

Joseph P. McGowan, MD, FACP, FIDSA June 15, 2017



CART Overview

Over 2100 active patients with HIV/AIDS

238 new patients with HIV initiated care in the past year (12% growth)

NCQA recognized Level 3 HIV Patient Centered Medical Home

Outpatient program located at 400 Community Drive in Nassau

Satellite office at the Dolan Family Health Center in Suffolk

Currently awarded 10 Competitive HIV Service grants

On-site 340B HIV Specialty Pharmacy

HIV Clinical Trials Program

Health Home Downstream Provider

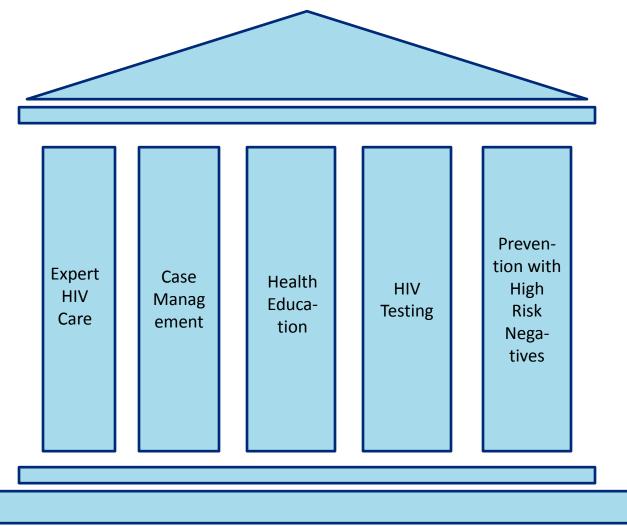
HIV Testing in Emergency Rooms Pilot Project

CDC Community based HIV Prevention Collaborative





Pillars of Care at CART





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Co-Located Services

Comprehensive Medical Case Management Model

- Medical Care provider
- RN Case Manager
- Social Work Case Manager

-Patient Care Team

Specialty Pharmacy (Pharm D has Collaborative Practice Agreement with all Clinicians)

Behavioral Health (2 P/T Psychiatrists, 9 SW therapists, SBIRT Behavioral Health Educator)

GYN Services

Nutritionist (Full time Dietician)

Health Education

Health Home

Hepatitis C Co-infection Treatment

Peer Support

Outreach/Retention in Care

Substance use (Buprenorphine prescribers)

Dental in adjoining suite

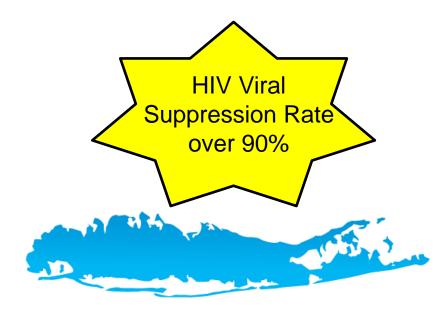
Legal Aid (Through Nassau Suffolk Law Services)

Client Advisory Board

CQI Program

vDOT, Daily Adherence Support









Specialized Pharmacy

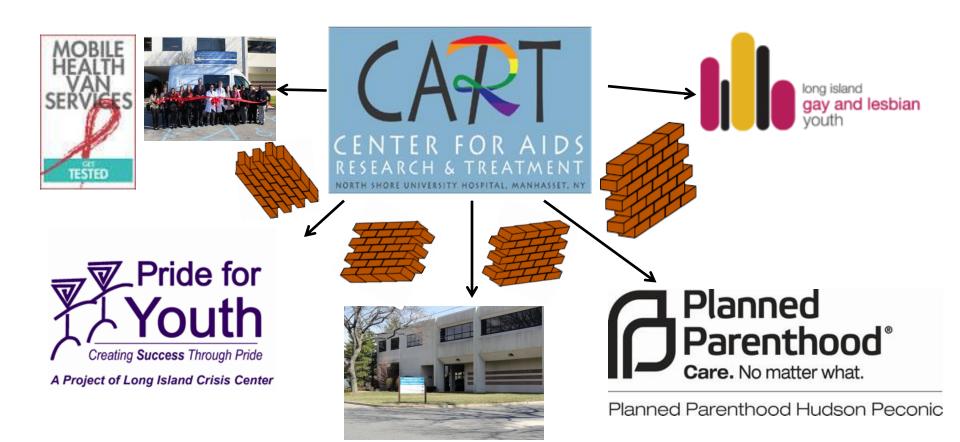


- The 340B Drug Pricing Program requires drug manufacturers to provide outpatient drugs to <u>eligible health care organizations</u> at significantly reduced prices
- Eligibility: FQHCs, Disproportionate Share Hospitals, Ryan White Grantees
- Adherence Support: Delivery, Pill Trays, Text Reminders
- Collaborative Practice Agreement with all CART clinicians
- HIV Specialty Pharm D Residency



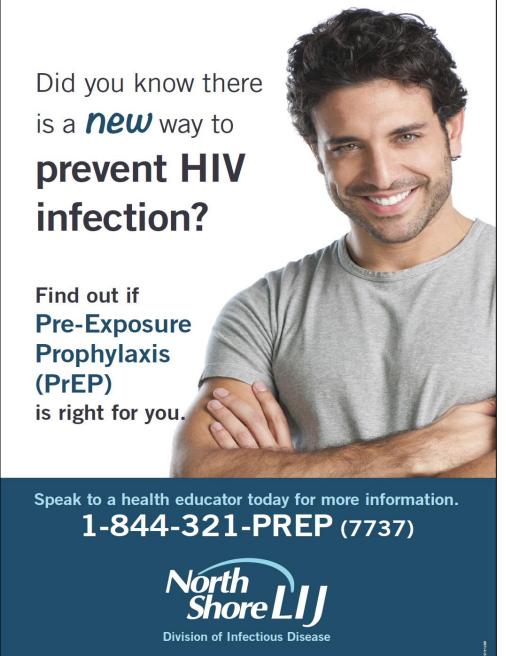


Breaking Down Walls



Dolan Family Health Center







Opportunities/Challenges

- Leverage Expertise and Community
 Relationships/Collaboration to impact HIV Epidemic Regionally
- Enhance use of Social Media
- Identify Health Care Disparities
- Use Data to assess program effectiveness and target areas of resource need





