### New York Links: Bronx Regional Group Meeting Agenda

**Thursday, June 30, 2016 – 8:30AM – 1:00PM**

Institute for Family Health (IFH) – 1894 Walton Avenue, Bronx NY

(Agenda and agenda timeframes are subject to change)

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<tr>
<th>Event Description</th>
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<td>Breakfast and Sign in</td>
<td>8:30-9:00</td>
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| Opening & Welcome: What is NYLinks and why is it key to      | 9:00-9:15 | Dan Belanger, LMSW  
Director, NYS Quality of Care Program, NYSDOH AIDS Institute  
Monica Chierici, MPA  
Project Management Director, Bronx Partners for Healthy Communities |
| Epidemiology Data & the Bronx                                | 9:15-9:30 | Sarah Braunstein, PhD  
Director, HIV Epidemiology and Field Services Program, New York City Department of Health and Mental Hygiene |
| Attendee Introductions                                       | 9:30-9:45 | All                                                                          |
| Small Group Work – Part One: The Living Cascade: Focusing   | 9:45-10:45 | Dan Belanger                                                                |
| on the Care in the Care Continuum                            |        |                                                                              |
| **BREAK**                                                    | 10:45-11:00 | All                                                                      |
| Small Group Work – Part Two: Report Back & Discussion       | 11:00-11:15 | Monica Chierici                                                            |
| Provider Viral Load Suppression QI Project Discussion        | 11:15-11:45 | David John, MD,  
Morrisania Diagnostic and Treatment Center  
Rebecca Greene, LMSW  
Institute for Family Health |
| Involving consumers to improve quality of care outcomes     | 11:45-12:00 | Penelope Dumas, PhD  
Jacobi Medical Center  
Dan Tietz, Consumer Advocate  
NYSDOH AIDS Institute |
| Retention & Viral Load Suppression Challenges and Success    | 12:00-12:30 | R. Candace Jones, MS  
Program Manager, CARE Services  
Morris Heights Health Center & TBA |
| Stories: Discussion                                          |        |                                                                              |
| Q&A, Meeting Evaluation, Next Steps and Wrap Up              | 12:30-1:00 | Dan Belanger, Monica Chierici                                                |
DSRIP Overview

- **What is DSRIP (Delivery System Reform Incentive Payment Program)?**
  - CMS has negotiated with individual states to reinvest Medicaid savings into delivery system reform (MRT waiver)
  - Incentive program to transform the healthcare delivery system for Medicaid and uninsured populations
  - Goal of promoting health of populations while reducing high cost care, specifically in ED and Hospital settings (Triple Aim)
  - At the end of 5 years, NYS must demonstrate 25% reduction in avoidable ED visits, admissions and readmissions

- **How do Providers participate in the DSRIP program?**
  - Providers need to join regional coalitions called a PPS (Performing Provider System)
  - A PPS selects 10 projects from a list defined by NYS
    - Each project has metrics/deliverables that trigger payments
    - Project selection guided by a community needs assessment
BPHC: Who We Are

- SBH is the lead hospital in a PPS called Bronx Partners for Healthy Communities
- BPHC comprises 211 unique organizations and over 5,500 providers who will manage the care of 270,000 Medicaid beneficiaries living in the Bronx through New York State’s Delivery System Reform Incentive Program (DSRIP)
- Founding members
  - Acacia Network
  - Bronx United IPA
  - Institute for Family Health
  - Montefiore Medical Center
  - Morris Heights Health Center
  - Puerto Rican Family Institute
  - SBH Health System
  - Union Community Health Center
BPHC: Who We Are

- BPHC’s network includes a wide array of organizations and services:
  - Hospitals
  - Primary and specialty care services
  - Behavioral health and substance abuse services
  - Long term care and assisted living facilities
  - Home care agencies
  - Health homes
  - IPAs
  - Community-based organizations (e.g., services for the developmentally disabled, housing, adult day care centers, advocacy, foster care, meal delivery, food banks, legal aid, counseling, youth development)
  - Educational institutions
  - Pharmacies
  - Unions
  - Health plans

