New York State Department of Health (NYSDOH) AIDS Institute
New York Links: Bronx Regional Group Meeting Agenda
Thursday, October 6th, 2016 – 9:30 AM – 2:00PM
Lincoln Hospital Center – 234 East 149th Street, Bronx NY

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speaker(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:30-10:00</td>
<td>Welcome and Introductions: What is the best thing that’s happened to you since the last meeting? What’s new in ETE? What’s new in Knows?</td>
<td>Dan Belanger, LMSW Director, NYS Quality of Care Program, NYSDOH AIDS Institute Monica Chierici, MPA Project Management Director, Bronx Partners for Healthy Communities</td>
</tr>
<tr>
<td>10:00-10:45</td>
<td>Managed Care Programs and VLS</td>
<td>Rashi Kumar, Health First Debra Williams, MetroPlus Jay Dobkin, MD, VNSNY SelectHealth Carey Brandenburg and Brittany Harrington, AmidaCare</td>
</tr>
<tr>
<td>10:45-12:15</td>
<td>Driving to the End of the Epidemic</td>
<td>Dan Belanger</td>
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<tr>
<td>12:15-12:30</td>
<td>Review of Project Charter and Reporting Form</td>
<td>All</td>
</tr>
<tr>
<td>12:30-1:00</td>
<td>Lunch</td>
<td>All</td>
</tr>
<tr>
<td>1:00-1:45</td>
<td>Consumer Involvement and Peer Training</td>
<td>Dan Tietz, Consumer Advocate NYSDOH AIDS Institute Monica Chierici</td>
</tr>
<tr>
<td>1:45-2:00</td>
<td>Q&amp;A, Meeting Evaluation, Next Steps and Wrap Up</td>
<td>Dan Belanger, Monica Chierici</td>
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</table>

*Disclaimer: timeframes re approximated and are subject to change*
We can end AIDS in the Bronx #BXEndAIDS
Bronx NYLinks Regional Group Meeting

October 6, 2016
Agenda

• Welcome and Introductions
• Managed Care Programs and VLS
• Driving to the End of the Epidemic
• Review of Project Charter and Reporting Form
• Lunch!
• Consumer Involvement and Peer Training
• Wrap Up
WELCOME!

Who are you and what is the best thing that’s happened to you since the last meeting, which took place on June 30, 2016?
Ending the Epidemic
Medicaid MCO Project
Linking Members to Achieve VLS
Bronx NY Links, October 6, 2016
Using Data Match to Achieve VLS

- Plans were given member data that identified those who are not suppressed at last viral load or have no documented viral load.
- Plans used own data to identify those members in need of follow-up, lost to care and not consistently on ARV.
- Plans are using data to group members for follow-up and targeted interventions.
Drilling Down the Data

• Greatest proportion in Bronx and Brooklyn
• Portion not on ARV
• Some with no HIV visits
• Overlap with care sites that receive grants for support of HIV population
• Identified sub-group with significant BH service needs (HARP eligible)
• 30% enrolled in care coordination of Health Home
Stratified by VL and HIV care history

- Unsuppressed fall into 3 groups
  1. Lost or not engaged
  2. Marginally adherent
  3. Mostly engaged/often suppressed

- Distribution across provider sites varies by plan (DAC to private providers)
2\textsuperscript{nd} quarter Reporting on Project

- No HIV visit in prior six months- 9\%-29\%
- No ARV fill in prior 3 months-16\%-25\%
- Filled ARV in all prior 6 months-32\%-42\%
- Filled ARV 3 or fewer times in prior 6 months-6\%-24\%
ETE MCO Project Goal

• Using Medicaid matched data to identify members with VL>200.
• Use plan infrastructure including non-plan resources to target interventions to support members and providers to achieve improved rates of VLS.
Ending the Epidemic (ETE):
Intervention Activities for Unsuppressed Members
The Bronx and Beyond

NYLinks Bronx Regional Group
October 6, 2016
ETE: The Bronx & Beyond

• Clinical Review of ETE Member Cases
  • Amida Care’s Medical Management department currently reviews all members based on their stratification level of High, Medium or Low Risk
  • The stratification is derived by analyzing the ETE Member Data using the following criteria: VIRAL LOAD, CD4 COUNT, BH RISK SCORE & CONNECTION TO CARE
  • The Medical Management Department identifies the areas of primary concern with each case and provides recommendations for next steps.
  • If members are not engaged with a Health Home or ADHC, the recommendations/requests for additional information are handled internally through outreach to the PCP/Case Manager, and in some cases directly referred to our Lost to Care Health Navigators or Treatment Adherence Coordinators for targeted outreach.