Quality Improvement



CART Quality Improvement

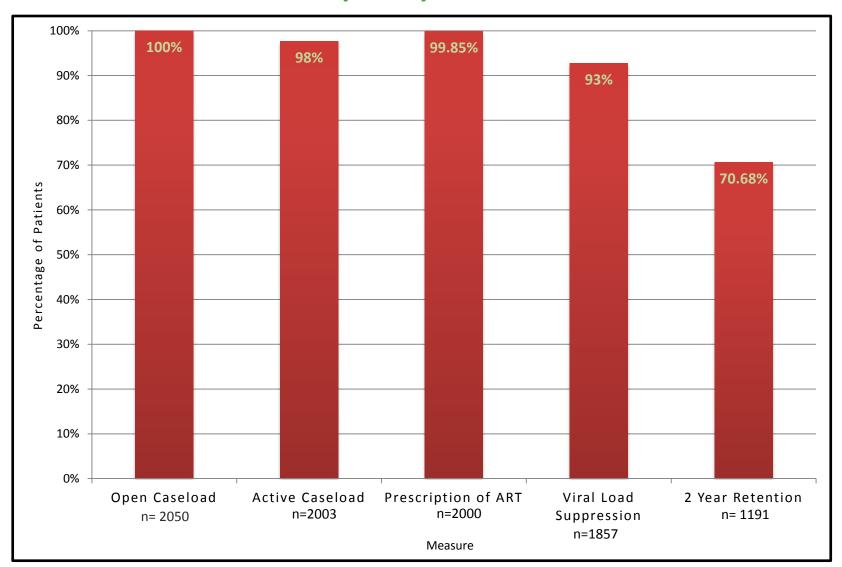
Quality Statement: The mission of the CQI Program is to maximize health outcomes of patients at the CART by ensuring access to and maintenance in HIV Primary Care.

The CART Annual CQI Plan is based on standards set forth by the AIDS Institute, HRSA and CDC. Projects are focused across various CART activities:

- Program wide CQI Project- Retention in Care
- RN Case Manager CQI Project- Advanced Directives
- 9 Grant Program Specific CQI Projects (e.g.: Prevention and Retention, Medical Nutrition, Mental Health, Part C, Part D, HIV Testing)
- PrEP Program CQI initiative
- CAB CQI plan review



CART HIV Care Cascade (2016)





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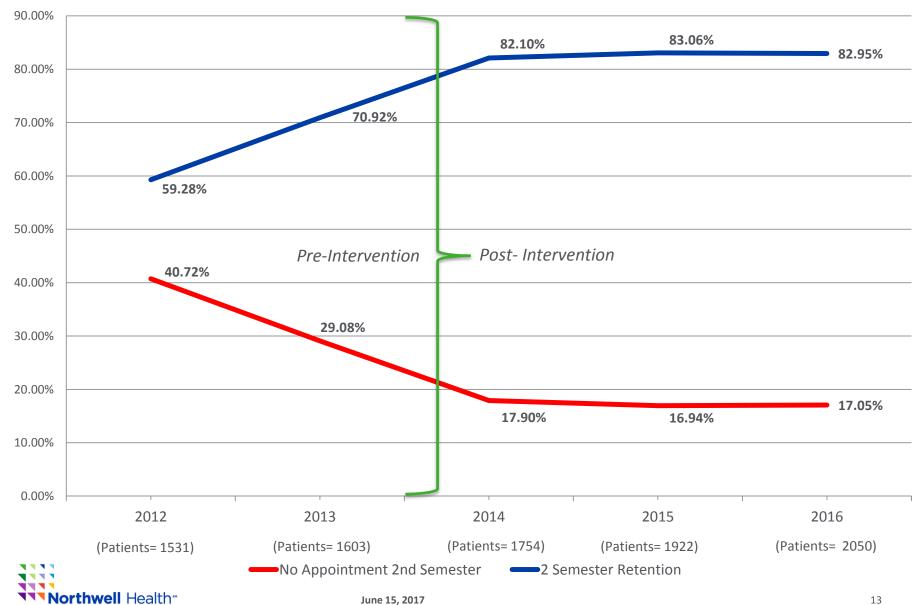
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Program-wide CQI Project

- Prospective Medical Case Management
 - Identify all patients among those seen in the past 2 years without a pending appointment
- Retention in Care Initiative
 - Interventions:
 - Send reminder calls for all scheduled patients and track all missed appointments.
 - Implement NY Links Appointment Procedures
 - Provide multidisciplinary consistent messaging to direct patients to make an appointment for follow-up with their HIV Primary Care clinician.
 - Peer intervention to contact patients to facilitate appointment scheduling.
 - Conduct outreach to patients lost to follow-up for > 6 months.
 - Assess Appointment pending by MD, PA, NP, PharmD and RN at time of medication Renewals.
 - Provide Visit summary and "appointment slip" to patient at time of RN Exit interview with F/U appointment interval highlighted.



Program Wide CQI



Retention & Outreach

disposition.