- Central Services Organization (CSO) supports the work of BPHC
ENGAGING MORRISANIA HIV PATIENT IN HEALTHY CARE

Increasing HIV Suppression Rates
Presented by:

Dr. David H.A. John
Medical Director Morrisania Health + Hospitals
Improvement Project Background

Viral load counts provides important information related to the HIV/AIDS patients health status, and how well they are responding to antiretroviral therapy (ART)

• In 2013 (Ehivqual):
  63% Virally Suppressed
  53% Always Suppressed

Presented by: Dr. David H.A John - Medical Director Morrisania Health + Hospitals
Improvement Project Goal

- To increase the number of patients with suppression from 63% - 90%
- To increase the continuous suppression from 53% - 70%

Presented by: Dr. David H.A John - Medical Director Morrisania Health + Hospitals
Plan/Do

There was not a dedicated Case Manager (CM) assigned to work with providers to ensure that patients were scheduled and kept their appointments; as well as retention in care.

Presented by: Dr. David H. A John - Medical Director Morrisania Health + Hospitals
Do/Study

- CM prepared daily reports on HIV patients scheduled and informed providers of any outstanding labs etc.

- CM made reminder calls to patients with regards to their appointments as well as follow-up

- CM presented monthly updates on patients as well as identified any fall-outs at the monthly HIV meeting

- The Systems Analyst prepared provider specific reports focusing on viral load suppression

Presented by: Dr. David H.A John - Medical Director Morrisania Health + Hospitals
Viral Load Suppression:

- 81% (85 of 95 patients)

Always Suppressed:

- 75% (78 of 95 patients)
Study

Patients visited more frequently:

- 12- Month Retention – 83%
- 24 – Month Retention – 63 %
- New Patient Retention – 75%

Presented by: Dr. David H.A John - Medical Director Morrisania Health + Hospitals
Act

Further investigation is required as to the loss of the 24 month retention.

- Indications suggests that the fall-out maybe attributed due to a gap in available appointment dates
- A segment of the population are not US residents as such they miss scheduled appointments and follow-up
- Check Care Systems Report (CSR) to ascertain whether patients are visiting other H+H facilities

Presented by: Dr. David H.A John - Medical Director Morrisania Health + Hospitals
Next Steps

• Look at other PDSA cycles that will improve patient outcomes

• Daily huddles with CM and providers:
  - Provide updates on non-compliant HIV patients
  - Identify missing services on existing patients
## BPHC’s DSRIP Projects

### Domain 2
**System Transformation**

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<td>Create Integrated Delivery Systems</td>
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### Domain 3
**Clinical Improvement**

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<td>Evidence-Based Strategies for Managing Adult Population with Cardiovascular Disease</td>
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<td>Evidence-Based Strategies for Managing Adult Population with Diabetes</td>
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<td><strong>3.d.ii</strong></td>
<td>Expansion of Asthma Home-Based Self-Management Program</td>
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### Domain 4
**Population-wide**

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<td>Strengthen Mental Health and Substance Abuse Infrastructure Across Systems</td>
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<td><strong>4.c.ii</strong></td>
<td>Increase Early Access to, and Retention in, HIV Care</td>
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Cardiovascular disease: Heart disease is the top cause of mortality among the white, black, and Hispanic populations of the Bronx. It is also the second leading cause of premature death in the borough.

Diabetes: The rate of hospitalizations for short-term diabetes complications among Medicaid beneficiaries is higher in the Bronx (151.22 per 100,000) than in the city overall (105.03 per 100,000), and higher than the state overall (110.31 per 100,000).

Asthma/COPD: While the observed rate of PQI respiratory admissions has declined in the Bronx since 2009, it remains at or above the expected rate.
  - There is a concentration of young adult asthma and respiratory hospitalizations in the southern part of the borough, extending across both sides of the Grand Concourse.

Mental/behavioral health: Only 53.3% of respondents reported that the mental health services are “available” or “very available” in their community.

Substance abuse: Substance abuse was the second most commonly cited health concern by survey respondents (47.2%)
  - Many (36.2%) also noted the need for education on the topic.

