

WORKSHOP IIC: APPROACHES TO IMPROVING UTILIZATION

Facilitator: Amida Castagne
Room 905-907
1:30PM — 3:15PM

Lloyd Goulbourne
Rainford Haughton
Brownsville Multi-Service

Improving HIV Annual Comprehensive Medical Visits for Care Coordination Patients

Blaz Bush
Peri Hawley
Callen- Lorde

The Creation of a Collaborative and Comprehensive Tracking Tool to Improve Staff Performance & Patient Outcomes

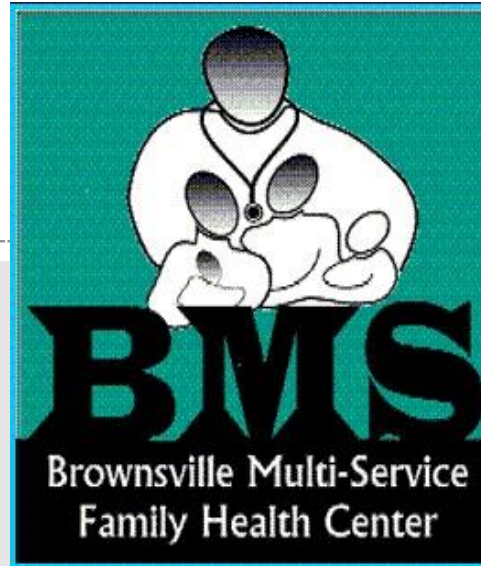
Jennifer Seager
Family Services of Westchester

Increasing Collaboration to End the Epidemic

Maria Rodriguez
Argus Community

Identifying and Addressing Barriers to Engagement and Retention to Care in a Community Based Setting

#POWEROFQI2016



BMS MEDICAL CASE MANAGEMENT PROGRAM (MCM)

WEBSITE: WWW.BMSFHC.ORG

MCM Motto



Work Smart!

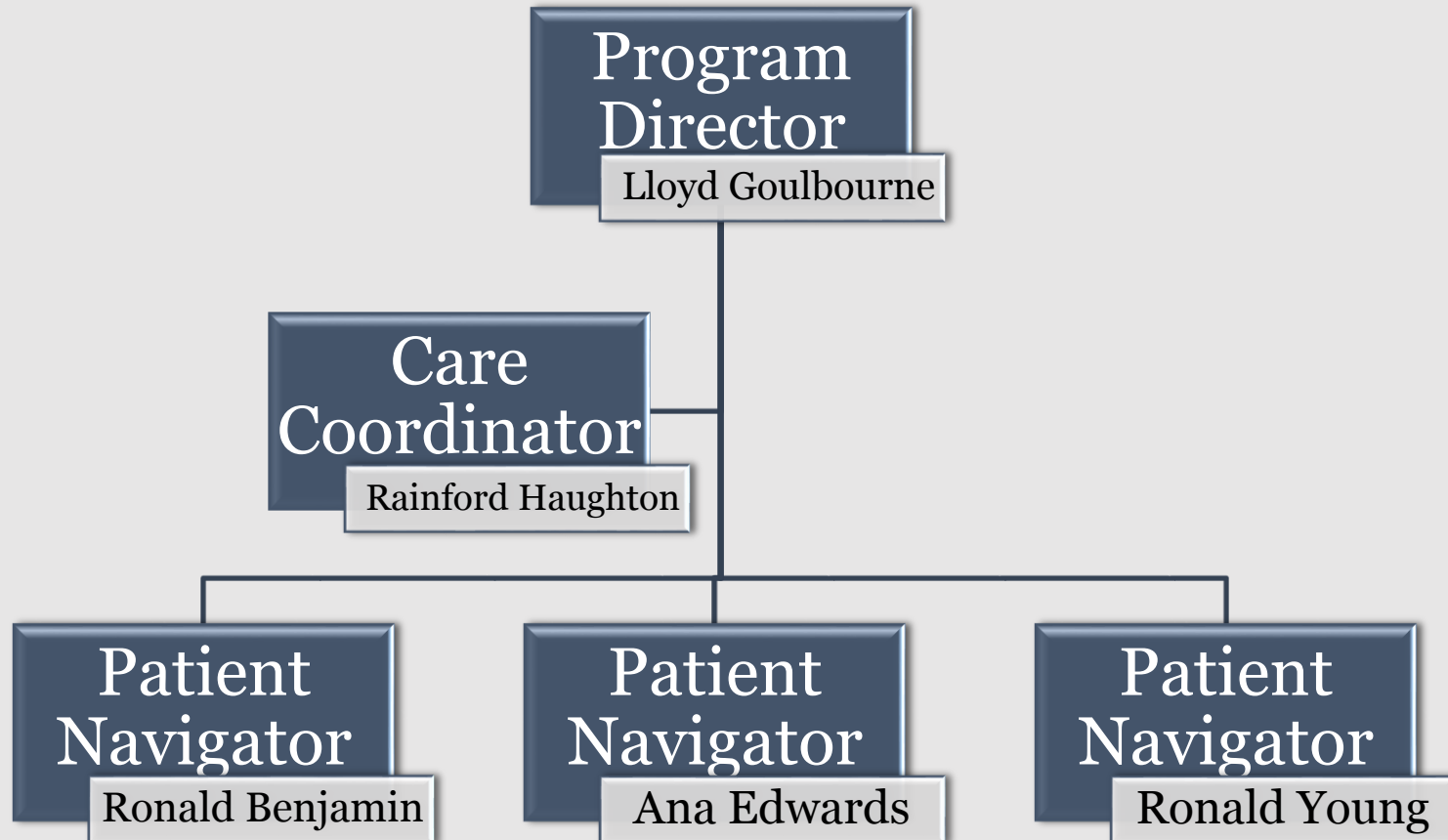
Improving HIV Annual Comprehensive Medical Visits for Care Coordination Patients



dreamstime.com

Presenters:
Lloyd Goulbourne, Program Director
&
Rainford Haughton, Care Coordinator

