Education and Training Centers (AETCs). The AETCs national, regional, and local centers are a part of the HRSA-funded Ryan White Program. The AETCs provide clinical education to the HIV workforce and capacity-building support to care systems. NAHEWD and its members support the work of the AETCs to build and maintain a well-educated and culturally-sensitive health professions workforce to ensure comprehensive care and treatment to people at-risk for and living with HIV across all phases of the HIV Care Continuum.

Data and Population Management

HIV Population Management Dashboard

Featuring labs, immunizations, an overview of total number of HIV patients

Ryan White
December 6, 1971 - April 8, 1990

Who Was Ryan White?

20 Years After Ryan White's Death...
Viral Load Suppression Rates

Viral Load Suppression

Definition: % of active HIV patients with a Primary Care visit in the past 12 months who have a Viral Load lab in the past 12 months with results < 200 copies, populated in the yellow lab attributes field.
Exclusion: patients with Graton or Gender Expansive Clinic as their default facility.

HRSA
Ryan White & Global HIV/AIDS Programs

Viral Load Population

Account No  Patient Name  HIV_DNA_PCR_LastCollect  Last PrimCareMed Visit  Viral Load Suppressed

- 5/12/2017  4/12/2017  Suppressed
- 6/13/2017  6/27/2017  Suppressed
- 7/18/2017  7/30/2017  Suppressed
- 8/4/2017  8/26/2017  Suppressed
- 9/4/2017  9/16/2017  Suppressed
- 10/16/2017  10/30/2017  Suppressed
- 11/13/2017  11/26/2017  Suppressed
- 12/1/2017  12/24/2017  Suppressed
- 1/9/2018  1/22/2018  Not Suppressed
- 2/6/2018  2/19/2018  Suppressed
- 3/10/2018  3/23/2018  Suppressed
- 4/13/2018  4/26/2018  Suppressed
- 5/17/2018  5/30/2018  Suppressed
- 6/11/2018  6/24/2018  Suppressed
- 7/15/2018  7/28/2018  Suppressed
- 8/12/2018  8/25/2018  Suppressed
- 9/15/2018  9/28/2018  Suppressed
- 10/9/2018  10/22/2018  Suppressed
- 11/2/2018  11/25/2018  Suppressed
- 12/6/2018  12/29/2018  Suppressed
Acuity and Retention

HIV Team Case Management Acuity Levels

Context of all Case Management:
- Long-term relational, accessible team-based care with well care, acute illness management, health advice/decision support, health education, patient/family health engagement and empowerment, mental health, addiction services, complimentary medical consultation and dental care or referral.

Low Acuity (1)
- Chronic Disease Care Team CM
- Chronic disease case management, with planned visits, adherence support, retention interventions, standard goal setting and proactive HCM and health screenings through CT

Medium Acuity (2)
- Complex CM
- RN led team-based care with individualized Self Management support, coordination of referrals and community resources

High Acuity (3)
- High Risk Client
- Multidisciplinary Team Management with focus on behavioral interventions, system coordination, resource solutions and barrier management
Features of Successful Teams

- Organizational culture supporting teams
- Stable Teams (Teamlets)
- Co-location
- Communication strategies
- Staffing ratios
- Defined roles and responsibilities
- Standing Orders/Protocols
- Training on roles/skills checklists
Organizational Culture
Supporting Team-based Care

• Leadership aligned to support teams
• Task-shifting vs. “Share the Care”
• Everyone work at the top of license
• Deep understanding of value of all roles
• Everyone on a Quality Improvement team
• Become a “learning organization”
## Shift in core beliefs for providers

<table>
<thead>
<tr>
<th>Lone Provider</th>
<th>Provider as Part of a Highly Functioning Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-sacrifice</td>
<td>Building Relationships</td>
</tr>
<tr>
<td>Provider-driven care</td>
<td>Collaborative health workers</td>
</tr>
<tr>
<td>Individual Hero</td>
<td>Well-being of all team members</td>
</tr>
<tr>
<td>Ownership: “My patient”</td>
<td>Collaborative responsibility: “Our care”</td>
</tr>
<tr>
<td>Full control</td>
<td>Shared control</td>
</tr>
<tr>
<td>Physician as lone expert</td>
<td>Team expertise</td>
</tr>
</tbody>
</table>

