Patient-Centered HIV Prevention: A Six Part Webinar Series

Part 2: Team-Based Care

Denise Anderson, MPH, PCMH CCE

Primary Care Development Corporation

HIP in Health Care
WELCOME!!!
**Patient-Centered HIV Prevention: A Six Part Webinar Series**

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Please use the question box to ask questions. Questions will be answered throughout the presentation. All unanswered questions will be addressed and sent out to attendees.

Attendees will receive webinar slide set, recording and evaluation link by the end of the webinar business day.
About the Primary Care Development Corporation (PCDC)

Founded in 1993, PCDC is a nonprofit organization dedicated to expanding and transforming primary care in underserved communities to improve health outcomes, lower health costs and reduce disparities.

- Certified as a Community Development Financial Institution (CDFI) by the U.S. Treasury
- Offices in New York City and Los Angeles County
- Three Programs:
  - Capital Investment
  - Performance Improvement
  - Policy & Advocacy
About HIP in Health Care

- PCDC's HIP in Health Care program is funded by the U.S. Centers for Disease Control and Prevention (CDC) to build the capacity of healthcare organizations to deliver HIV prevention services and strategies within clinical settings.

- We provide training and technical assistance at no cost to healthcare organizations (i.e., direct service providers) across the United States and its affiliated territories.

- In support of the *National HIV/AIDS Strategy: Updated to 2020 (NHAS)* and CDC’s High-Impact Prevention approach, our capacity building assistance (CBA) is focused on:
  - HIV Testing
  - Prevention with Positives
  - Prevention with High-Risk Negatives
About the CPN:

- HIP in Health Care is part of the Capacity Building Provider Network (CPN)

- The CPN is a network of 21 organizations that are funded by CDC to build the capacity of the nation’s HIV prevention workforce in 3 Settings:
  - Health Departments
  - Community-Based Organizations
  - Health Care Organizations

- CPN providers provide CBA in the following areas:
  - HIV testing
  - Prevention with HIV-positive persons
  - Prevention with HIV-negative persons
  - Condom distribution
  - Organizational development & management
  - Policy

http://www.cbaproviders.org
About the Presenter and HIV Related Experience

- Peer Reviewer for the Ryan Unit of the City of Newark DOH and Community Wellness
- Consultant – Management Strategist Consulting Group, LLC – TA and HRSA site visits
- 2008 Public Health Prevention Specialist (PHPS), CDC – Atlanta, GA & Los Angeles, CA

In Newark, NJ:

- Program Manager, HIV – Medical Home Resource Center (MHRC) & for HIV Prevention
- Program Manager, Program Support Specialist for LPS funded by NY/NJ AETC
- Clinical Dietitian, Ambulatory ID Practice & Inpatient General Medicine & HIV unit
- Past member of the New Jersey HIV Planning Group (NJHPG)
- Past attendee of Newark Eligible Metropolitan Area (NEMA) planning council & priority setting committee
- Past staff lead for Consumer Advisory Board (CAB)
Part 2 Learning Objectives

1. Briefly review the Patient-Centered Medical Home (PCMH) model and the National Committee for Quality Assurance (NCQA) as a recognizing body of the model.

2. Examine the components of team-based care in relation to HIV prevention.

3. Apply team-based care principles utilizing case studies.

THE PCMH MODEL
PCMH

According to the Joint Principles (American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics and American Osteopathic Association), a medical home:

“is characterized by every patient/family having a personal physician who provides first contact care, understands the health care needs of the patient/family, facilitates planned co-management across the lifespan, and has the resources and capacity to meet the patient/family needs”
The Joint Principles of the PCMH
Developed by the ACP, AAFP, AAP and AOA

- Personal physician (Clinician) directed medical practice
- Whole person orientation
- Care is coordinated and/or integrated across health care systems and patient’s community
- Quality/safety are hallmarks of medical home
- Enhanced access
- Payment reform
Recognizing PCMH Agencies

- National Committee for Quality Assurance (NCQA)
- The Joint Commission
- The Accreditation Association for Ambulatory Health Care (AAAHC), Inc.
- URAC (formerly known as Utilization Review Accreditation Commission)
NCQA