HIV/AIDS: Four neighborhoods in the borough have a higher HIV/AIDS prevalence rate than the city as a whole: High Bridge/Morrisania, Crotona/Tremont, Fordham/Bronx Park, and Hunts Point/Mott Haven.

Data from the CNA support our project selections
Presentation Overview

- HIV surveillance in NYC
- HIV Care Continuum in The Bronx
Objectives of HIV surveillance

• To monitor and characterize the complex and evolving HIV epidemic

• To detect changing patterns of HIV transmission

• To inform public health planning, including testing, prevention and treatment strategies

• To guide the allocation of funding for prevention and care services
HIV surveillance in NYC

- HIV case reporting
- HIV-related laboratory reporting
- HIV incidence surveillance
- HIV drug resistance surveillance
- HIV behavioral surveillance
- Many more ...
HIV surveillance in NYC

- HIV case reporting
- HIV-related laboratory reporting
  - HIV incidence surveillance
  - HIV drug resistance surveillance
  - HIV behavioral surveillance
- Many more ...
HIV Case Reporting

• Passive surveillance
  • Healthcare facilities report newly diagnosed HIV cases to NYC DOHMH
    • Name
    • date of birth
    • date of HIV diagnosis
    • etc.

• Active surveillance
  • NYC DOHMH staff conduct field investigations and registry data matches to identify and confirm HIV cases

• ~3,000 cases a year
HIV-related laboratory reporting

- **Passive surveillance**
  - Healthcare facilities report HIV-related laboratory test results to NYS DOH, and then NYS DOH sends NYC test results to NYC DOHMH
    - Diagnostic tests: Western Blot, 3rd or 4th gen EIA, HIV 1/2 differentiation assay, and qualitative RNA test
    - CD4 counts and percents
    - Viral loads
    - Nucleoside sequence results

- **Active surveillance**
  - NYC DOHMH staff conduct field investigations to identify and confirm HIV-related test results

- ~800,000 test results a year
The Evolution of HIV/AIDS Surveillance in NYC

1981
First cases of PCP, KS

1983
AIDS case reporting mandated

1993
AIDS case definition expanded; includes additional OI’s and CD4<200

1998
AIDS reporting expanded to include HIV cases

2000
HIV surveillance expanded to include incidence and resistance testing

2005
HIV reporting and partner services law implemented

2010
Amended NYS HIV law: oral notification of test; expanded data sharing

2014
Amended NYS HIV law: routine offer of HIV test, streamlined consenting; limited data sharing
NYC HIV Surveillance Registry

• HIV case registry
  – Over 230,000 individuals
    • ~50% have died
  – Variables (name, sex, race/ethnicity, date of birth, date of diagnosis, date of death, etc.)

• HIV-related laboratory test registry
  – ~10 million tests
    • CD4: ~6 million
    • VL: ~3 million
    • Other: ~1 million
  – Variables (name, test date, test type, result, etc.)
Monitor HIV-infected persons at the population level along the steps from infection to viral suppression

- Infected
- Diagnosed
- Retained in care
- Prescribed antiretroviral therapy (ART)
- Virally suppressed
HIV Care Continuum

- HIV-infected
- HIV-diagnosed
- Retained in care
- Prescribed ART
- Virally suppressed
HIV Care Continuum – Methods (1)

• HIV-infected
  – Number of people living with HIV (PLWH) by the end of 2014
  – Calculated as “HIV-diagnosed” divided by the estimated proportion of PLWH who had been diagnosed (93.3%), based on a back-calculation method

• HIV-diagnosed
  – Number of PLWH who had been diagnosed by the end of 2014
  – Calculated as PLWH “retained in care” plus the estimated number of PLWH who were out of care, based on a statistical weighting method.
• Retained in care
  – Number of PLWH with ≥1 CD4/viral load test in NYC in 2014