2015 Out of Care for 6 Months	20.75% (of active patients)
Moved/Transferred/Deceased (of those out of care)	27.20%
Out of Care after Removal	15.11%
Returned to Care	75.85%
2016 Out of Care for 6 Months	18.62% (of active patients)
Moved/Transferred/Deceased (of those out of care)	27.65%
Out of Care After Removal	13.47%
Returned to Care	76.83%
neturied to care	70.0370

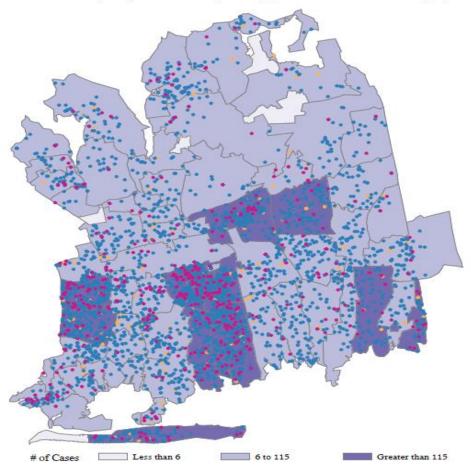
By the end of this year, there will be enough data in REDCap to analyze demographic, mental health, etc. data and identify trends as it relates to retention and those of unknown



Heat Maps and Testing



Reported cases of Chlamydia, Gonorrhea, and Syphilis in Nassau County by Zipcode, 2016





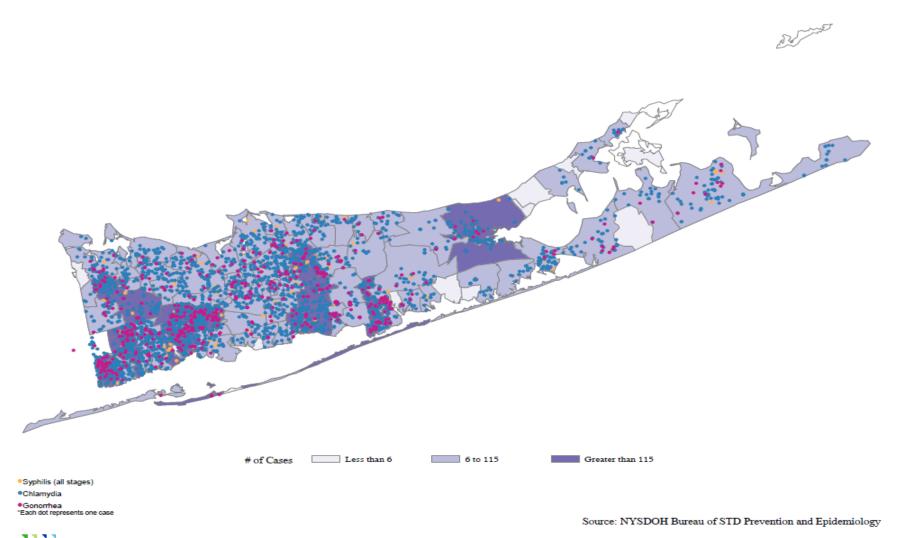
Chlamydia

Gonorrhea
 Each dot represents one case

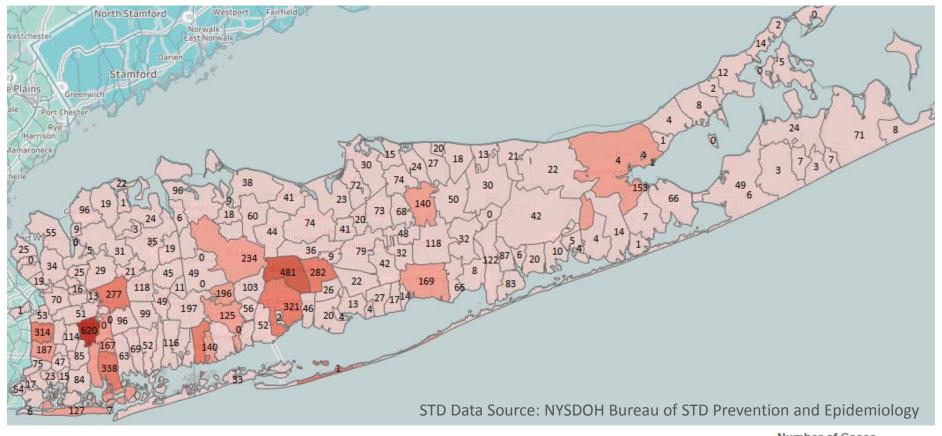


Source: NYSDOH Bureau of STD Prevention and Epidemiology

Reported cases of Chlamydia, Gonorrhea, and Syphilis in Suffolk County by Zipcode, 2016



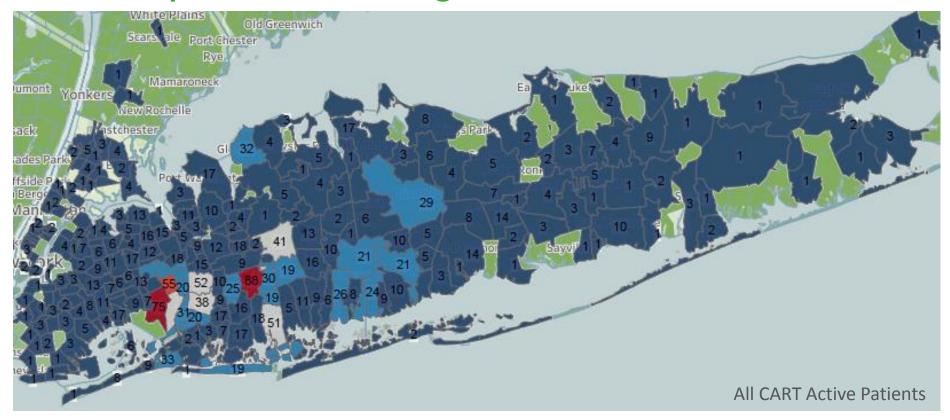
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Combined Nassau & Suffolk Reported cases of Chlamydia, Gonorrhea and Syphilis in 2016





CART develops "Heat Maps" using Tableau Software indicating by zip code the location of:



Number of Patients

Health System Unsuppressed Viral Load





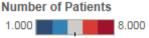
Based on 3 months of Data from the Northwell Health System. Areas highlighted are Hempstead, Far Rockaway, St. Albans, Jamaica, Corona and Brooklyn.



CART Unsuppressed Viral Load



43% of Unsuppressed CART Patients live within this zone.



Areas highlighted are Hempstead, St. Albans, Springfield Gardens, Rosedale and surrounding areas.