<table>
<thead>
<tr>
<th>Active Member Borough</th>
<th>% ETE Population</th>
<th>% AC Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronx</td>
<td>54%</td>
<td>45%</td>
</tr>
<tr>
<td>Brooklyn</td>
<td>24%</td>
<td>28%</td>
</tr>
<tr>
<td>Manhattan</td>
<td>13%</td>
<td>17%</td>
</tr>
<tr>
<td>Queens</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>Staten Island</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
Connection to Care & Treatment Adherence

Lost to Care Health Navigators:
focus on finding the ETE members identified as being lost to care (defined as No PCP Visit within the last 6 months) and re-connecting them to primary care.

They adhere to the following engagement action plan:
• High Level Investigation of the ETE Member profile (utilizing all available data sources internal and external)
• Targeted Telephonic Outreach
• Home Visits

Once successfully re-connected to care, Members will be transitioned to their assigned Integrated Care Team for monitoring and review of their on-going need for intervention.

Referrals for the Lost to Care Health Navigators are created through the ETE clinical profile review process as well as a claims based report that is run regularly.

Treatment Adherence Counselors:
meet with members where they feel comfortable whether in their home or in the field, to build on the knowledge they already have and address barriers to care using five modules:

   HIV 101, My Doctor and Me, Symptom Management, Health Literacy and Goal Setting.

The Treatment Adherence Coordinators work with:
• Members who have an elevated viral load.  
• Members who are co-infected with Hep C and may need added support now that they are on a more complex regimen.  
• Members who are connected / engaged in care, AND:
  ❖ PCP requests added support & education around their medication  
  ❖ Have never taken Antiretrovirals (ARVs)/ARV naïve  
  ❖ Self-identify they are non adherent and want extra support  
  ❖ Have developed resistance, and/or are having a regimen change  

Amida Care proprietary information developed by Amida Care and for the sole purpose of community education.
Amida Care’s Health Home Unit: Contracts

Amida Care contracts with eight of the eleven lead Health Homes that provide care management to members in the five boroughs:

1. BAHN (Bronx Accountable Healthcare Network)
2. Bronx Health Home
3. CBC (Coordinated Behavioral Care)
4. CCMP (Community Care Management Partners)
5. CHN (Community Healthcare Network)
6. Mount Sinai
7. QCCP (Queens Coordinated Care Partners)
8. Brooklyn Health Home

★ NY Presbyterian, H + H, and Northwell Health have yet to agree to contract with Amida Care.

To advance care coordination for the membership of Amida Care, reoccurring meetings with the 8 contracted lead Health Homes cover the following subjects:

- Updates from the city, state, and all other relative workgroups
- Retrospective and prospective billing reconciliation
- Clinical updates, including outreach prioritization
- Roster reconciliation and areas for quality improvement
- Amida Care’s Health Home hotline (844. 402.4277) for use by lead Health Homes and CMAs operates M - F, 9am - 5pm.
- As always, Amida Care members requiring plan intervention for Health Home concerns should call Amida Care’s member services line (800.556.0689; TTY - 711).

Amida Care directly communicates with care managers to support members, and their care networks, in viral load suppression. Updated contact information, claims, clinical data, and Health Home POCs - including those for HCBS - are frequently reviewed between the plan and CMA.

★ NY Presbyterian, H + H, and Northwell Health have yet to agree to contract with Amida Care.