• Prescribed ART
  – Number of PLWH who were prescribed ART in 2014
  – Calculated as PLWH “retained in care” multiplied by the estimated proportion of PLWH who were prescribed ART (96.1%), based on NYC Medical Monitoring Project data.
• Virally suppressed
  – Number of PLWH with a suppressed viral load (≤200 copies/mL) by the end of 2014
  – Calculated as PLWH in care with a most recent viral load measurement in 2014 of ≤200 copies/mL, plus the estimated number of out-of-care 2014 PLWHA with a viral load ≤200 copies/mL, based on a statistical weighting method.
Viral suppression is defined as viral load ≤200 copies/mL.
As reported to the New York City Department of Health and Mental Hygiene by June 30, 2015.
HIV Care Continuum in NYC and The Bronx, 2014

Viral suppression is defined as viral load ≤200 copies/mL.
As reported to the New York City Department of Health and Mental Hygiene by June 30, 2015.
HIV Care Continuum in The Bronx in 2014, by Sex

Viral suppression is defined as viral load ≤200 copies/mL.
As reported to the New York City Department of Health and Mental Hygiene by June 30, 2015.
HIV Care Continuum in The Bronx in 2014, by Age

PLWH younger than 13 (N = 44) were excluded from the analysis.
Viral suppression is defined as viral load ≤200 copies/mL.
As reported to the New York City Department of Health and Mental Hygiene by June 30, 2015.
HIV Care Continuum in The Bronx in 2014, by Race/ethnicity

Viral suppression is defined as viral load ≤200 copies/mL.

As reported to the New York City Department of Health and Mental Hygiene by June 30, 2015.
Viral suppression is defined as viral load ≤200 copies/mL.
As reported to the New York City Department of Health and Mental Hygiene by June 30, 2015.
HIV Care Continuum in The Bronx in 2014, by Area-based Poverty

Viral suppression is defined as viral load ≤200 copies/mL.
As reported to the New York City Department of Health and Mental Hygiene by June 30, 2015.
Case Conferencing
to Viral Load Suppression

Viral Load Suppression Efforts at
The Institute for Family Health

Rebecca Green LMSW, Regional Director of HIV Programs
Institute for Family Health
- Federally Qualified Health Center
- Network of 27 full and part-time clinics in Manhattan, the Bronx and the Mid-Hudson region, serving over 90,000 patients annually
- Joint Commission accredited, Level 3 Patient Centered Medical Home
- Primary care, mental health, dental care, case/care management, community programs and more
- HIV specific services at 3 locations: Family Health Center of Harlem, Urban Horizons (Bronx), Sidney Hillman/Phillips Clinic (Union Square)
- Ryan White Part A, C and AIDS Institute supplemental funding.
- Serve approximately 1000 patients with HIV/AIDS annually
The Institute has formally focused on VLS as a Continuous Quality Improvement (CQI) area since 2012:

- **2012**: Small sample, program specific, tightly monitored (140 patients at one clinic site)
- **2013**: Expanded to all IFH clinics, developed reports to facilitate data, more attention paid to process outcomes
- **2014**: Continued focus on all IFH clinics, more structured intervention and shared responsibility of site leaders to ensure validity of intervention
The Institute has formally focused on VLS as a Continuous Quality Improvement (CQI) area since 2012:

- **2015**: Previous CQI intervention becomes best practice, monthly case conferences are continued, interventions options refined. No longer a CQI project, just what we do

- **2016**: A focus on Chronically Unsuppressed (CU) patients
  - Patients with 2 or more unsuppressed VLs
Goal: Increase the percentage of HIV+ patients receiving HIV care across the Institute who are virally suppressed (viral load ≤200 copies/ml) from 75.6% to 85%

Intervention: Monthly case conferences at each site where HIV care is provided, to review VLS barriers, identify appropriate patient level intervention and assign staff member follow-up.
METHODS

- Create a report in Electronic Medical Record (EMR) to identify patients with unsuppressed viral load
- Monthly case conferences to review all patients with an unsuppressed viral load lab in the month previous
- Choose from a menu of individualized, patient specific interventions and assign specific staff person to follow-up within 2 weeks
- Create and utilize smart phrases to track the case conferences and the follow-up interventions
- Site leaders chart review to ensure process goals (interventions) are being attempted/carried out
- Provide regular trainings to increase staff capacity to carry out interventions
A focus on psychosocial staff as CQI leaders