CART Newly Diagnosed

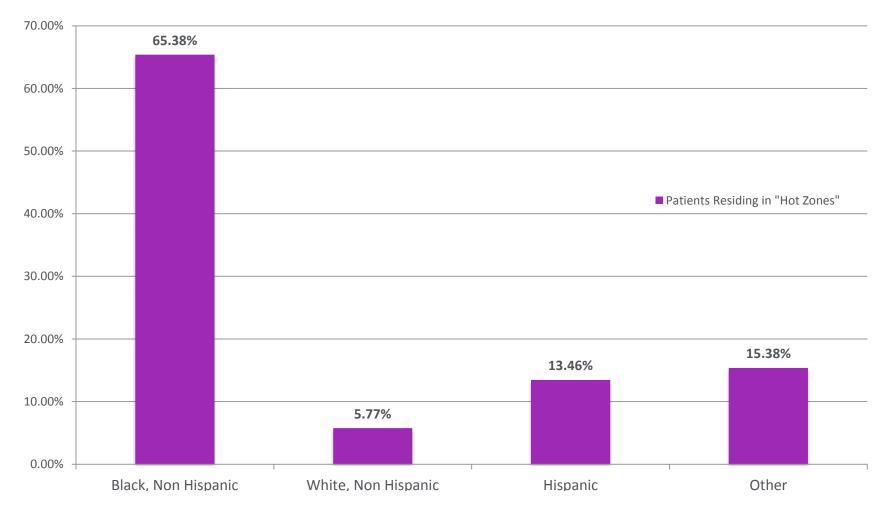




46.34% of Newly Diagnosed CART patients live within this zone.



Unsuppressed Patients & "Hot Zones"

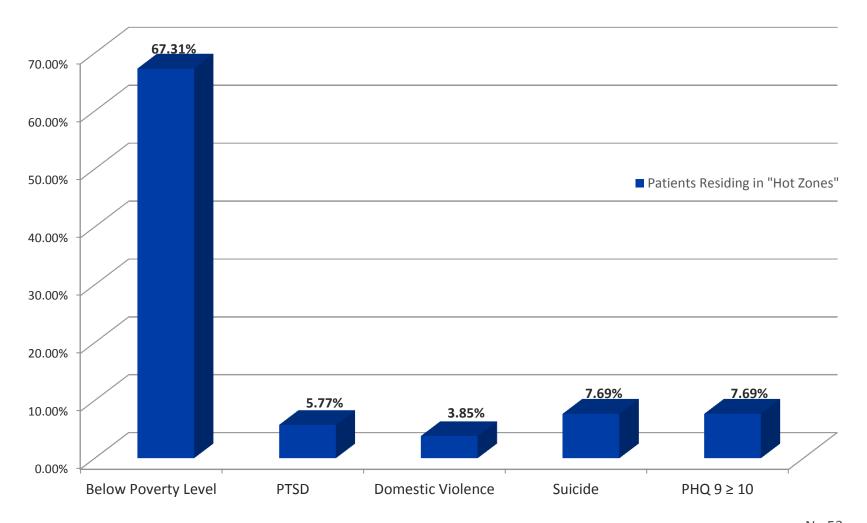




N = 53

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Unsuppressed Patients & "Hot Zones"





N = 53



REDCap- a browser-based, metadata-driven electronic data collection software solution and workflow methodology for designing clinical and translational research databases.

Social work case managers provide a Comprehensive Psycho-Social Assessment with a Care Plan every six months to the total patient population.

Assessments contain over 300 questions ranging from demographics and mental health status to substance abuse.

The REDCap initiative, which involved building a user friendly, electronic version of the assessment, took 11 months to complete from conception to implementation.

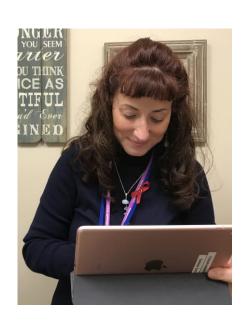


By using REDCap's logic capabilities, the system allows fewer questions for some patients and more in-depth questions for other patients; if a particular question does not apply for a specific patient, then the question would not be asked during the assessment.

REDCap went live as of November 4, 2016

Houses two electronic versions of the psychosocial assessment

- Adult (296 fields) and Young Adult (320 fields) versions





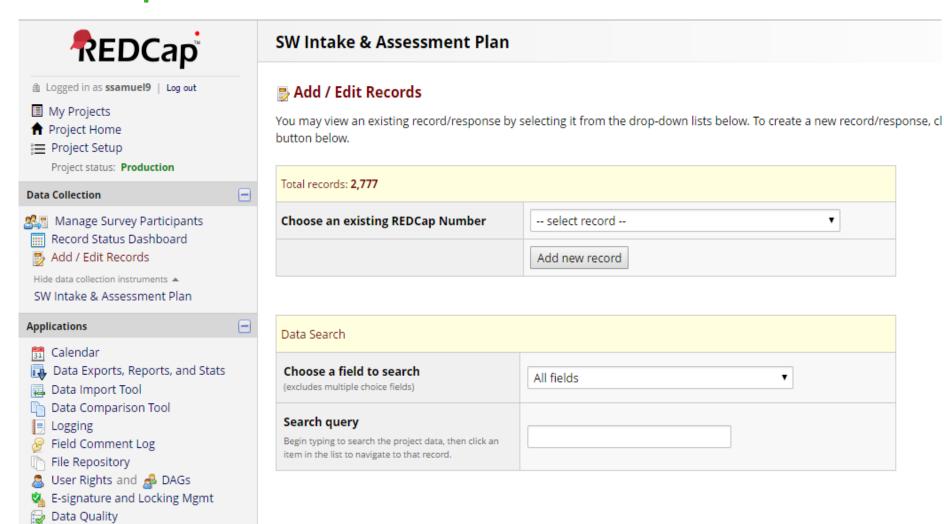
Allows for mining of data from the database in real time

- Create custom reports and extract data to find disparities based on age, mode of transmission, housing status, mental health history, etc.