<table>
<thead>
<tr>
<th>Health Home (Assignment Status)</th>
<th>% of ETE Pop. (Overall)</th>
<th>% of ETE Pop. (Bronx Residents)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assigned/Recently Referred</td>
<td>28.9%</td>
<td>27.7%</td>
</tr>
<tr>
<td>Enrolled</td>
<td>33.2%</td>
<td>32.2%</td>
</tr>
<tr>
<td>Outreach (including Hiatus)</td>
<td>34.2%</td>
<td>35.7%</td>
</tr>
<tr>
<td>Scheduled for Referral</td>
<td>3.7%</td>
<td>4.4%</td>
</tr>
</tbody>
</table>
Carey Brandenburg
ETE Program Manager/Health Services Project Manager
cbrandenburg@amidacareny.org

Brittany Harrington, LMSW
Community Based Services Coordinator for Health Homes
bharrington@amidacareny.org
Ending the Epidemic
Strategy and Implementation Update
October 6, 2016
Healthfirst 2015 Data: ETE Member Demographics

**Members by Age Band**

<table>
<thead>
<tr>
<th>Age Band</th>
<th># Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-29</td>
<td>157</td>
</tr>
<tr>
<td>30-39</td>
<td>209</td>
</tr>
<tr>
<td>40-49</td>
<td>273</td>
</tr>
<tr>
<td>50-59</td>
<td>288</td>
</tr>
<tr>
<td>60-69</td>
<td>82</td>
</tr>
<tr>
<td>70-75</td>
<td>4</td>
</tr>
<tr>
<td>Under 20</td>
<td>23</td>
</tr>
<tr>
<td>Total</td>
<td>1,036</td>
</tr>
</tbody>
</table>

**County of Residence**

- **BRONX**: 42%
- **KINGS**: 28%
- **QUEENS**: 9%
- **ERIE**: 0%
- **NASSAU**: 1%
- **NEW YORK**: 15%
- **WESTCHESTER**: 3%
- **RICHMOND**: 2%
- **SUFFOLK**: 3%

**Zip Code**

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>Neighborhood</th>
<th># Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>10453</td>
<td>Morris Heights, Bronx</td>
<td>45</td>
</tr>
<tr>
<td>10456</td>
<td>Claremont, Bronx</td>
<td>45</td>
</tr>
<tr>
<td>10457</td>
<td>Claremont/Tremont, Bronx</td>
<td>40</td>
</tr>
<tr>
<td>11212</td>
<td>Brownsville, Brooklyn</td>
<td>38</td>
</tr>
<tr>
<td>10458</td>
<td>Fordham, Bronx</td>
<td>36</td>
</tr>
<tr>
<td>10452</td>
<td>Highbridge, Bronx</td>
<td>31</td>
</tr>
<tr>
<td>10467</td>
<td>Norwood, Bronx</td>
<td>30</td>
</tr>
<tr>
<td>10472</td>
<td>Parkchester, Bronx</td>
<td>28</td>
</tr>
<tr>
<td>11208</td>
<td>East NY, Brooklyn</td>
<td>26</td>
</tr>
<tr>
<td>10029</td>
<td>East Harlem, Manhattan</td>
<td>25</td>
</tr>
</tbody>
</table>

**Total active members as of 1/1/16**: 1,036

- Mean/SD Age: 43/12
- % Under Age 40: 35%
- % Female: 49%
- % English speaking: 92%
Healthfirst Strategy

Assignment of outreach lead based on risk stratification (engagement in care and/or health history)

- Levels 1-3: Leverage existing touch point in healthcare delivery system
- Level 4: “Lost to care” work with peers
- If member not engaged or needs more assistance, levels 1,2,3 members can be referred to Peers

0. Universe

1. HARP
   - HARP eligible or enrolled (150)
   - Not HARP eligible (850)

2. Previous Healthfirst Care Management
   - Care Management Open Case, updated since Nov. 2015 (80)
   - No recent or current care management interactions (780)

3. Engaged in HIV Care (2 visits annually – HEDIS 2015)
   - Meets HEDIS engaged in care guidelines (2015) with HIV provider (150)
   - Does not meet HEDIS engaged in Care (630)

4. Health Home Status
   - Current HH enrollment (380)
   - Not Currently HH enrolled (250)

Key:
- HARP team takes lead
- Healthfirst Care Management team takes lead
- Physicians Take Lead + HF Care Management Support
- Peer Navigators take the lead