- We know our patients
- We are facilitators, advocates, problem solvers, communicators – skill sets that poise us to be CQI change agents
- Our skills allow us a unique, person centered perspective to examining systems and gaps in services
- We can put a value or measure on things that are considered unmeasurable like the impact of relationships on engagement in care or how the environment of care influences retention
INTERDISCIPLINARY CASE CONFERENCES

- Various disciplines
- Sharing of expertise
- Shared focus/goal
- Formal, planned structured event
- Provide holistic case conceptualizations, coordinated care and avoid duplication of services
- Some evidence that interdisciplinary meetings improve patient outcomes
- Staff report high levels of satisfaction
- Structured list pushes staff to try out different interventions
- “Hearing about the improvement of our patient's health after implementing the new QI intervention was nice to hear! It definitely helps motivate me to continue working on the QI protocol. It's always a benefit to learn about the improvement that may be an indication of the efforts that were made to help our clients.” (Social Worker)

- “First and foremost, anytime the patient's viral load improved or became suppressed was tremendously encouraging to me as being able to be part in improving their health, with support and inspiration. It was motivating because my effort did pay off in better health for the patients.” (Case Manager)
RESULTS ALL INSTITUTE: 2014

% of Pts with VL ≤200

Baseline | 2014 Q1 | 2014 Q2 | 2014 Q3 | 2014 Q4
---|---|---|---|---
75.6% | 78.6% | 75% | 77.30% | 78.90%
3.3% improvement in VLS across the Institute

Interventions much harder to carry out in clinics without dedicated HIV psychosocial staff

Drilling down the data – what are the characteristics of those patients chronically unsuppressed?
- Substance use
- Mental Illness
- Unstable Housing

Multiple factors impact medication adherence/viral load suppression and many patients receive multiple interventions

2015 - continue case conferences, interventions will be continued on a monthly basis vs. one time, further refine the data
Baseline VLS rate = 79%
Goal VLS rate = 85%
VLS Case Conferences are no longer a CQI project, now best practice, continue monthly
Pulling the right data
  - Defining who “our patients” are
  - Defining, identifying and tracking chronically unsuppressed patients
What is our next creative intervention?
  - Drilling down the data
  - Targeting those chronically unsuppressed
  - More structured data management and patient tracking
Baseline VLS rate = 81%
Goal VLS rate = 90%
By reducing number of chronically unsuppressed patients
Chronically unsuppressed defined as patients with 2 or more unsuppressed (VL ≥ 200) VL labs in the previous year, who were not suppressed at the end of 2015.

Patients are no longer considered chronically unsuppressed when they have had at least 2 suppressed (VL ≤ 200) VL labs.
INVESTIGATING THE PROBLEM

- Grew out of 2015 VLS CQI project – monthly case conferences for any patient with an unsuppressed lab in the month previous
  - High percentage of patients case conferenced monthly were chronically unsuppressed
  - Compassion/creativity fatigue on part of staff
  - Often, these are patients at risk of falling through the cracks, because difficult to enroll in more structured program
  - Need emerged for an additional level of follow-up/intervention

- Test of change/Proposed Intervention: Develop a mechanism to do a deep dive into these patients, better tracking and follow-up, fresh eyes on the case
  - Chronically Unsuppressed Caseloads
IMPROVEMENT STRATEGY

- Internally define “chronically unsuppressed” patients, run baseline reports
- Regional Director assigned out 5-8 patients per staff member end of January
- Initial expectations – set up shared patient list in EMR, do in depth chart review; identify untried interventions; weekly “action” – outreach, check-in, adherence assessment, health promotion, collateral contact, provider case conference, etc
- February was start-up month, staff given reminders via email, staff meetings and individual supervision about efforts
- Project is still in flux at this time, some moving pieces not yet figured out, including how patients will come off and go on caseloads
- Some staff slow to take this on, resentful of ‘added work’, confused about patient lists or expectations of what to do with patients on their caseloads
- March and April – efforts made to clarify expectations
- March and April – first wave of official reorganization of caseloads (patients removed and added)
Of the 93 patients considered chronically unsuppressed at baseline/assigned out, 15 removed at end of 1st quarter.