MCM TEAM

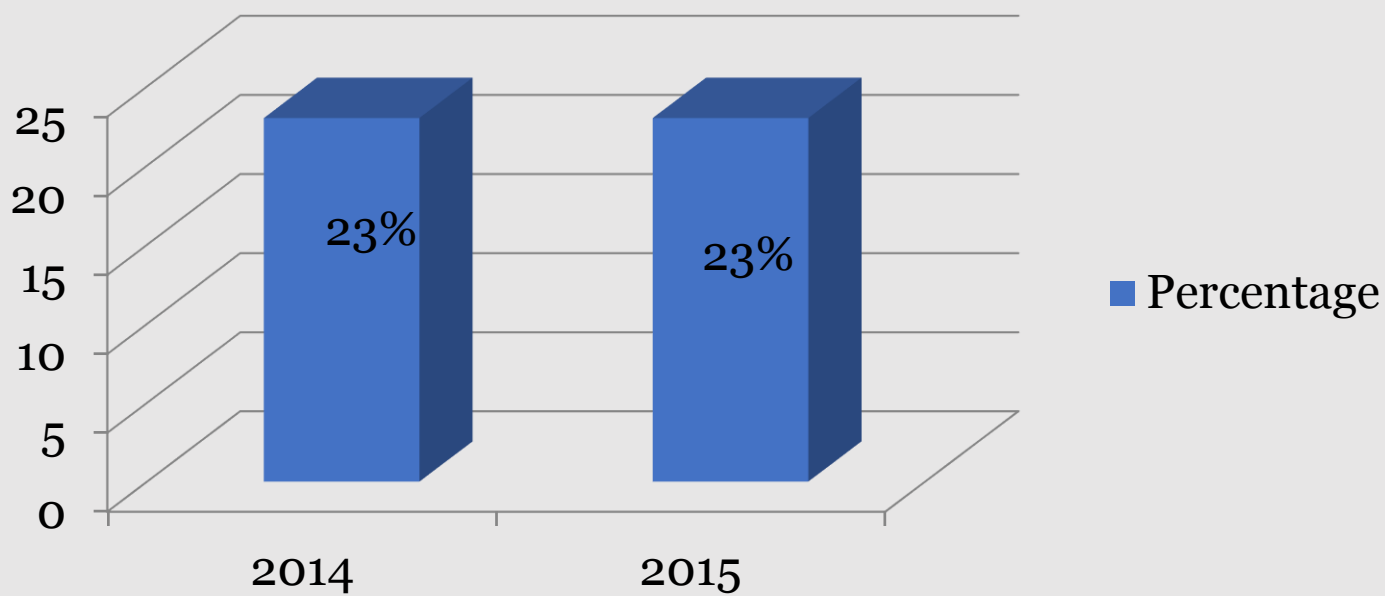


Project Background



According to data collected from our electronic medical record (NextGen), for 2014 and 2015 we had an average active caseload of 53 enrolled clients, of which only 13 had an Annual HIV Comprehensive Medical Visit for both years.

Percentage



Barriers and Challenges



☐ Substance Use

marijuana, alcohol, cocaine, heroin

☐ Mental Health

non-adherence to medication, undiagnosed conditions

☐ No source of contact

turned off cell phones, no home phones, unreliable
emergency contacts

☐ Transportation

fixed income, rising mass transit costs, difficulty scheduling
Medicaid transport

Annual Comprehensive Visits – Benefits to Clients



Annual Comprehensive Visits are important to patients

- ❑ Coordination of care including the designation of a professional member of the health care team as the Care Coordinator, who will assume continual input from all appropriate members of the health care team, the client and significant others where appropriate and assurance information flow between the ambulatory setting and other providers or sites of care
- ❑ Standard laboratory tests reviewing CD4 and Viral Load counts are completed
- ❑ Patients receive health education regarding orientation to facility procedures, including the rights/responsibilities of the patient
- ❑ Comprehensive visits last approximately forty-five (45) minutes compared to Monitoring and Follow-up visits which last thirty (30) minutes. During the comprehensive visits, it allows the PCP to make a complete health assessment, write-up: prescriptions, provide clients with medication adherence guidance and to make appropriate referrals.

Annual Comprehensive Visits – Benefits to Clients, 2



- Referrals are provided for specialists, tests conducted, and consultations made to ensure appropriate care for patients
- Psychosocial services and screenings for any social, economic and emotional concerns, and referrals are provided for these services when necessary
- Risk reduction needs identified, partner counseling referrals are provided and discussed as needs are identified

Goal of Project

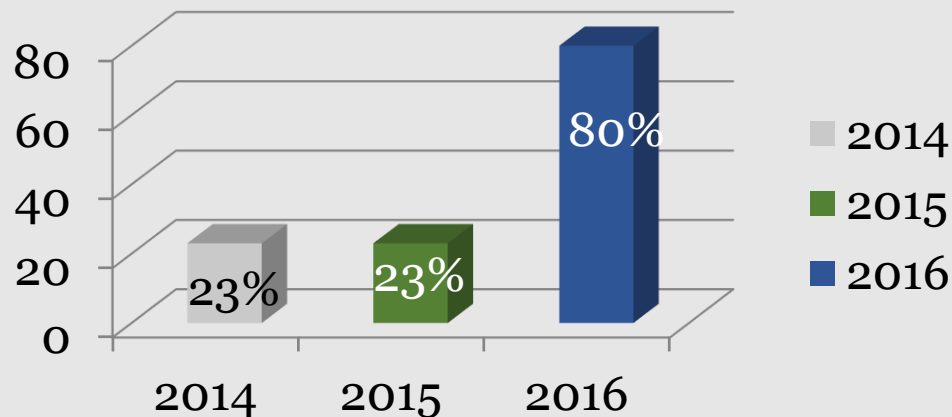


Our goal is to increase Annual Comprehensive Visits for our actively enrolled clients from 23% (13 CMV) to 80% (44 CMV).

We implemented the task of reaching that 80% mark as of March, 2016. The time frame for this project initiative was to run from March 2016 – February 2017

The expectation is that in increasing the annual comprehensive visits, will result in the decrease in walk-in visits, updated bloodwork and closer monitoring of medication adherence.

Percentage Goal



Methods of Increasing Annual Comprehensive Visits



Medical Case Management staff decided to implement the following methods, which we felt would help to ensure that quality and comprehensive care available in the comprehensive visit, is provided to more of our patients.

The methods we tried:

- Clients are educated by Patient Navigators and the Care Coordinator about the importance of the annual medical visit, during all times we have contact with the patient--home visits, office visits, clinic visits and telephone contacts.
- The Care Coordination curriculum will be used to reinforce the benefits of appointment follow-up.
- Care Coordinator and Patient Navigators will assist clients in making comprehensive visit appointments by reminder calls, home visits, and office encounters. If a client is at the BMS Bristol site, the Care Coordinator or Patient Navigator will assist that client with scheduling an appointment.