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PeerPlace database established

PeerPlace database allows contracted project partners to make secure referrals and document outreach, assessment, referrals, and interventions. Current partners:

- Healthfirst (live)
- Peer Navigation program (live)
- Physicians (phase 2)

Healthfirst PeerPlace Database populated with member profiles
Provider Needs Assessment Administration Developed

Domains we will learn about:

- Practice Characteristics (size, staffing, certifications)
- HIV care protocols/clinical guidelines
  - Social needs
  - Community-clinic linkages
- Barriers to care
- ARTs
  - Education & assessment activities
  - Monitoring adherence
  - Barriers to initiating ART

https://www.surveymonkey.com/r/3VR2VL5
Special Needs Plan - Partnership in Care
End the Epidemic (ETE)
Bronx NY Links Meeting
Health & Wellness Advisor Role and Responsibilities:

- Territory-based Caseload Assignment
- Face-to-face case management
- Care coordination; Assessment, Plan of Care and Reassessments
- Health Education and Health Information Resource
- Adherence counseling and support
- Benefits Orientation
- Medicaid Recertification Reminders
- ETE referral and follow-up
Three Pronged Approach

Street Outreach and Engagement
No VL ever or > 1 Year VL

7 Territories Across NYC

Metro Plus ETE Central

Peer Care Connection
VL: > 10 K

TeleNurse Adherence Support
VL: 201 -10 K
ETE Interventions

Hospital Based Peer Intervention

- Support Groups Facilitator
- Escorting to appointments
- Appointment Reminder Calls
- HIV Health Literacy Education
## Population Eligible for ETE Intervention

### 10/01/2016

<table>
<thead>
<tr>
<th>Territory</th>
<th>Facility / Hospital</th>
<th>Tele Nurse Adherence support</th>
<th>Street outreach and Engagement</th>
<th>Peer care Connection</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bronx South</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lincoln Hospital</td>
<td>14</td>
<td>4</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>Morrisania D&amp;TC</td>
<td>4</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Segundo Ruiz Belvis D&amp;TC</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Brightpoint Health</td>
<td>11</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Morris Heights Health Centers</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Acacia Network</td>
<td>15</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>All Med – Damian Centers</td>
<td>3</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Institute for Family Health</td>
<td>9</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Institute for Urban Family Health</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Vocational Instruction Project</td>
<td>3</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Bronx North</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other PCPs</td>
<td>6</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Jacobi Hospital</td>
<td>36</td>
<td>10</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>North Central Bronx Hospital</td>
<td>16</td>
<td>3</td>
<td>17</td>
</tr>
</tbody>
</table>
A Unique Project Design for *Engagement*
A Unique Project
Design

The Client

- Peer Navigators
- Medical Provider
- Home, hospital and ER visits
- Linkage to services; housing, food, pharmacy
- Escorting members to appointments
PCP Appointment Report
Analysis

As of October 1\textsuperscript{st}, 2016

- 27 Doctor appointments were made 18 occurred, 8 were missed and 1 walked out.
- 17 appointments scheduled by the peer.
- Peers escorted members on 19 occasions only 11 were served. 7 out of 11 have attended MD appointments. Five were escorted by peer navigators.
A Case Example

40 y/o woman living in the Bronx, out of care and off of meds for 18 months:
- 2 Peer home visits
- 2 peer escorted PCP visits

A return to clinic->return to ARVs->linkage to services
Bronx NYLinks
Driving to the End of the Epidemic
Drivers of Sustainable Viral Load Suppression
Agenda

• Build a driver diagram for improving viral load suppression rates in the Bronx

• Use the system of profound knowledge to investigate primary drivers of viral load suppression

• Discuss improvement ideas

• Analyze forces that may drive or restrain implementation of improvement activities
Learning objectives

• Learn how to use a driver diagram to strategically plan improvements

• Understand the system of profound knowledge as a way to gain a more comprehensive understanding of areas for improvement

• Learn how to work with interagency, cross-functional peers to identify improvements

• Refine improvements after investigating driving and restraining forces of process changes for improvement
Driver Diagram