- The National Committee for Quality Assurance
- A private, 501 (c) 3 not-for-profit founded in 1990
- Dedicated to improving health care quality
- Central figure in driving health care system improvement and helping to elevate the issue of health care quality to the top of the national agenda

http://www.ncqa.org/about-ncqa
### NCQA 2014 Standards

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<th>1: Enhance Patient Access and Continuity</th>
<th>2: Team-Based Care</th>
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<td>A. <em>Patient-Centered Appointment Access</em></td>
<td>A. Continuity</td>
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<td>B. 24/7 Access to Clinical Advice</td>
<td>B. Medical Home Responsibilities</td>
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<td>C. Electronic Access</td>
<td>C. Culturally and Linguistically Appropriate Services (CLAS)</td>
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<td></td>
<td>D. <em>The Practice Team</em></td>
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<th>3: Population Health Management</th>
<th>4: Care Management and Support</th>
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<tr>
<td>A. Patient Information</td>
<td>A. Identify Patients for Care Management</td>
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<tr>
<td>B. Clinical Data</td>
<td>B. <em>Care Planning and Self-Care Support</em></td>
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<tr>
<td>C. Comprehensive Health Assessment</td>
<td>C. Medication Management</td>
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<tr>
<td>D. <em>Use Data for Population Management</em></td>
<td>D. Use Electronic Prescribing</td>
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<tr>
<td>E. Implement Evidence-Based Decision- Support</td>
<td>E. Support Self-Care and Shared Decision-Making</td>
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<th>5: Care Coordination and Care Transitions</th>
<th>6: Performance Measurement and Quality Improvement</th>
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<td>A. Test Tracking and Follow-Up</td>
<td>A. Measure Clinical Quality Performance</td>
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<tr>
<td>B. *Referral Tracking and Follow-Up</td>
<td>B. Measure Resource Use and Care Coordination</td>
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<tr>
<td>C. Coordinate Care Transitions</td>
<td>C. Measure Patient/Family Experience</td>
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<td>D. <em>Implement Continuous Quality Improvement</em></td>
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<td>E. Demonstrate Continuous Quality Improvement</td>
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<td>F. Report Performance</td>
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<td>G. Use Certified EHR Technology</td>
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http://www.ncqa.org/
TEAM-BASED CARE AND HIV
10 Building Blocks

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

Willard and Bodenheimer
California HealthCare Foundation April 2012 www.chcf.org
What is Team-Based Care?

- Team-based care is when individuals from different disciplines come together to care for patients.

- The two questions in health care team development are:
  1. Who is on the team?
  2. How do team members work together?
The 5 Key Characteristics of Cohesive Health Care Teams

1. Clear goals with measurable outcomes
2. Clinical and administrative systems
3. Division of labor
4. Training of all team members
5. Effective communication

Continuity

- Patient empanelment/patients selecting a personal clinician
- Monitoring the percentage of patient visits with selected clinician or team
- Orienting new patients to the practice
Audience Poll:

Do you ask your patients which provider they would like to see for their care?

1. Yes
2. No
Medical Home Responsibilities

- The practice coordinates patient care across multiple settings
- Patients are given instructions for obtaining care and clinical advice both during and after hours
- Patients provide a complete medical history and information about care obtained outside of the practice
Medical Home Responsibilities (Cont.)

- The care team provides evidenced-based care, patient education and self-management support
- The practice provides the scope of services available within the practice to patients to include how behavioral health needs are met
- The practice provides equal access to all of their patients regardless of source of payment
Medical Home Responsibilities (Cont.)

• The practice gives uninsured patients information about obtaining coverage

• Patients are given instructions on transferring records to the practice, including a point of contact at the practice
Challenges with Medical Home Responsibilities

- The practice must explain the concept of the medical home to their patients
- The medical home responsibilities must be communicated and distributed to patients
Audience Poll:

Does your practice distribute information to your patients about office hours and services offered?

1. Yes
2. No
Culturally and Linguistically Appropriate Services

The practice:

- Assesses the diversity of its population
- Assesses the language needs of its population
- Provides interpretation or bilingual services to meet the language needs of its population
- Provide printed materials in the language of its population
Question for Audience?

What is the concern with having a patient’s family member interpret during a medical visit?
The Practice Team

- Having defined roles for clinical and nonclinical team members
- Holding scheduled patient care team meetings (huddles)
- Using standard orders for services
- Training and assigning members of the care team to support patients in care coordination, self-management support and population management
Video: Team Huddle

https://www.youtube.com/watch?v=q84aAeMV4C4
Challenges with The Practice Team

- Assessing current practice structure
- Clearly defining care team – clinical/non-clinical staff
- Identifying specific roles/responsibilities of each team member
- Reorganizing roles/responsibilities
- Training to maximize highest level of capacity and the law
Challenges with The Practice Team (Cont.)

- Regular reassessment of care team, roles and responsibilities
- Establishing regular communication about patients/practice evolution (huddles and operational meetings)
- Involving team in performance measurement
- Including patients in defining and communicating roles/responsibilities
### Share the care: who does it now?