Methods of Increasing Annual Comprehensive Visits, 2

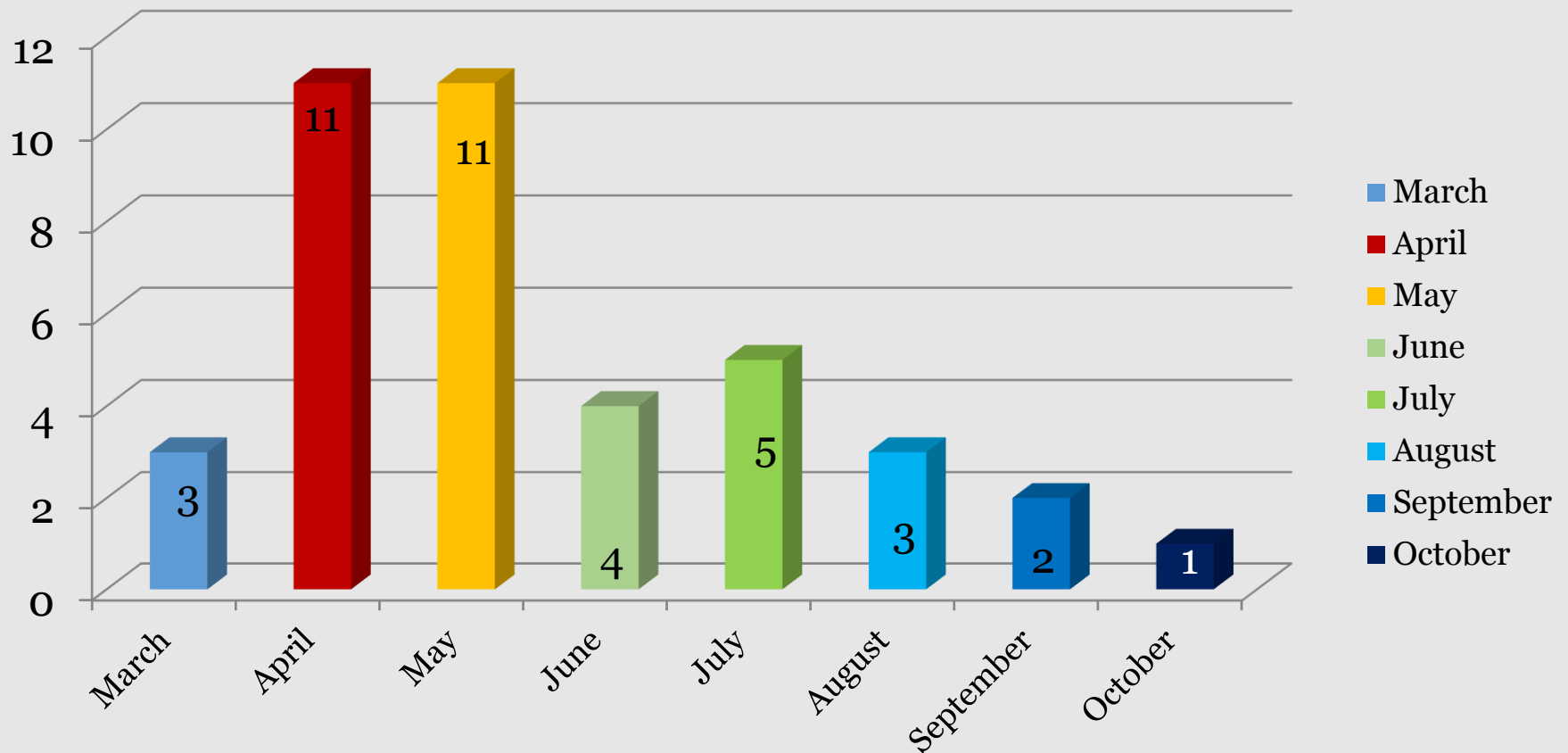


- Patient Navigator and Care Coordinator will provide appointment reminders via telephone, text and home visit. Additionally, they will accompany client to the appointment if needed, ensure client leaves clinic with follow-up appointment, and provide a metro card to assist with return visit follow-up.
- MCM Manager will conference with HIS Department Manager regarding the documentation of the coding showing the Electronic Medical Record capture of scheduled and attended visits.

YTD HIV Annual Comprehensive Medical Visits



2016 HIV Annual Comprehensive Medical Visits



YTD HIV Annual Comprehensive Medical Visits Initial Results



April and May show significant increase in appointment attendance

- ❑ Priority was given to those clients not having an annual appointment in 2 years
- ❑ Coordinated effort encompassing the MCM Team, clients and BMS/ISIS medical staff was heavily effective
- ❑ Subsequent months were initiated according to appointment need and time frame

YTD HIV Annual Comprehensive Medical Visits



- ❑ As of October 2016, 45 of the 53 active MCM clients have completed their annual comprehensive medical visit-85% of MCM patients
- ❑ We exceeded our goal of 80%
- ❑ We want to focus now on the 15% remaining
 - ❑ Appointments scheduled for October, November and December
 - ❑ Others are providing scheduling issues

Medical Case Management Results and Findings



- ❑ Trust of the clients was important (earning it and showing it)
- ❑ Effectively listening to patients proved essential
- ❑ Coordination with BMS/ISIS medical site team was very valuable and useful
- ❑ Utilization of Care Coordination Health Promotion proved useful. (topics 10, 11, 2 and 6)
- ❑ The MCM Program will continue to provide quality care to our clients

MCM Program Director along with Care Coordinator on a monthly basis conduct chart reviews and coordination surveys to monitor comprehensive appointment scheduling and attendance.

Utilization of Incentives



Incentives from the MCM Program were provided to clients

- ❑ NYC transit Metro cards
- ❑ Gift cards

Difficulties utilizing incentives:

- Turnover time to receive the gift cards
- Cost and non inclusion in program budget line for incentives
- Continued provision of incentives takes away from self ownership of care and health
- Clients continue to return for service because of the quality of service and care received.

Sustaining Gains



- ❑ Team will maintain diligent follow up with clients
- ❑ Continue providing metro cards for use with appointment attendance
- ❑ Utilize clinical supervision to make adjustments and improvements
- ❑ Maintain good communication and cooperative relationships with other BMS medical sites
- ❑ MCM team will engage ongoing Team reviews and supervisions
- ❑ Attend relevant and meaningful off site trainings and conferences

Team Work



The project is well supported and encouraged agency wide.

BMS executive and administrative staff

Various internal unit committees

BMS at Bristol Specialty Unit medical and support staff

Care Coordination staff

Director of Health Home Care Management and staff

BMS Senior Administrator



Thank you to MCM Staff; BMS Administrators and
Colleagues for all of your support and diligence







TRACKING OUR EFFORTS:

The Creation of a Collaborative & Comprehensive Tracking Tool to Improve Staff Performance & Patient Outcomes



*Peri Hawley, Program Data Coordinator, Pronouns: They/Them

*Bláz Bush, Director of Care Coordination, Pronouns: He or They



BACKGROUND:

* We had a problem:

- Grant Year 22 (2012 – 2013) 2,670 insufficient days = a loss of \$49,167.72

* The Difficulties:

- Adjusting to Per Member Per Day (PMPD) payment scale
- Too much reliance and trust on ability to track days with services
- Inability to check services without running reports plus no visual aid

* Implementation of Tracking Table:

- Deanna Duval, Manager of Intensive Care Coordination developed tool Spring 2013

* Tracking Table as Quality Service Improvement:

- Ability to better monitor services allow for consistent service delivery for patients
- Frequent, regularly scheduled visits which can easily be tracked by staff to assist in patient outcomes and engagement in the program.