Primary Outcome

Primary Drivers

Secondary Drivers
Driver Diagram

- **Driver diagram**: Visual tool to help understand and prioritize factors within a system that drive desired outcomes called the primary outcome.
- **Primary drivers**: main factors that drive the primary outcome.
- **Secondary drivers**: subsets of the primary factors, which push those factors.
- The driver diagram can help you to think strategically about what changes you can make to your current system to achieve your improvement goal.
Driver Diagram Example: Attaining a Masters Degree

Primary Outcome
- Attain a Masters Degree

Primary Drivers
- Study
- Pay tuition
- Write Thesis
- Complete fieldwork
- Attain all credits

Secondary Drivers
- Take notes
- Schedule time to read
- Buy books
- Take out student loan
- Get a part time job
- Research/talk to the experts
- Develop a theory
- Interview
- Adjust work schedule
- Complete homework
- Pass tests
- Take all classes
Driver Diagram Example: End World Hunger!

**Primary Outcome**
- Ending world hunger

**Primary Drivers**
- Food Production
- Economic health
- Leadership
- Food delivery
- Environmental factors

**Secondary Drivers**
- New scientific methods of producing food
- Irrigation
- Cost containment
- Employment
- Education
- Partnerships
- Government linkages
- NGO commitment
- New transportation technology
- Truce agreements
- Diminish global warming effects
- New fertilization technologies
How about Viral Load Suppression? (10 minutes)

• What is your primary outcome?
• What are the primary drivers of viral load suppression?
• What are some secondary drivers?
Driver Diagram

**Primary Outcome**
Improve VLS in the Bronx through working together

**Primary Drivers**
- Linkage to Care
- ARV Adherence
- Retention
- Social Determinants

**Secondary Drivers**
- Knowing your status
- Peer Support
- Insurance/Benefits
- Health Literacy
- Transportation
- Cultural Competency
- Reduced Substance Use
- Mental Health
- Language Barriers
- Immigration Status
- Child Care
- Stigma
- Housing
To significantly improve the health outcomes for people living with HIV by increasing the HIV viral load suppression (VLS) rate by 8% by June 31, 2017 (a 10 month interval) in NYLink participating clinics in Brooklyn.
Primary Drivers of Sustainable VLS

1. Linkage To Care
2. ARV Adherence
3. Retention
4. Social Determinants of Health
## W. Edwards Deming’s System of Profound Knowledge

<table>
<thead>
<tr>
<th>Appreciate the System</th>
<th>Understand Variation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychology</td>
<td>Theory of Knowledge</td>
</tr>
</tbody>
</table>
Deming’s System of Profound Knowledge

- As you discuss ideas to improve the primary drivers, keep in mind Deming’s System of Profound Knowledge:
  - **Psychology** of patients, staff and other stakeholders
  - **Systems** within which they work and live
  - **Variation** in lives and data outcomes, both expected and unexpected
  - What is **known** about working with this community of patients and how that can impact your work
Driving Lessons
(60 minutes)

• To help focus your efforts, four driving instructors will drive around the room, conducting 15 minute discussions at each table:
  – “Driving Instructors” facilitate discussions on the primary drivers and Deming’s System of Profound Knowledge
  – Each instructor focuses on one driver
  – After 15 minutes, the driving instructors move to the next table
  – Instructors continue to rotate until all tables have considered each primary driver from all aspects of the system of profound knowledge
Driving Instructors

• Driving instructor One: Linkage to Care  
  *(Primary Driver 1)*

• Driving Instructor Two: ARV Adherence  
  *(Primary Driver 2)*

• Driving Instructor Three: Retention  
  *(Primary Driver 3)*

• Driving Instructor Four: Social Determinants  
  *(Primary Driver 4)*
Talking Points

• Answer questions *(see handout)* to elicit further details about how you can improve processes in support of primary and secondary drivers and how changes will help to improve viral load suppression in the Bronx.
Brain Hurricane
(10 minutes)

• As informed by the profound discussion, list as many improvement ideas as you can to improve processes in areas identified as secondary drivers of viral load suppression—anything goes!
  – What changes can your clinical and supportive service team make to improve VLS?
  – How can you work across agencies to improve VLS?
Force Field Analysis (10 minutes)

• Each team votes on the top improvement ideas
  – Which of these ideas will be most effective in improving viral load suppression?