Stable Teamlets

Health coach, behavioral health professional, social worker, RN, pharmacist, panel manager, complex care manager

1 team, 3 teamlets
Co-location

- Architecture is important
- Physical proximity facilitates communication
- Technology can be used to create virtual co-location
Teamlet A

B

C

Patient exam room

Patient exam room

Patient exam room

Patient exam room

Patient exam room

Patient exam room

Patient exam room

Patient exam room
Clinica Family Health Services: Colorado
South Central Foundation: Alaska
Virtual Co-location
Insert slide of provider video conferencing with Karen
Staffing Ratios Per Team

Benton
- 2 Provider
- 2 MA
- 1 RN
- 1 Health Navigator
- Shared Team Members:
  - Behaviorist
  - Clinical Pharmacist
  - Panel Manager
  - Health Navigator (depending on site)

Clinica Family Health Services
- 3 FTEs of Provider
- 3 FTEs of Medical Assistant
- 1 Nurse Team Manager
- 1 Case Manager
- 1 Behavioral Health Professional
- 2 Front Desk
- 1 Medical Records
- ½ Referral Case Manager
- Dental Hygienist
- Consulting Psychiatrist
3 Levels of Communication

• Structure for communication on goals, strategies, interface with larger organization: Team meetings
• Structure of getting on the same page around immediate work: Huddles
• Attention to minute-to-minute communication
# Defined Roles and Responsibilities

## Team Roles and Responsibilities

### Core Team

<table>
<thead>
<tr>
<th>Provider</th>
<th>PharmD</th>
<th>Team Assistant</th>
<th>Reception</th>
<th>Behavioral Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care Delivery</strong></td>
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<tr>
<td>Medical/MH Dx</td>
<td>Collaborative Practice</td>
<td>Monitors schedules in advance for problems and works collaboratively with care team to maximize access</td>
<td>Confirms insurance coverage and schedules appointments as indicated with Eligibility or Outreach Eligibility Worker</td>
<td>As outlined in Behavioral Health (BH) charting guide</td>
</tr>
<tr>
<td>Follows provider script</td>
<td>Collaborative drug therapy management</td>
<td>Schedules appointments with team providers</td>
<td>Patient check-in for appts.</td>
<td>Determines BH intervention and treatment</td>
</tr>
<tr>
<td>Therapeutic plan for urgent/chronic problems</td>
<td>Medication therapy management</td>
<td>Primary responsibility for reminder calls</td>
<td>Collects, verifies, and updates demographic information and insurance coverage</td>
<td>Therapeutic plan for urgent/chronic BH problems</td>
</tr>
<tr>
<td>Determines clinical monitoring schedule</td>
<td>Consultation on complicated medication regimens</td>
<td>No show flu and mgmt</td>
<td>Collects co-pays, payments on account balances</td>
<td>Determines need and recommends BH monitoring schedule</td>
</tr>
<tr>
<td>Determines need / schedule for tracking for high risk</td>
<td>Controlled-substance agreements</td>
<td>Acts as communication liaison between patients and providers &amp; MA’s to maximize efficiency and effectiveness of patient appointments</td>
<td>Distributes and explains client forms</td>
<td>Provides consultation to providers and team regarding BH diagnosis and resources</td>
</tr>
<tr>
<td>Manages abnormal tests</td>
<td>Refill authorizations</td>
<td>Makes flu scheduling calls at providers’ request, including chơiing</td>
<td>Customer service</td>
<td>Liaison with Mental Health (MH) and other programs at Health Services regarding MH / BH issues</td>
</tr>
<tr>
<td>Determine overall patient education needs</td>
<td>Immunizations</td>
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<tr>
<td>Decisions regarding comprehensive care to panel</td>
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</tr>
</tbody>
</table>