	A	B	C	D	E	F	G	H	I	J	K	L
1	Patient Information	MR#	11111	11112	11113	11114	11115	11116	11117	11118	11119	11120
2		Last	One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten
3		First	Patient	Patient	Patient	Patient	Patient	Patient	Patient	Patient	Patient	Patient
4		Last VL	32159	0	0	0	0	188	21	0	0	65
5		Last VL Date	9/16	7/7	8/26	4/27	3/16	6/2	6/13	6/2	10/4	6/13
6		Time Elapsed			73	194		158		158	34	147
7		Next Labs	OK	OK	OK	Due		Due	OK	OK	OK	Due
8		Track	C2	C2	C2	C2	C2	C2	C2	C1	C1	C1
9												
46	Mar-16	8		X			X	OV		OP	FF	
47		9		X			X				OP	
48		10		X			X					
49		11		X			X				OP	
50		12		X			X					
51		13		X			X					
52		14		X		OP		OP		OP	OP	
53		15		X	FF	FF		FF			OP	
54		16		X							OV	OP
55		17		X						OP	FF	
56		18		X						FF		OP
57		19		X								
58		20		X								
59		21			FF		X					OP
60		22				FF		OP	OP			
61		23					X	OP				OP
62		24					X				NS/OP	NS/OP

HOW
THE
TRACKING
TOOL
WORKS



	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
1	Patient Information	MR#	11111	11112	11113	11114	11115	11117	11118	11119	11120	CLOSED	11116				
2		Last	One	Two	Three	Four	Five	Seven	Eight	Nine	Ten		Six				
3		First	Patient	Patient	Patient	Patient	Patient	Patient	Patient	Patient	Patient		Patient				
4		Last VL	32159	0	0	0	0	188	21	0	0			Total	9	100.00%	
5		Last VL Date	9/16	7/7	8/26	4/27	3/16	6/2	6/13	6/2	10/4			QA	0	0.00%	
6		Time Elapsed	38	109	59	180	222	144	133	144	20			QB	0	0.00%	
7		Next Labs	OK	OK	OK	Due	Due	Due	OK	OK	OK			C1	0	0.00%	
8		Track	D	C2	C2	C2	C2	C2	C2	C2	C2		QA	C2	8	88.89%	
9														D	1	11.11%	

"PATIENT INFORMATION"

1. Open or Closed
2. Medical Record #
3. Name
4. Last VL (and Date)
4. Time Since Last VL Labs
5. When Next HIV Labs are Due
6. ICC Track
7. Caseload Track Breakdown



MONTHLY SERVICE TRACKING

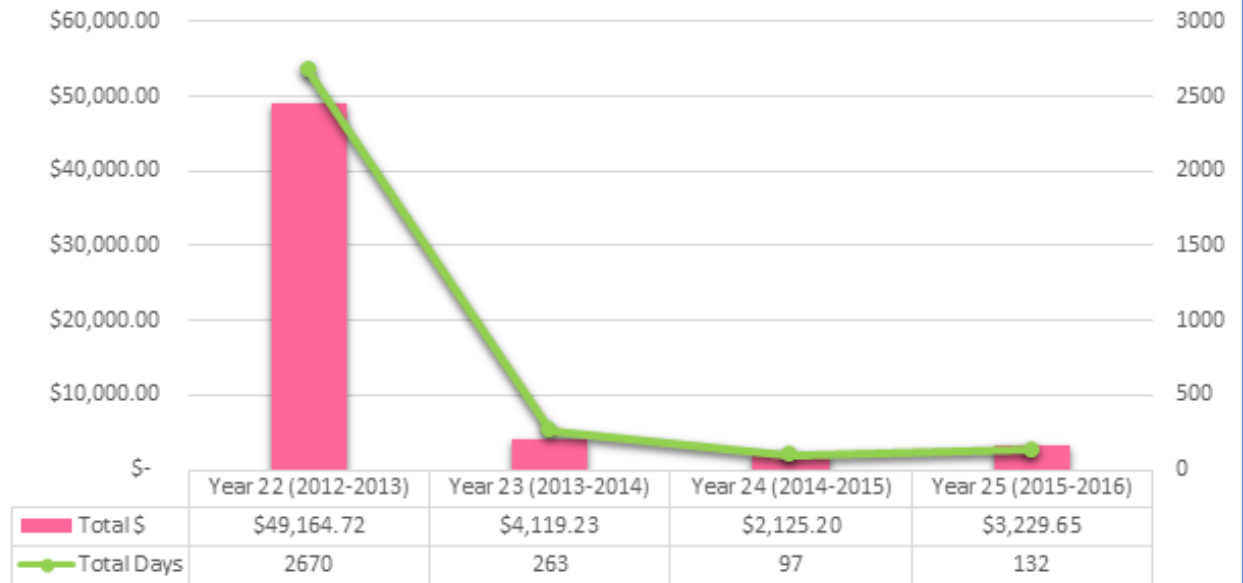
10		1						OV		FF		
11		2				FF				OP		
12		3				FF		FF				
13		4								OP		
14		5										
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16		7			FF					OP		
17		8						OV		OP	FF	
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21		12										
22		13										
23		14				OP		OP		OP	OP	
24		15			FF	FF		FF		OP		
25		16								OV		
26		17								OP	FF	
27		18								FF		
28		19										
29		20										

1. Open or Closed
2. Services Performed
 1. OP = Outreach Phone Call
 2. OV = Outreach Visit
 3. FF = Face-to-Face
 4. NS = No-Show
3. Expected Upcoming Activities
4. Insufficient Days
5. Corrected Insufficient Days

OUTCOMES:

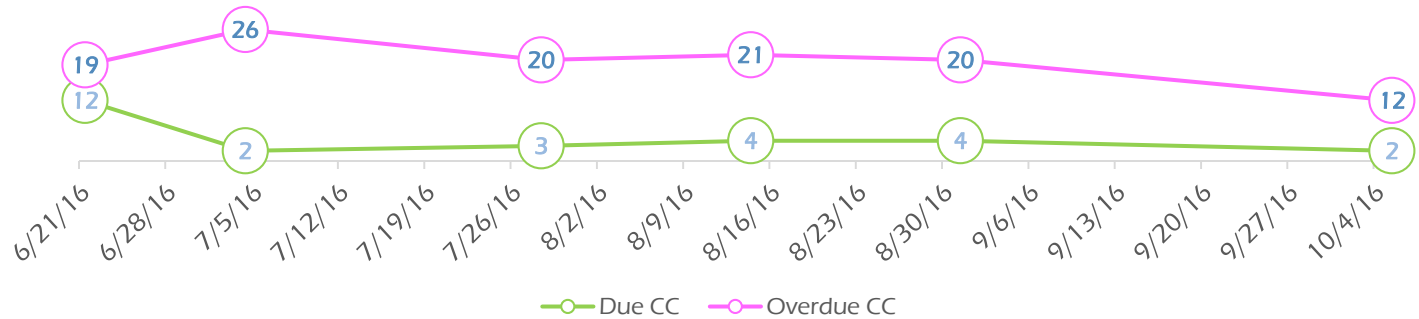


Total Insufficient Days & Unpayable Monies
[Years 22-25]

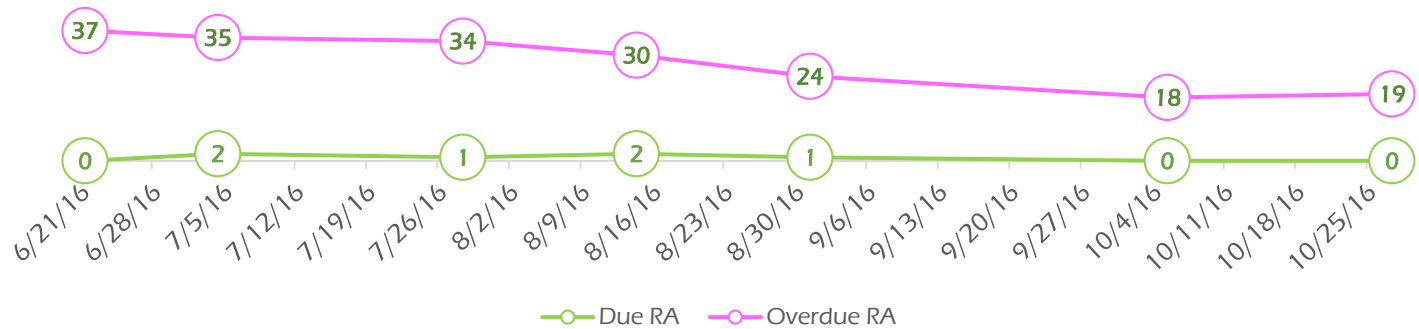


OUTCOMES:

CASE CONFERENCES 06/21 - 10/5



RE-ASSESSMENTS 06/21 - 10/5





NEXT STEPS:

*** Track improvements to Reassessments, Case Conferences and Viral Load**

- Helpful or too burdensome?

*** Create best practices for tracking table**

- Some better utilize the table than others



QUESTIONS?



INCREASING COLLABORATION TO END THE EPIDEMIC

THE PARTNERSHIP FOR CARE PROGRAM
OF FAMILY SERVICES OF WESTCHESTER

THE PARTNERSHIP FOR CARE PROGRAM



END THE EPIDEMIC BY 2020!

Governor Cuomo's 3 point plan to reduce the number of new infections to 750 by the year 2020:

- Identify persons with HIV who remain undiagnosed and link them to health care.
- Link and retain persons diagnosed with HIV in health care to maximize virus suppression so they remain healthy and prevent further transmission.
- Facilitate access to Pre-Exposure Prophylaxis (PrEP) for high-risk persons to keep them HIV negative.

WHERE AND HOW DO WE FIND UNDIAGNOSED PEOPLE?

Current Outreach Strategies

WHICH ORGANIZATIONS MIGHT BE SERVING UNDIAGNOSED, HIGH-RISK PERSONS?

We anticipate that many “high risk” persons and persons with HIV can be reached through HIV service organizations & public venues. We want to ensure that non-medical organizations are aware that they may be working with persons with HIV but don’t know it, as well as how they can also take steps to connect their HIV clients to care.

PARTNERSHIP FOR CARE

Goal #2: To increase incoming and outgoing referrals through heightened collaboration with existing Community Based Organizations (CBOs) and development of new partner relationships.

PARTNERSHIP FOR CARE

The Partnership for Care program implemented an outreach plan template in June 2016. The purpose was:

- To increase awareness about the prevalence of and supportive services available for persons with HIV in Westchester County
- To engage non-medical partner organizations who may work with at-risk or HIV positive individuals
- To increase incoming and outgoing referrals and strengthen the network of services for persons with HIV in Westchester County

PARTNERSHIP FOR CARE

In addition to direct outreach, we propose the implementation of a “train the trainer” model so that CBOs are aware of the most recent information and what resources are available to their clients. By providing access to information, contacts, and HIV prevention & treatment resources, we anticipate that the rate of transmission will decrease.

ASSESS CURRENT REFERRAL SOURCES

- What types of organizations are referring?
(i.e. hospitals, community clinics)
- Who are they referring and why?
(i.e. transgender males, 65+)
- Who are we missing?

ENGAGEMENT STRATEGIES

- Engage and Understand (i.e. what are their program goals?)
- Housing
- Discharge
- Job Placement/Training Program
- Increased Community Awareness/Traffic

ENGAGEMENT STRATEGIES

- Put on Your Director of Development Hat!
- Cultivate Prospective Referral Sources
 - What are you going to do for them?
- Train the Trainer
- Offer a Brief, User-Friendly Guide
 - How to Talk with clients about HIV awareness
 - How to have a 1:1 conversation with someone who thinks they may have been exposed or who is positive

ENGAGEMENT STRATEGIES

- Multiple “Touches” Required. Remind them that you’re here. Then Remind them again!
- Phone calls
- Email blasts
- Personal emails
- Flyers/brochures
- Refer your Clients!

PUT ON YOUR DIRECTOR OF DEVELOPMENT HAT!

- ❖ **Thank them for the referrals and follow up**
- ❖ **Remember, our job is to make their jobs easier**

PARTNERSHIP FOR CARE OUTREACH PLAN

CORRECTIONAL PROGRAMS

Correctional Facilities
Re-entry Juvenile

HOUSING SERVICES

Breaking Ground/VA
Traditional Housing
Facilities(SROs)

HIV AWARENESS
PREVENTION
TREATMENT
SUPPORT

PUBLIC VENUES

Libraries
Community Events (fairs)
Colleges/Training Programs

YOUTH SETTINGS

Residential Settings
SNUG (youth empowerment)
Social service programs

NEXT STEPS

- ❖ Think about the organizations in your surrounding area who might be working with folks who are at risk and/or positive
- ❖ Develop your own engagement strategy

**FAMILY SERVICES OF WESTCHESTER
PARTNERSHIP FOR CARE PROGRAM
20 SOUTH BROADWAY YONKERS NEW YORK
914-964-6767X132**

Medical Case Management

A wrap-around service for clients needing support to participate in medical care and/or remain treatment-adherent, or who need assistance navigating issues such as medical coverage, spend-downs, transportation to medical appointments, and benefits.