• After reaching consensus on the most effective intervention, perform a force field analysis using the tool included in your packet
Report Back
(10 minutes)

• Driving instructors report back on the most innovative ideas that they heard for improving processes in the associated primary driver

• Each group reports back their top ideas for improving each area
  – What was your top improvement idea?
  – What were the opportunities and challenges that you identified in the force field analysis?
Next Steps

• Develop a collaborative interagency team to begin to test your process change ideas
• Submit quarterly QI data
• Report back on your tests of change on the next webinar
• Discuss with peers opportunities and challenges identified in your tests of change. Compare notes
Thank you!
Bronx NY LINKS Regional Group
Consumer Involvement Presentation

Presented by:
Daniel Tietz, NYSDOH AI Manager Consumer Affairs
A Multidimensional Framework
Patient/Family Engagement In Healthcare

Continuum of engagement

Levels of engagement
- Direct care
- Organizational design and governance
- Policy making

Consultation
- Patients receive information about a diagnosis
- Organization surveys patients about their care experiences
- Public agency conducts focus groups with patients to ask opinions about a health care issue

Involvement
- Patients are asked about their preferences in treatment plan
- Hospital involves patients as advisers or advisory council members
- Patients' recommendations about research priorities are used by public agency to make funding decisions

Partnership and shared leadership
- Treatment decisions are made based on patients' preferences, medical evidence, and clinical judgment
- Patients co-lead hospital safety and quality improvement committees
- Patients have equal representation on agency committee that makes decisions about how to allocate resources to health programs

Factors influencing engagement:
- Patient (beliefs about patient role, health literacy, education)
- Organization (policies and practices, culture)
- Society (social norms, regulations, policy)

©2013 by Project HOPE - The People-to-People Health Foundation, Inc.

Carman K L et al. Health Affairs 2013;32:223-231
Consumer Involvement in Quality Improvement (Venues)

- Entire Caseload or Patient Population
  - Satisfaction surveys
  - Patient interviews
  - Focus groups

- Consumer Advisory Board

- Quality Management Team/Committee

- Regional Group

- EMA/TGA

- Statewide Quality Management Committee
(AIDS Institute Model)
Consumer Involvement in Quality Improvement
Training of Consumers on Quality
TCQ Goals

• To build capacity for people living with HIV/AIDS (PLWHA) to serve on internal quality management (QM) teams/committees and to be engaged in quality improvement (QI) activities (ideally within a Ryan White recipient or health care organization where consumer receives HIV primary care services)

• To be involved in local, regional, state, and national quality improvement (QI) activities
TCQ Learning Objectives

• Increased understanding of the Ryan White Program with a focus on QM requirements and expectations

• Increased understanding of basic vocabulary for quality improvement (QI) including methodologies, tools, activities, and processes

• Increased competency to be a ‘consumer quality champion’ in HIV health care
TCQ Learning Objectives

• Increased confidence to serve as members of QM teams and/or committees

• Increased understanding of group dynamics, roles/responsibilities, and decision-making processes, to address specific aspects of HIV care

• Increased understanding of the various forms of consumer involvement (individual/systematic) and appropriate frameworks for involvement
TCQ Learning Objectives

• Increased awareness of basic HIV care and treatment terminology

• Increased knowledge of health numeracy/health literacy to better understand performance measurement, indicator development, data collection methodologies and data reporting

• Exposure to other consumer quality leaders for peer support, networking, and learning
TCQ Participant Expectations

• Completion of standardized survey to assess basic QI competencies (1 hour)

• Complete pre-work assignments (3 hours)

• Attend and actively participate in TCQ session (approximately 2 ½ full days)
Participant Post-training Expectations:

• Become QM team/committee member (ideally within a health care organization where TCQ participant receives HIV primary care services)

• Participate in NQC sponsored activities including webinars for additional QI capacity and skills-building