Of the 3 patients lost to follow-up at end of 1st quarter, 2 returned in the 2nd quarter.
RESULTS & NEXT STEPS

Baseline end of 2015 = 93
13 patients removed Q2 but 40 patients added
Q2 total = 133

Why?
- Increased outreach done in 1st quarter resulted in many out care patients returning: unsuppressed VL labs in Feb = 18 vs. March = 29

Further analysis of chronically unsuppressed patients
INSTITUTE VLS RATE 2013-2016

% of Pts with Suppressed VL (VL ≤200)

- 2013: 76%
- 2014: 79%
- 2015: 81%
- 2016: 81%
The Living Cascade
Consumer Journey Process Flow Map
Part One
Cascade: Each team selects a Cascade Captain who will assist the group in navigating the discussion of the consumer’s cascade journey.

- Each team will designate an artist to draw a process flow map for each milestone in the cascade. Draw an oval for the first and last step in each process. Draw a rectangle for steps in between (see example on pages 6 and 7). The artist will use a black marker to draw the current processes and a color marker to draw improved processes. The artist will link each process flow map into a single consumer journey cascade flow map.

- Add process steps by using a color marker to draw a rectangle and writing the activity within. Connect the new process with a line drawn to the previous and next steps in the map.

- Eliminate processes by using your color marker to draw an “X” over the step you want to eliminate.

- Improve process steps by writing changes within or beside the process step rectangle with your color marker.
What is your process: Linkage to Care

• What are the human interactions to linking patients to care?
  • Staff and consumers
  • Staff and leadership
  • Staff at testing and supportive service programs
  • The county and state DOH and staff at clinical care programs

• Working together, how can we improve the human interactions that make up the process steps of successfully linking patients to care?

• As you talk, complete a chart mapping the current process steps, using a color marker to draw improved process steps for this important portion of the care continuum.
What is your process: Engagement and Retention

• What are the human interactions for engaging and retaining patients in ongoing care?
  
  • Staff and consumers
  • Staff and leadership
  • Staff at testing and supportive care programs
  • the county and state DOH and staff at clinical care programs

• How can the human interactions that make up the process steps of successfully engaging patients in care be improved?

• Working together, how can we improve the human interactions that make up the process steps of successfully retaining patients in care?

• As you talk, complete a chart mapping the current process steps, using a color marker to draw improved process steps for this important portion of the care continuum
What is your process: Viral Load Suppression

• What are the human interactions that support sustained viral load suppression?
  - Staff and consumers
  - Staff and leadership
  - The county and state DOH
  - Staff at testing programs and staff at clinical care programs

• Working together, how can we improve the human interactions that make up the process steps of successfully helping patients to viral load suppression?

• As you talk, complete a chart mapping the current process steps, using a color marker to draw improved process steps for this important portion of the care continuum
The Living Cascade
Consumer Journey Process Flow Map
Part Two
The Cascade Captain and team will present their consumer journey cascade process flow map and report back to the larger group on the journey and aspects to consider for improvement.
Process Flow Chart Symbols
Most Commonly Used Flowchart Symbols

- Activity
- Terminator
- Decision
- Wait symbol

Connecting lines

Page connector

Consumer Journey Process Flow Map
Flow Chart: Is This an Efficient Process?

Patient arrives at front desk → Staff asks name, searches database for file → Patient in system?

Yes → Staff asks patient to be seated

No → Staff asks patient to provide information → Patient waits

Nurse takes patient to exam room
Quality of Care Improvement: Involving Consumers

HIV Services – Jacobi Medical Center

Penelope Demas
Draft as of June 16, 2016
Overview

- > 1,400 clients seen at HIV Services yearly

- **NY State DOH – AI grant 2011 to 2015**
  - Primary Care Initiative
  - Enhanced Linkage model to target new/newly diagnosed clients

- **Retention and Adherence Program/RAP (2015)**
  - More targeted service model
  - Viral suppression major goal
• Viral load results monitored
  – Monthly report generated by IT department
• Viral suppression rate of 85%
  – Defined as <200 copies/mL
• Retention rate: QI Project Report
  – HIVQUAL sample of patients in care during 2014
  – 90% were retained in care in 2015
Consumer Advisory Board at Jacobi