Mental Health

Our article 38 clinic in Yonkers has the capacity to work specifically with persons with HIV. We provide individual, couples, and family therapy with the philosophy that healing the mind can aid in healing the body. Our Ryan White mental health program also partners with community organizations to provide mental health services in the community.

Living Together

Our groups are run for and by persons with HIV. Men's and Women's Support Groups include a meal and a sense of comradery, while the general groups address state and local policy changes for persons with HIV. Participants are encouraged to take ownership of their own healthcare and become advocates for policy change while supporting one another in the process.

Argus Community Inc. ACCESS II Care Coordination Program



760 East 160th Street
Bronx, NY 10456
718-401-5400

Care Coordination Team

PROGRAM STAFF

DOT Field Specialist (3)

Patient Navigators (6)

Care Coordinators (2)

Medical Center Liaison

Data Manager

Program Director

CLIENT

MEDICAL PARTNERS

11 Clinics from the Montefiore
Medical Group-CICERO
Program

Montefiore Hospital The AIDS
Center

HHC Lincoln Hospital

Medcare Consultants

Balm of Gilead Medical Office,
PC

Desmond Family Center



Program Goals

To assist clients/patients with overcoming treatment adherence barriers and assist them with achieving and maintaining viral suppression

Enroll clients/patients for Directly Observed Therapy

Achieve yearly at least 80% of our Quality Indictors

1. Home/Field Visits

Measured according to tracks

2. Health Promotion

Measured according to tracks

3. Case Conferences

4. Adherence Assessments



Plan

Directly Observed Therapy

Modified services for clients/patients in the program indicated for and prescribed ART, and/or other prescribed non-ART medications (psychotropic, opportunistic infections, and/or Hepatitis C) who are not viral load suppressed or have history of non-adherence to medications. Modified services means not all prescribed doses and not seven(7) days a week. Service can be conducted at home/field, office site, or clinic. (Conducted by CC, PN, and or DOT Field Specialist).



Challenges

Not co-located with our medical providers

Provider Buy-In

Communication with providers

Resistance from the clients/patients

Other services needed income, housing, mental health, and
substance use

Scheduling DOT Services

Staff Turn Over



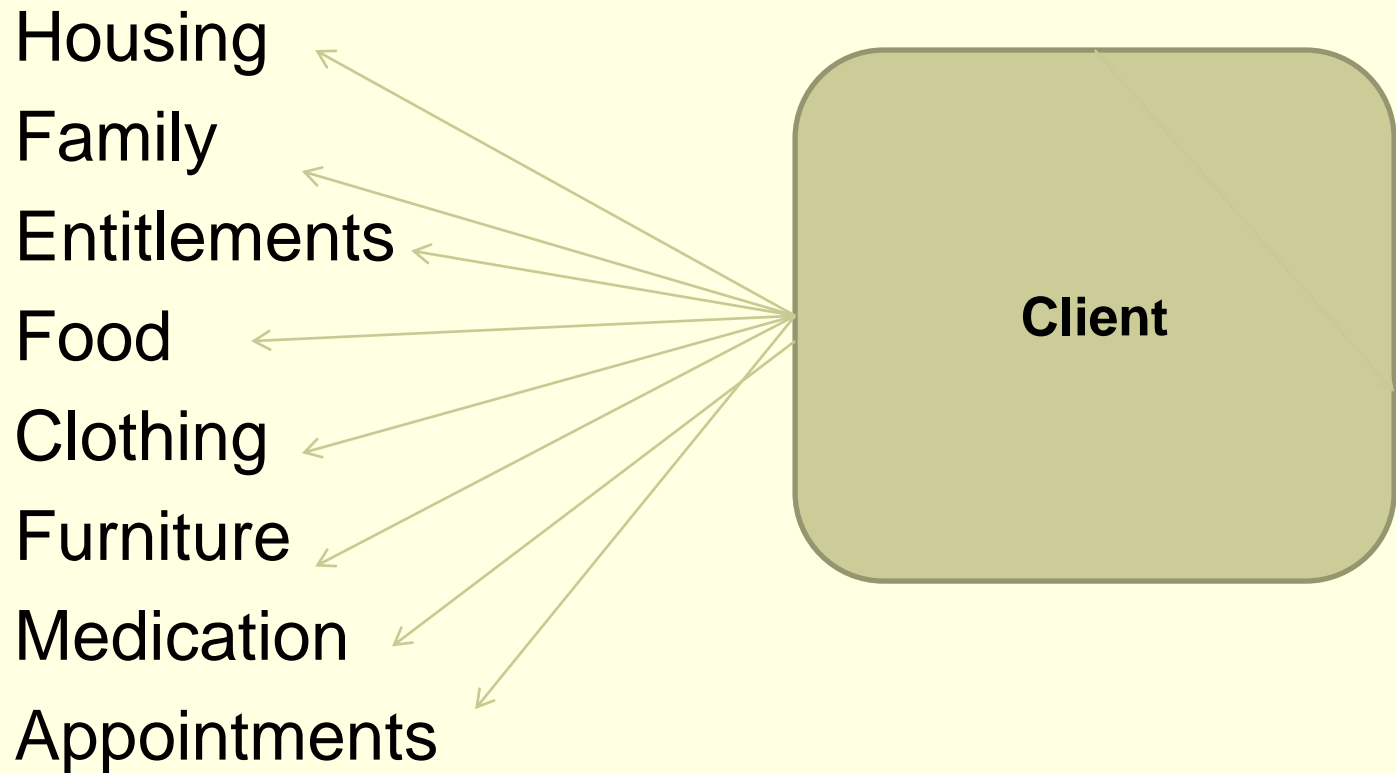
Prioritizing Needs

■ **Primary Care Providers**

- Seeking assistance with their most difficult patients that have not achieved viral load suppression or their attendance to medical appointments is poor.
- Ongoing reports of what is happening with their patients in their community. Any reports on side effects, not taking their meds, not having any refills, and/or refusal of services.
- Seek assistance from PCP when necessary. Do not wait until next medical appointment to update the PCP on client/patient.



Prioritizing Needs



Brainstorming

The 3 C's of the ACCESS II CCP

- Collaboration
To work with another person or group in order to achieve or do something.
- Communication
the act or process of using words, sounds, signs, or behaviors, to express or exchange information or to express your ideas, thoughts, feelings, etc., to someone else.
- Consistency
 - Conformity in the application of something, typically that which is necessary for the sake of logic, accuracy, or fairness.
 - the achievement of a level of performance that does not vary greatly in quality over time.