### Education

- Patient education about disease
- Patient education about overall health and

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The table above outlines the defined roles and responsibilities for various team members, including providers, PharmDs, team assistants, receptionists, and behavioral health professionals. Each role is detailed with specific tasks and responsibilities to ensure efficient and effective patient care.
Standing Orders/Protocols

CARE TEAM MEDICAL ASSISTANT STANDING ORDER

DIAGNOSIS:
- HIV/AIDS 042

Care Team Medical Assistants may, without consulting the Medical Provider, perform the following tasks:

- HIV RNA QT BDNA, 3rd Generation
  - No HIV RNA QT BDNA within the last 4 months
- T-Lymph CD4/CD8
  - No T-Lymph CD4/CD8 within the last 4 months
- CBC Automated
  - No CBC within the last 4 months
- CMP
  - No CMP within the last 4 months
- RPR/Relex TPPA (diagnosis)
  - RPR/Relex TPPA (diagnosis) within the last year
- TB-Quantiferon Gold
  - No TB-Quantiferon Gold within the last 2 years
- LIPID Profile
  - No Lipid Profile within the last year
  - Use diagnosis code V59.69 Medication exposure, long-term use high risk medication
- Microalbumin, Random Urine
  - No Microalbumin, Random Urine within the last year
  - Use diagnosis code V59.69 Medication exposure, long-term use high risk medication

Create an Open Access Alert:

- For a INFLUENZA VACCINATION
  - No Influenza Vaccination within the last year
  - Between the months of November and April
- For a Pneumovax
  - If the patient has never received a dose
  -
- Other Orders:
  -
  -

Using a Telephone Encounter, create a Virtual Visit and order the following Labs, Diagnostic Imaging or Referral using the HIV Order Set or through the HIV Lab Requisition Form.

Start Date: ___________________________ End Date: ___________________________

Patient Name: ___________________________

DOB: ___________________________

Care Team Provider Signature: ___________________________
CARE TEAM MEDICAL ASSISTANT STANDING ORDER

DIAGNOSIS:
- HIV/AIDS 042

Care Team Medical Assistants may, without consulting the Medical Provider, perform the following tasks:

- HIV RNA QT BDNA, 3rd Generation
  - No HIV RN QT BDNA within the last 4 months
- T-Lymph CD4/CD8
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- CBC Automated
  - No CBC within the last 4 months
- CMP
  - No CMP within the last 4 months
- RPR/Reflex TPPA (diagnosis)
  - RPR/Reflex TPPA (diagnosis) within the last year
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  - No Lipid Profile within the last year
# Training on Roles, Skills

## Community Health Center
*Phlebotomist and Lab Orientation Checklist*
*2010*

<table>
<thead>
<tr>
<th>Patient Care Tasks</th>
<th>Date Sign Off</th>
<th>Signature Approving Task</th>
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</thead>
<tbody>
<tr>
<td>1. Venipuncture:</td>
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<td>2. Urinalysis</td>
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Building Block Model and the Care Continuum

The U.S. HIV Care Continuum

1. 40,000 new infections per year

Number of Individuals

<table>
<thead>
<tr>
<th>HIV-Infected</th>
<th>HIV-Diagnosed</th>
<th>Linked to HIV Care</th>
<th>Retained in HIV Care</th>
<th>Undetectable Viral Load</th>
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<tr>
<td>100%</td>
<td>87%</td>
<td>75%</td>
<td>57%</td>
<td>55%</td>
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Funding

- West County Health Centers, Inc. receives RW Part C and B funding.
  - Outpatient Medical Care
  - Medical Case Management
  - Nutrition Services
Contact Information

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  • mdavey@wcchealth.org
Getting to Zero

- Increasing access to Care and improving health outcomes for PLWH in California
- Reducing HIV-related disparities and Health Inequities in California
Effective Strategies for Engaging and Retaining Clients in HIV Care and Treatment

Questions??