Assessment is categorized into the following sections:

- Demographics
- Financials
- Housing/Transportation/Food
- Case Management Information
- Mental Health Assessment (mood/affect, anxiety screening, PTSD screening, Depression/PHQ-9, Suicide/Homicide screening)
- Substance Use History
- Legal Assessment (Domestic Violence, Child Protective Services, Adult Protective Services, Criminal Activity)
- Treatment Adherence Assessment
- Service Plan & Referrals
- Short term & Long term Goals



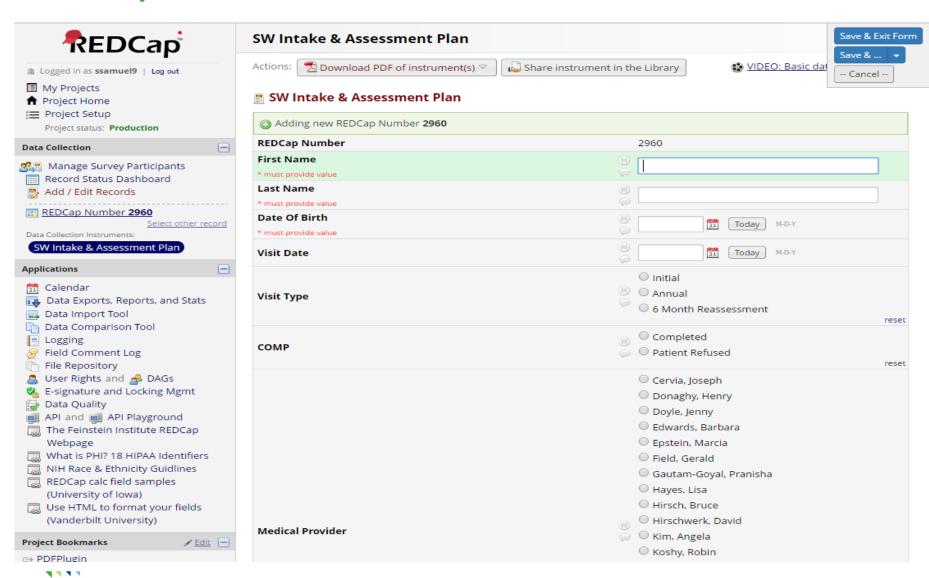




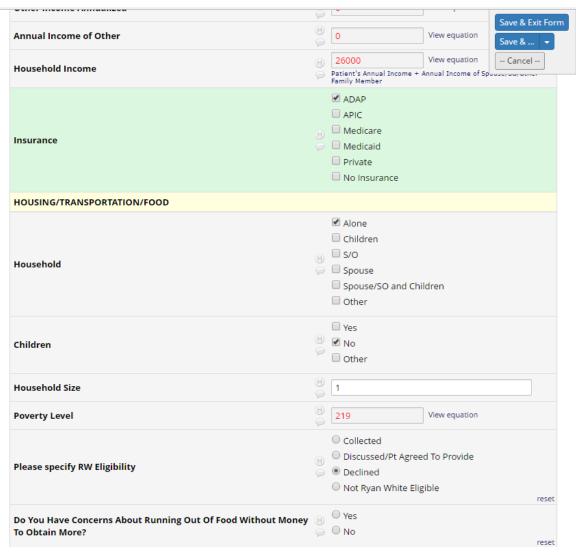
API and API Playground
The Feinstein Institute REDCap

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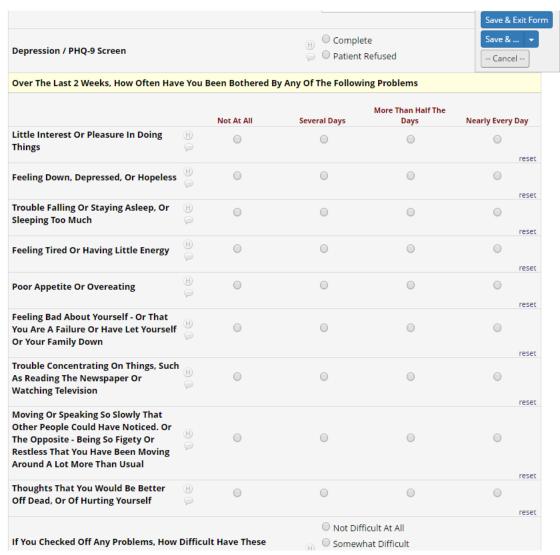






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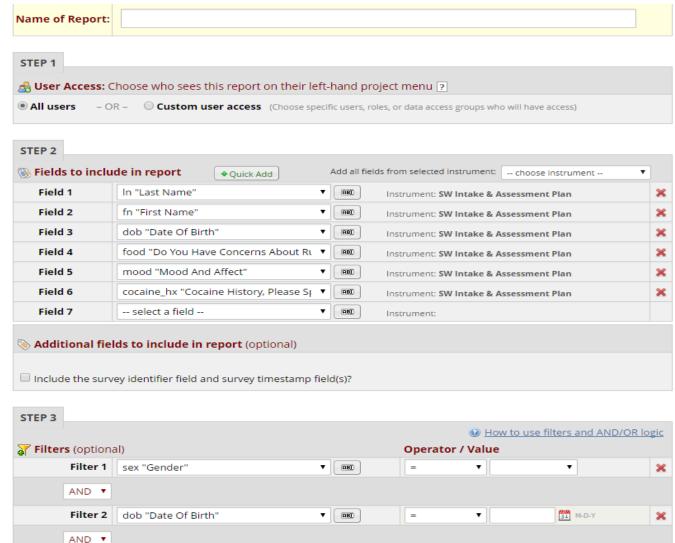