• New CAB reorganized in 2013
  – Technical Assistance from AI including Dan Belanger and Dan Tietz

• Needed fresh start
  – To evolve from “Advocacy” model of consumer participation more appropriate to earlier in the epidemic…
  – To “Advisory” model more relevant to HIV as a chronic condition which emphasizes ownership of Quality of Care projects
Current JMC CAB

- 8 to 10 active members
- Meet monthly except August, December
- Created By-Laws
- Held elections
- Composition:
  - 75% female,
  - LGBTQ representation
- Completed first QI project in 2015
Walk-in “Sick” Visits at the Adult Comprehensive Services Clinic of Jacobi Medical Center: “What should I do when I’m ill?”

Consumer Advisory Board of HIV Services and Staff Facilitators

BACKGROUND

CAB members reported:

• There was confusion regarding the process for walk-in visits for acute illnesses, e.g., the flu.
• Adult Comprehensive Services (ACS) clients were not sure what to do when they were ill.
• There did not appear to be clear policies regarding “walk-in” visits e.g., hours and staff capacity.
• Concerns that inconsistent or confusing policy could result in unclear communication, navigation difficulties, and poorly managed illnesses.

SURVEY RESULTS

• Showed a high rate of client satisfaction with acute care: 95% reported being at least moderately happy and/or satisfied (93/98).
• More than 80% reported they had received clear instructions for what to do and who to call.
• Substantially fewer clients were clear regarding more specific aspects of acute care procedures such as contacts, hours for walk-in visits and in which circumstances to go to the ER.
• While there were few reports of negative experiences at ACS during acute illness (22%), 42% of those clients reported the experience as at least moderately upsetting or stressful.
• Support Resources: 22% reported that they did not have family or friends available to help them when ill.

AIM

The project aims were to:

• Investigate the concerns reported by the CAB by developing and administering a survey to ACS clients assessing knowledge and beliefs regarding these issues.
• Share the survey findings with ACS clinical and administrative leadership in order to make improvements and clarifications.
• Develop and disseminate new ways to improve patient self-care and health management.

METHODS

A survey was developed by the CAB in collaboration with Jacobi staff and was administered by CAB members to over 100 ACS clients.

ACS Patient Survey Responses

- Were you ever told when to go to the ER if you are ill? 57.7% Yes, 15.4% Not sure, 26.9% No
- Were you ever informed of the “Walk-in” hours if you are ill? 61.4% Yes, 11.9% Not sure, 26.7% No
- Were you told who to call at ACS? 67.9% Yes, 14.6% Not sure, 17.5% No
- Clear instructions for calling ACS 83.8% Yes, 9.5% Not sure, 77% No
- Clear instructions from ACS staff 80.9% Yes, 12.4% Not sure, 77% No

“Next Steps & Lessons Learned”

- While most clients are satisfied with acute care services, there is confusion regarding policies and procedures which may result in or exacerbate negative experiences for clients when they are ill.
- Almost a quarter of clients report a lack of tangible social support when they are ill. This may be related to fears of stigmatization and disclosure to close family members and friends and may increase anxiety regarding acute illness episodes and impair coping responses.
- The CAB is engaged in educating the ACS clinic population to be better prepared for illness-making a “checklist” with key phone numbers and tasks, and preparation of an “emergency kit” with thermometers and other urgent care supplies.
What role do consumers play in retention efforts at JMC?

• Contribute to improvements in clinic policies, procedures, and environment that help keep our clients in care….
  – TV’s in waiting room
  – Walk-in, acute care visits

• Advisory capacity
  – Front Desk issues
  – Trauma-Informed Care
• Continuing QI projects
  – Next up: Smoking Cessation

• Peer Worker Services
  – RAP beginning to implement
  – Peer services include:
    • Reminder calls for clinic appointments
    • Escort to specialty, benefits appointments
    • Home visits
    • In-patient linkage: visit new clients while still in-house to establish rapport and begin engagement in care for post-discharge visit to clinic.