Do

- **Provider Buy-In**

Met with providers to discuss referrals, eligibility, and follow-up with DOT services. Provide email feedback to providers after first month of enrollment and ongoing . Attend monthly meetings with providers and provide them with a copy of their patients monthly DOT logs.

- **Communicate**

Present DOT services as a temporary service to the clients being referred.

Assign clients to workers that speak their language (English, Spanish, French).

Providers sometimes provide staff members with their cell phone numbers for emergencies.

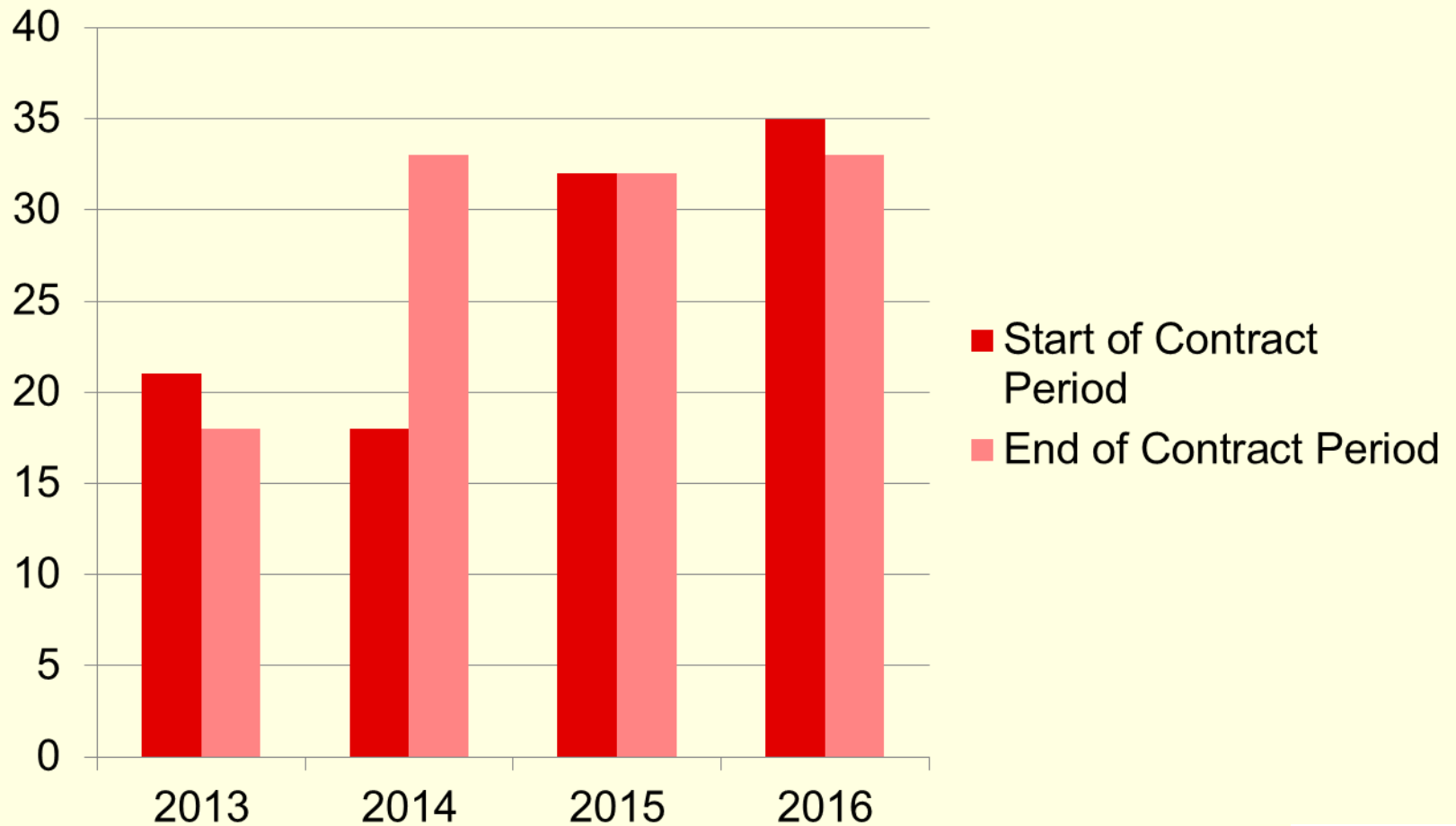
Medical Staff provides team members with upcoming medical appointments.

- **Training for Staff**

Provide team field safety training, assess staff availability to assign them with DOT client, provide Metro Cards ,and cell phones. Ensure that client meets more than one person in CCP so there is no interruption in services when staff member becomes ill or no longer works with the program.