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<thead>
<tr>
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<th>RN</th>
<th>LVN</th>
<th>Medical assistant</th>
<th>Pharmacist</th>
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<td>Orders mammograms for healthy women between 50 and 75 years old</td>
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## Totals
TEAM-BASED CARE CASE STUDIES
Marcus and Rosa

- 17 year old African American MSM
- Homeless and dropped out of high school
- He is having transactional sex with strangers for cash
- He wants to get tested for HIV

- 33 y.o. Puerto Rican female in a serodiscordant relationship with Juan
- During sex this evening the condom broke
- It is 8 PM and the practice is closed
- Rosa remembers reading about nPEP
Audience Poll:

The practice team and culturally linguistically appropriate services are both important to both Marcus and Rosa.

Instructions for obtaining care and clinical advice during office hours and when the office is closed are essential for HIV testing and nPEP. Which component of team-based care do these represent?

1. Continuity
2. Medical Home Responsibilities
A Sample HIV Testing/nPEP Team

Intake  Tester  Clinician  Medical Case Management
Johnny

- 45 year old White male
- Was in a car accident in his mid-20s w/significant back injuries
- After several surgeries, with multiple pain prescriptions, Johnny was sniffing heroin for pain management
- Johnny quickly progressed to injecting heroin
- Unable to maintain steady employment due to back injuries
- When he has money, will purchase syringes
- When he doesn’t have money or is high, he shares needles with individuals with unknown HIV statuses
- Johnny saw a commercial about a pill you can take daily to reduce the risk of acquiring HIV
Question for Audience?

As for Marcus and Rosa, the practice team and culturally linguistically appropriate services are both important to Johnny as well.

Which component of team-based care supports having a PrEP provider that Johnny sees for most of his PrEP visits?
A Sample PrEP Team

Intake  MA/RN  Tester  Provider  MCM
TEAM-BASED CARE RELEVANCE TO NHAS, THE HIV CARE CONTINUUM AND THE RYAN WHITE HIV/AIDS PROGRAM PARTS
# Team-Based Care and NHAS

<table>
<thead>
<tr>
<th>Team-Based Care</th>
<th>Priorities for HIV Prevention</th>
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<tr>
<td><strong>Medical Home Responsibilities</strong>&lt;br&gt;The care team provides evidenced-based care, patient education, and self-management support</td>
<td>- Expand targeted use of effective combinations of evidence-based HIV prevention approaches&lt;br&gt;- Educate all Americans about HIV and how to prevent it</td>
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Team-Based Care and NHAS

NHAS Goal 2: Increasing access to care and improving health outcomes for people living with HIV

- Developing models of competent care that treat the whole person, as well as the virus, is crucial:
  - Culturally competent workforce
  - Skilled workforce – training
  - Team: peer navigators, nurses, doctors, case managers, pharmacists, and social workers

HIV CARE CONTINUUM:

THE SERIES OF STEPS A PERSON WITH HIV TAKES FROM INITIAL DIAGNOSIS THROUGH THEIR SUCCESSFUL TREATMENT WITH HIV MEDICATION

https://www.aids.gov/federal-resources/policies/care-continuum/
# Team-Based Care and The HIV Care Continuum

<table>
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<tr>
<th>HIV Care Continuum Recommendations (2013)</th>
<th>As Integrated into the Updated National HIV/AIDS Strategy</th>
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<tr>
<td>Support, implement and assess innovative models to more effectively deliver care along the care continuum</td>
<td>Support and strengthen capacity to implement innovative and culturally appropriate models to more effectively deliver care along the care continuum</td>
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PCMH Model

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# Team-Based Care and Ryan White HIV/AIDS Program Parts

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<th>Team-Based Care</th>
<th>Part A</th>
<th>Part C</th>
<th>Part D</th>
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<tbody>
<tr>
<td>- Medical home responsibilities</td>
<td>- Linguistic services</td>
<td>- Early Intervention Services (EIS) – patient education in conjunction with medical care</td>
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<tr>
<td>- Culturally and Linguistically Appropriate Services</td>
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<td>- Staff training (Clinical Quality Management)</td>
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<tr>
<td>- The practice team</td>
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https://hab.hrsa.gov/
Conclusion

Reflection: How can you establish and/or enhance team-based care in your practice?

- What are actions I can take right away?
  - Orienting new patients to your practice
  - Assessing the diversity and language needs of your population
  - Examining how care is currently provided by your care team
Conclusion (Cont.)

- What are intermediate actions I can work towards?
  - Empanelment
  - Provision of interpretation or bilingual services
  - Provision of forms and educational materials in preferred language of population served
  - Restructuring the roles of the care team if it makes sense
  - Training the care team on new team roles
Conclusion (Cont.)

- What are long-term actions I can work towards?
  - Monitoring the percentage of patient visits with selected clinician/team for continuity
  - Continuously monitoring, re-training and re-defining care team roles as needed
QUESTIONS
Bibliography

- Prevention and HIV Care. (nd).
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For more information about PCDC's HIP in Health Care capacity building assistance services, contact us at:

T: (212) 437-3970
E: hip@pcdc.org
W: www.pcdc.org/hipinhealthcare