• Complete an evaluation tool (approximately 6 months after completing the TCQ program)
Ryan White Recipient Expectations

• Participate in TCQ Orientation Webinar on October 3 (announcement in meeting packet)
• Identify and select consumer(s) to attend Albany TCQ Program (scheduled November 18-20, 2016) and assist with completing application and required documentation
• Review and offer feedback to TCQ participant on personalized goal statement developed during the TCQ program
• Coach and mentor TCQ participant to support them in their role as a member of QM team/committee
• Participate in NQC evaluation activities to assess TCQ program impact on consumer engagement in QM program/QI activities
Questions/ Next Steps
Peer Worker Certification
(Review of Process and Current Status)

Presentation developed by Cassandra Kahl and Richard Cotroneo
AIDS Institute Office of the Medical Director
AIDS Institute Peer Certification Initiative

• Support overall goal of the Governor’s plan to end the AIDS epidemic (ETE) by 2020
• Two specific ETE objectives relate to peer certification
  • Build a peer workforce
  • Create employment opportunities for people living with HIV
• Meet the requirements and rigor needed for Medicaid reimbursement
Unique Contributions of Peers

• Peers share characteristics of their target client populations, including
  • Racial, ethnic, sexual orientation, gender identification
  • Life-experience; same medical conditions; stigma

• Shared “lived experience” allows Peer Workers to relate more easily with clients and increases client comfort. (HRSA; 2010)

• Peers “help bridge the gap between patients and the professional staff.” (CORE Center Clinic Rush-Presbyterian-St. Luke's Medical Center Peer Educators At The Core Center http://www.univ.rush.edu/core/peers.html)
Evidence for Return on Investment

• Peer Workers Increased Primary Care Visits
  • Increased primary care visits by 40% to 50% (Whitley, E. M; et al; 2006)
  • Increase post-hospital connections with Primary Care (Kangovi, S; et al; 2014)

• Primary care providers will see multiple sources of income from peers
  • Potential direct re-imbursement from Medicaid for peer-delivered services
  • Indirect income increase by increased primary care visits from peer-assisted patients.
Peer Contributions & Effectiveness (HIV Care)

• Jones, James, MD; et al; (2003)
  • Peers help women get to HIV Specialists:
    • 6.8% HIV specialist care before Peer support
    • 84.7% with HIV specialist after peer support (Increased 12-fold!)
    • Increased kept appointments by 50%
    • Increased usage of case management services

• Perry and colleagues in 2014 review
  • “reduced viral loads and increases in CD4 counts in 13 of 16 studies, with statistically significant results in 7 studies.”

• Higa, Darrel H; Marks, Gary; Crepaz, Nicole; (2012)
  • Peer support increased retention in care
  • Peers as effective in using Motivational Interviewing techniques for outcomes as professionals using same interventions

• Kangovi, S; Mitra, N; Grande, D; et al; (2014)
  • Peer support increased post-hospitalization connections with primary care
Steering Committee

<table>
<thead>
<tr>
<th>Composition</th>
<th>Provide guidance around:</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statewide representation</td>
<td>Code of Ethics</td>
<td>Began meeting in June; three meetings to date.</td>
</tr>
<tr>
<td>Health Care Facilities</td>
<td>Core Competencies</td>
<td>Subcommittees: Code of Ethics; HCV; Harm Reduction; Assessment: Compensation and Benefits</td>
</tr>
<tr>
<td>CBOs</td>
<td>Compensation Issues</td>
<td></td>
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<tr>
<td>Peer Workers</td>
<td>Access to Benefits</td>
<td></td>
</tr>
<tr>
<td>Consumers</td>
<td>Supervision and Support</td>
<td>Work on schedule for completion by end of December, 2015</td>
</tr>
<tr>
<td>Harm Reduction focus</td>
<td>Training programs</td>
<td></td>
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<tr>
<td>Hepatitis C focus</td>
<td>Knowledge assessment</td>
<td></td>
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</tbody>
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Who is eligible for certification?