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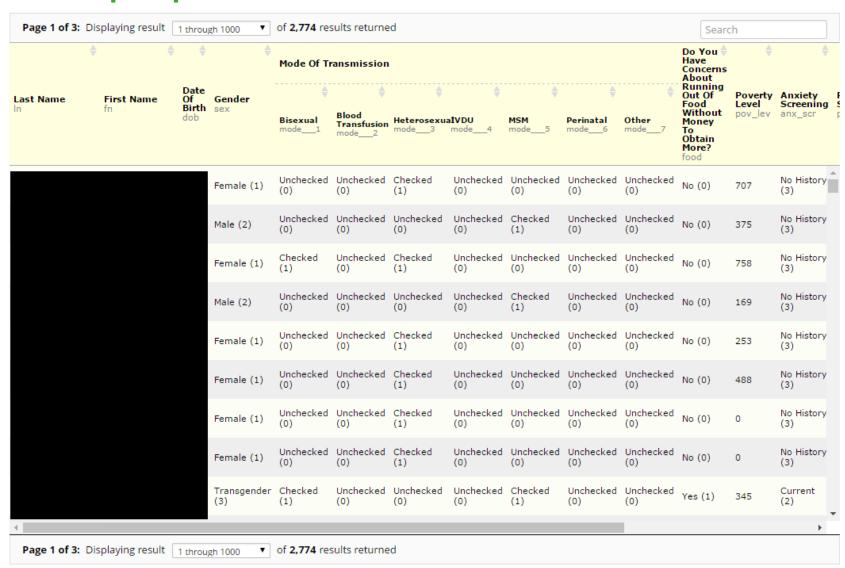
REDCap Reports







REDCap Reports





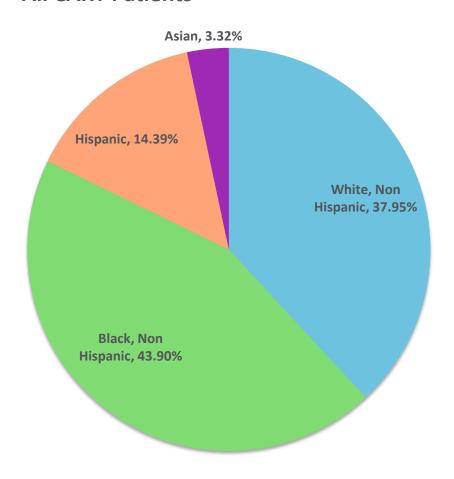
REDCap Data & Disparities in Care

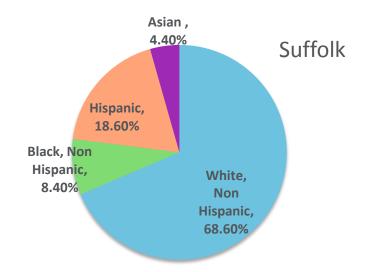


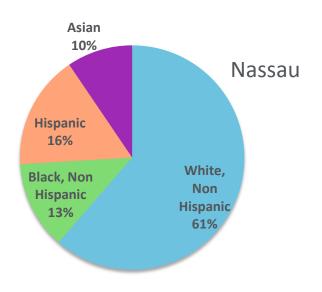


Patient Demographics

All CART Patients



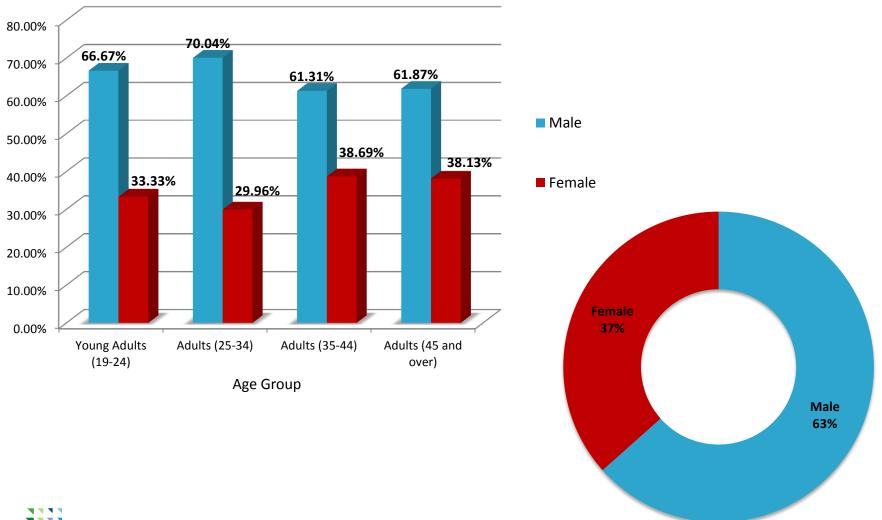






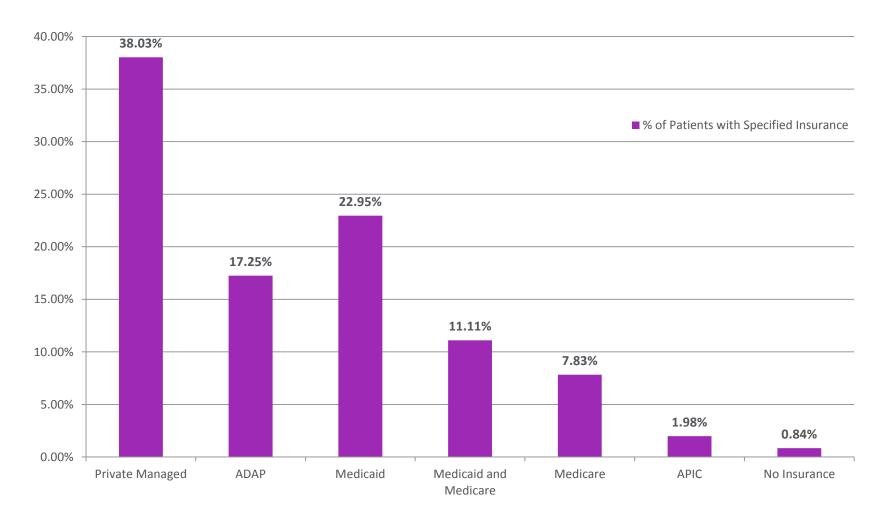
*Nassau & Suffolk Data based on U.S. Census Bureau, 2015