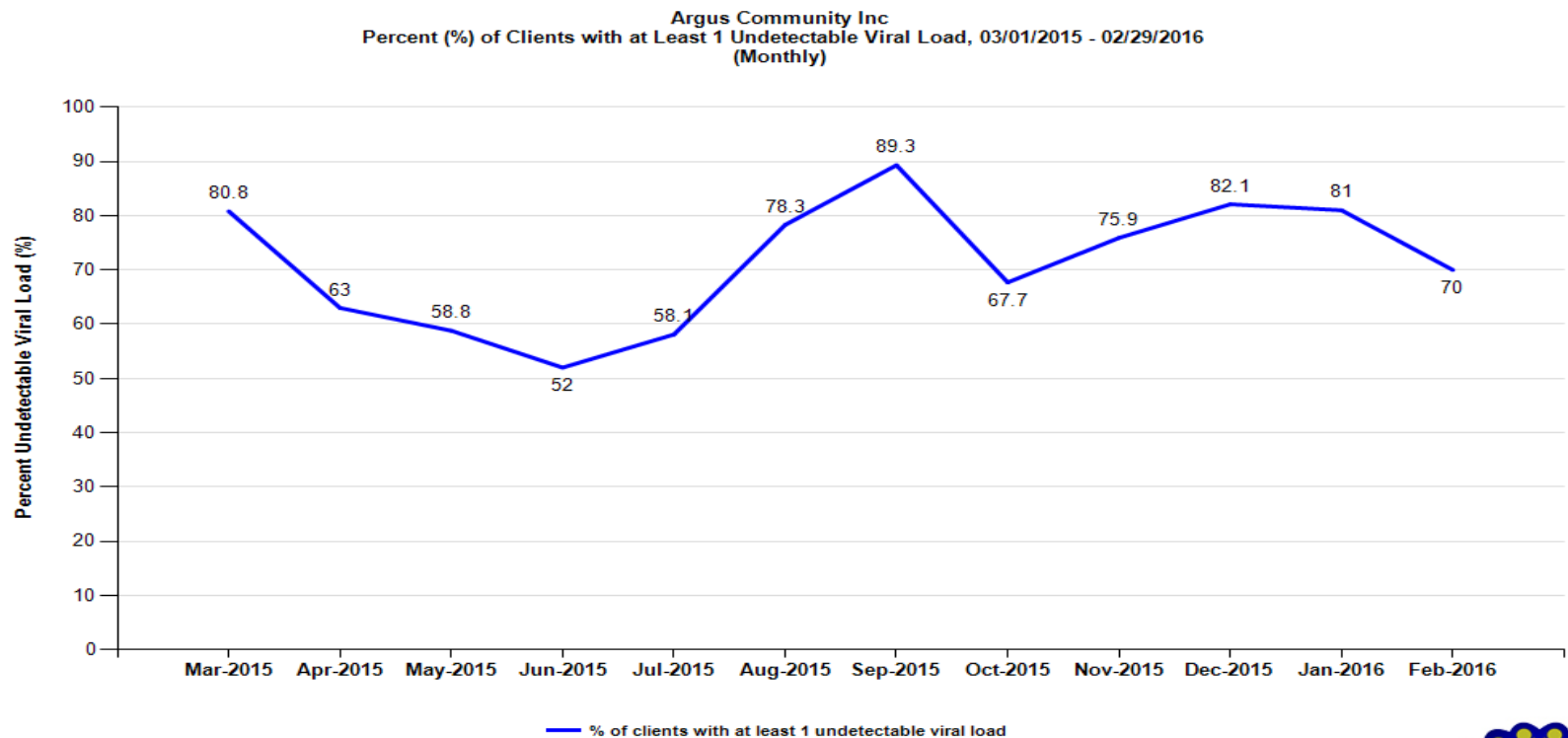


Study DOT Enrollments



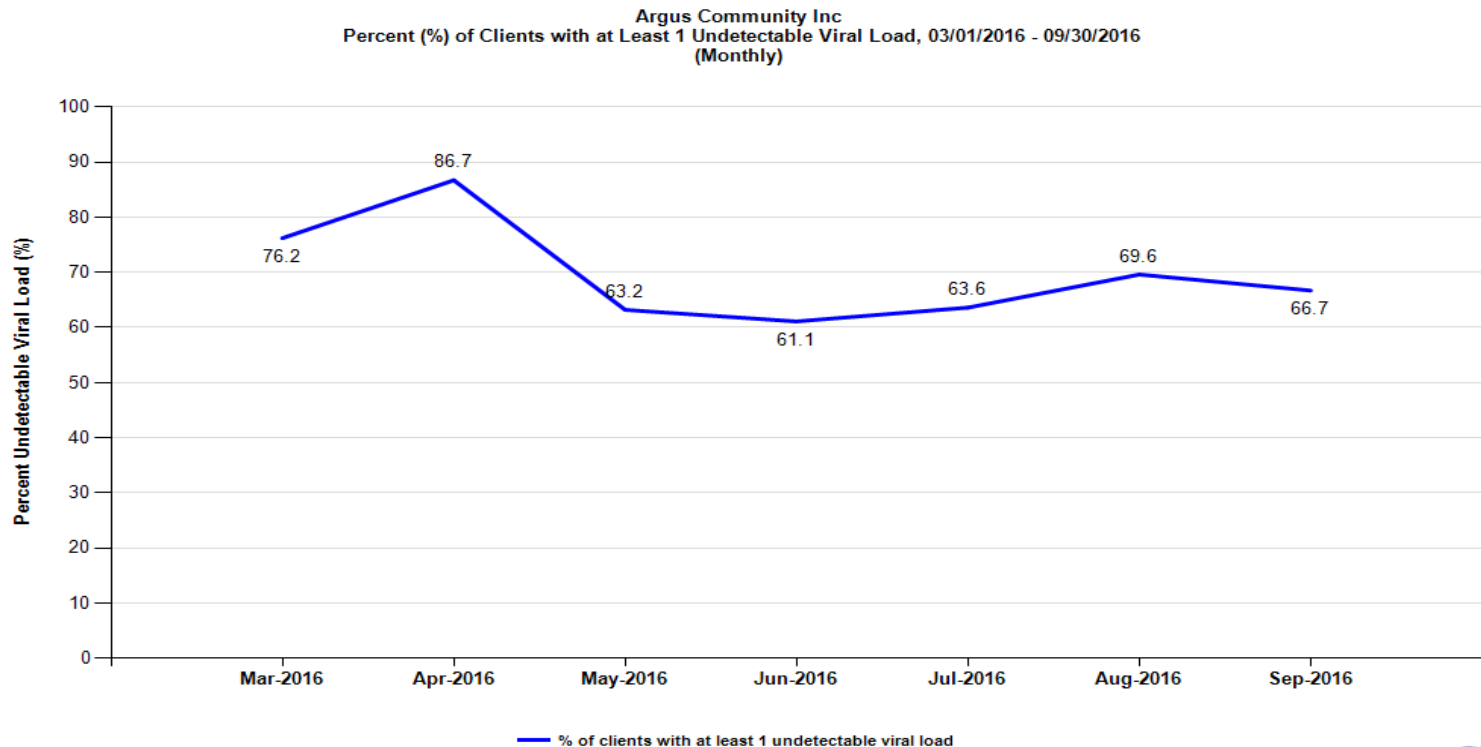
Outcomes

Percent of client with 1 undetectable VL monthly for last contract year (2015)



Outcomes (Cont..)

- Percent of client with 1 undetectable VL monthly for last contract year (2016)



Lessons Learned

DOT services is not for all clients/patients

time, readiness, willing to try something new is important.

Team members need to work together to meet clients daily and assist the clients with understanding adherence. Team needs to show compassion for their client's situation and the difficulties they have with adherence. Advocate for their clients when necessary.

Primary Care Physicians get a better picture of what's happening with the client at home. We are their eyes and ears in the community and they rely on us to report the barriers and and/or accomplishment with each patient.



Next Steps

- Study DOT clients VL from time of enrollment to VL suppression (determine time frame).
- How long does it take for a DOT client to graduate from the program?
- Survey DOT clients at the time of graduation to determine what was helpful to them and what wasn't.





BCHN

Bronx Community Health Network, Inc.

COMMUNITY PARTNER AWARD

**Presented To
ARGUS COMMUNITY ACCESS II
CARE COORDINATION
PROGRAM**

**In Recognition Of Your Hard Work,
Dedication And Accomplishments In
The Community We Serve**

**BRONX COMMUNITY
HEALTH NETWORK, INC.
BOARD OF DIRECTORS**

August 11, 2016



Contact Info.



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