• AI Peer Worker is someone who has the “shared lived experience” of:
  • Living with HIV/AIDS
  • Living with Hepatitis C
  • or having experience accessed Harm Reduction services

• Individuals who are “affected” are not eligible for AI Peer Certification.
Eligibility Considerations

• High school diploma/GED- not required

• Criminal history or substance use restrictions- not a barrier
What is Foundational Training?

• A readiness/preparedness program
• Occurs before Certification Coursework or practicum
• An opportunity for individuals to achieve a level of understanding and mastery of their own HIV/HCV/behavioral healthcare, treatment and psycho-social needs
• Standards for foundational training (60 hours) established by Steering Committee – available on www.hivtrainingny.org/peercertification
• Future considerations: review/approval of shorter self management trainings to meet this requirement
How can I obtain Foundational Training?

• For a list of AIDS Institute-approved foundational training programs visit: http://hivtrainingny.org/peercertification
Key Elements to Certification Process

Materials available at www.hivtrainingny.org
• Code of Ethics has been established which outlines standards for:
  • Professional Behavior
  • Professional Boundaries
  • Abiding by agency policies

• Peer Workers sign an attestation to follow Code of Ethics

• Code of Ethics available for download
Peer Worker Core Competencies

- HIV and HCV Testing
- Engagement, Linkage to, and Retention in Care
- Treatment Initiation (ART and HCV) and Treatment Adherence
- Self Management
- Patient Navigation
- Health Coverage
Peer Worker Core Competencies

- Harm Reduction, Syringe Access and Health Promotion
- Support Groups
- Case Conferencing
- Client Involvement in Quality Improvement
- Documentation of Activities
From Competencies to Job Descriptions

• Peer Worker Competencies are intended to be comprehensive
  • Specific job **description** would likely be a **subset** of these competencies
  • Focus on one or several major areas of work

• Job **Title** need not mirror the certification
Livable Wage for Peer Workers

• How is livable wage defined?
• NYS efforts toward a $15 minimum wage
• How would per worker wages relate to the organization’s overall salary structure, union contracts, etc?
• AMIDA Care Peer Worker Reimbursement survey
• Impact of wages/ stipends on peer worker’s benefits – series under development
Impact of Work on Benefits

- Critical concern of many peer workers is the impact of income from peer work on range of government benefits
- Documents Available online: SSI, SSDI, Ticket to Work
Peer Worker Employment LISTSERV

• Help connect employers with Peer Workers
• Employers forward job opportunities
• Job announcements sent to Peer Workers who signed up
• Established June 22, 2016
• As of September 19, 282 peer workers signed up.
Capacity-Building Series: www.hivtrainingny.org

• Webinar series explores implementing Peer-Delivered Services
  • Reviewing agency need for Peer services
  • Assessing Readiness
  • Reviewing Financial Issues
    • Reimbursement for services
    • Return on investment
    • Compensation of Peers and benefits as staff person
    • Sustainability of Peer position
  • Outlining Job descriptions
  • Exploring approaches to supervision
    • Practicum
    • Employment
• 2 day Supervisor training
Organizational Readiness Assessment

• Consider key issues regarding implementing peer-delivered services

• The assessment is an information gathering or “awareness-raising” tool to be used to identify
  • Policies, infrastructure, and other factors that need to be addressed for successful Peer-delivered services
  • Areas where new policies or changes to existing one should be made
  • Mechanisms that needed to be created or improved or modified

• Organizational Assessment Tool is available for download at www.hivtrainingny.org
Fiscal Issues

• Peer worker salary/ stipends might be supported through:
  • Grant funding
  • DSRIP
  • General funds
  • Future possibility: Medicaid reimbursement
Status of Certification

• First review board meeting to approve applications approved 4 applicants

• Review board will meet quarterly

• By next meeting in Fall, 2016 it is anticipated that (15-30 peers) will have met the requirements
Contact Information

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NYSDOH AIDS Institute

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Next Steps

• Bronx Teams plan interagency viral load suppression QI projects
• Teams begin to test out their improvement ideas in short cycle small scale (PDSA) tests of change
• Teams pilot the QI project reporting book (October 15-December 31)
• Teams report on their pilots on the next Bronx NYLInks webinar (TBA)
• Next NYLInks regional data reporting deadline is December 1
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