CART Patient Demographics



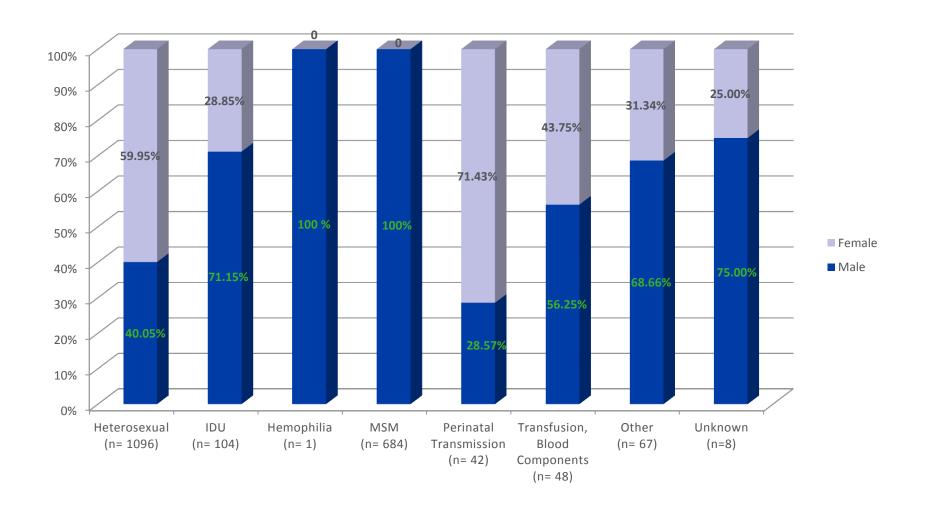


Patient Insurance





Mode of Transmission and Gender





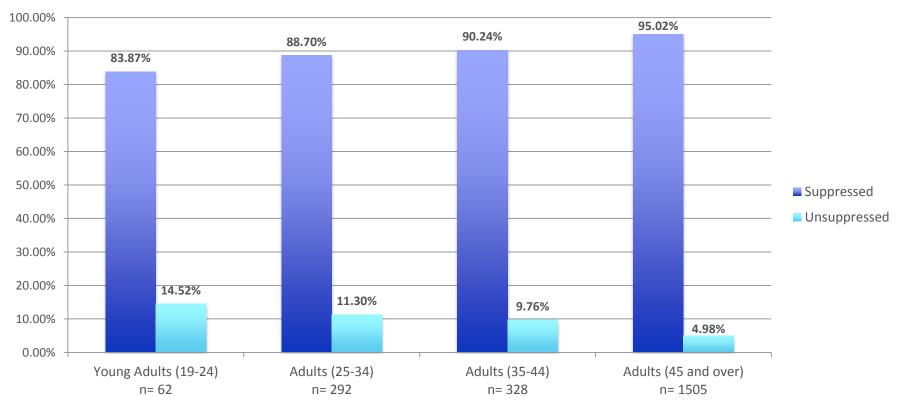
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Viral Load Suppression

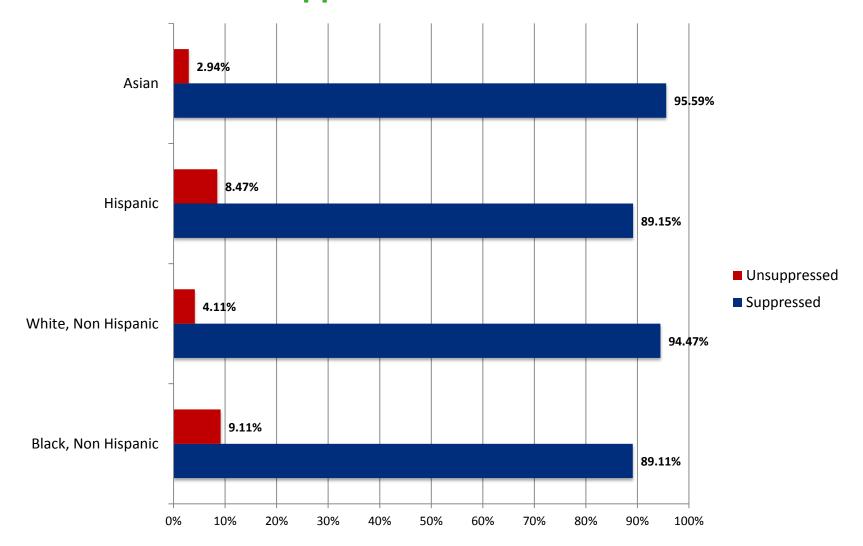
CART Clinic-Wide Viral Load Suppression Rate: 93.18%

Viral Load Suppression By Age Group



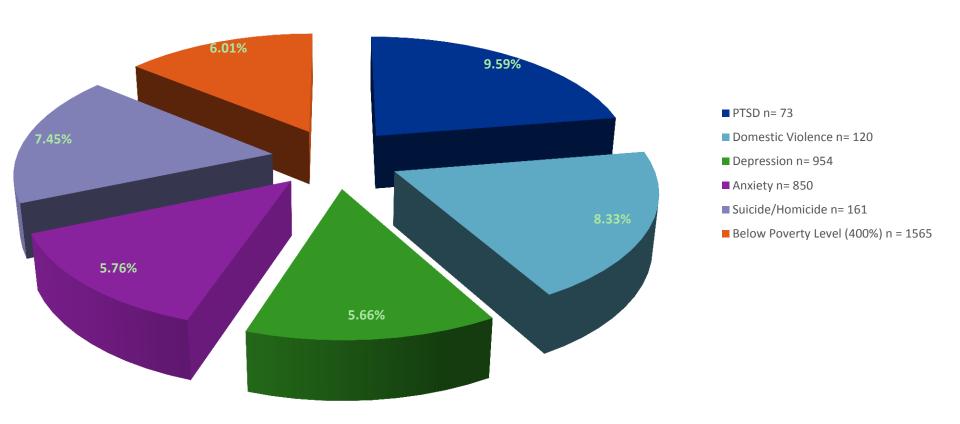


Race & Viral Load Suppression





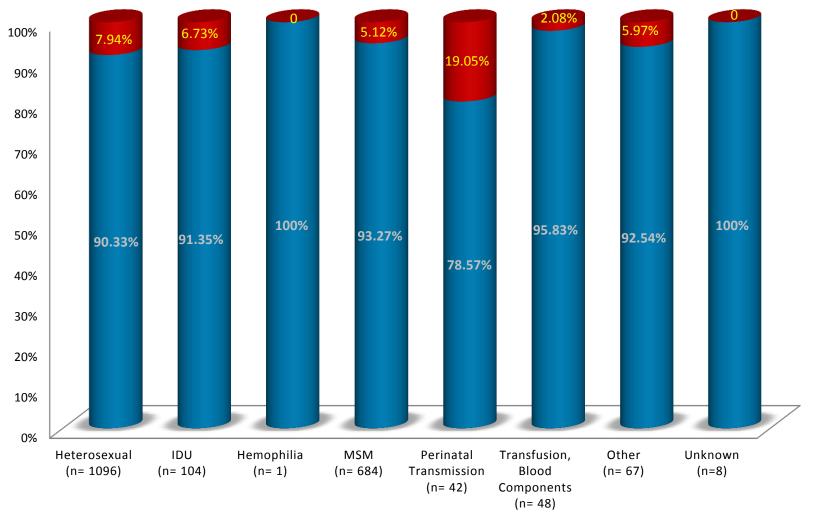
Virally Unsuppressed at Last Visit



Percentage of patients with current or past history of each subgroup that had a VL >200 at their last visit.



Viral Load Suppression & Risk Factor

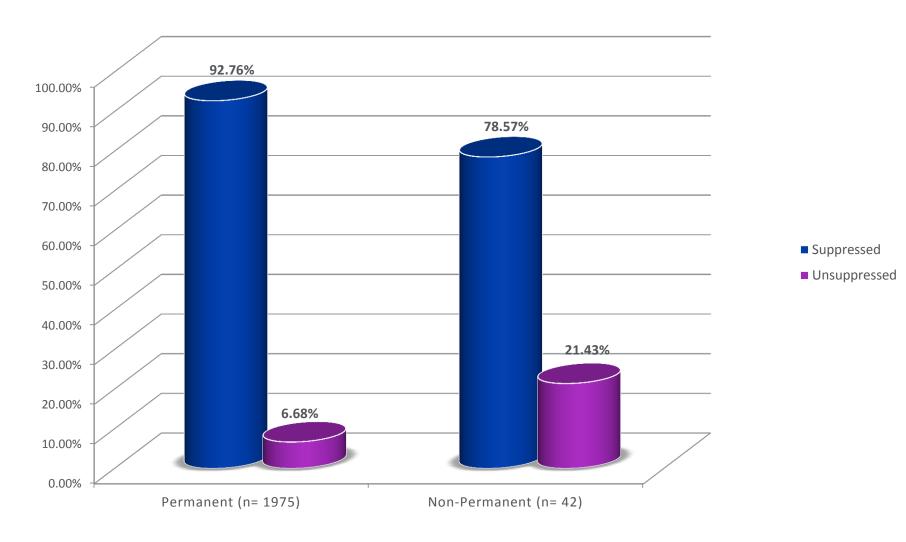




■ Suppressed ■ Unsuppressed

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Viral Load Suppression and Housing





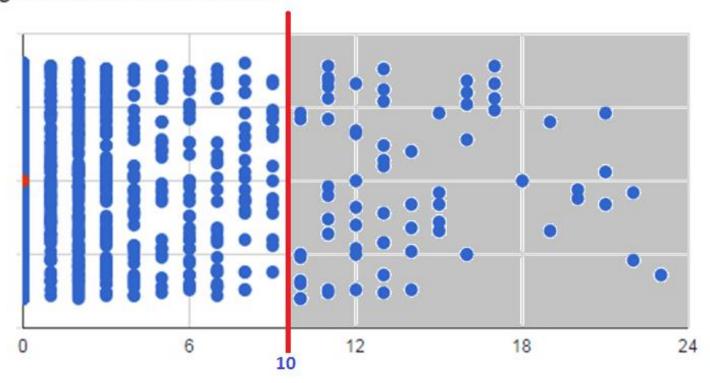
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PHQ-9 Screen

Lowest values: 0, 0, 0, 0, 0

Highest values: 21, 21, 22, 22, 23



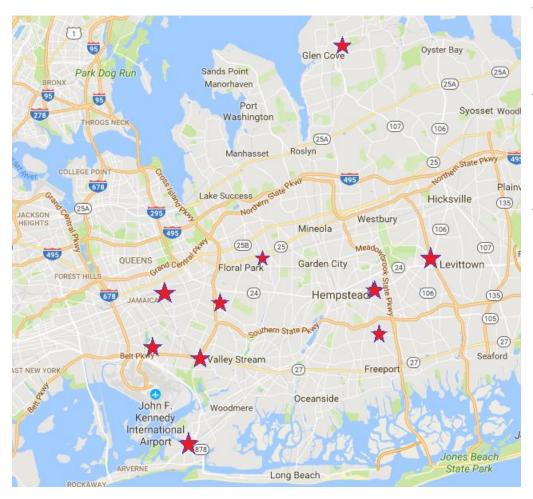
15.49% of Patients with a PHQ-9 Score ≥ 10 have a VL >200 4.97% of Patients with a PHQ-9 Score <10 have a VL >200



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Initiatives to Target Outcomes



- ✓ Expand retention efforts.
- Conduct outreach and testing in high incidence locations.
- ✓ Identify and engage POLs from disparately affected communities-disengaged/unaware stakeholders
- Scale up behavioral, biomedical, and organizational HIV intervention strategies to significantly impact the HIV epidemic and reduce health disparities identified with:
 - Young HIV-infected Adults
 - Race/Ethnicity
 - Patients with history of PTSD/Domestic Violence/Suicide-Homicide
 - Patients below the poverty level and those with unstable housing



Thank You



