

# The New York City HIV Care Coordination Model 2010 Ryan White Grantee Meeting August 25, 2010

Care, Treatment and Housing Program  
Bureau of HIV Prevention and Control  
NYC Department of Health and Mental Hygiene

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# Conflict of Interest Disclosure

- Fabienne Laraque, MD, MPH
  - Has no financial interest or relationships to disclose
- HRSA Education Committee Disclosures
  - HRSA Education Committee staff have no financial interest or relationships to disclose
- CME Staff Disclosures
  - Professional Education Services Group staff have no financial interest or relationships to disclose

# Learning Objectives

- Identify strategies to develop a comprehensive care coordination program using a structured protocol and diverse program innovations
- Recognize the challenges in implementing a new program
- Describe how to apply surveillance and provider data to plan and evaluate programs

# Outline

1. Epidemiologic Background
2. HIV Treatment and Care
3. Care Coordination
4. NYC Care Coordination Model
5. Implementation



# New York, NY

## Eligible Metropolitan Area (EMA)

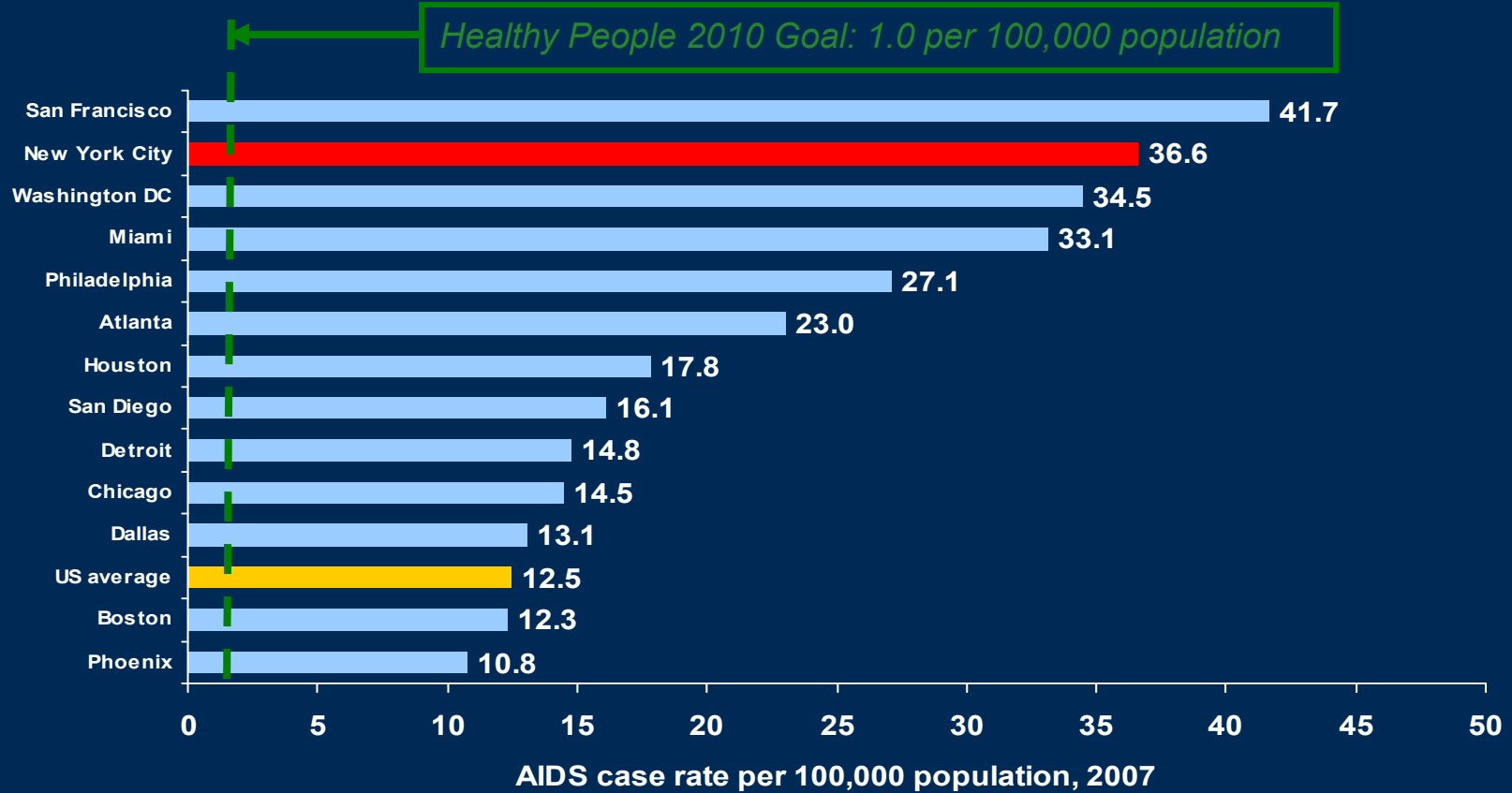
- New York, NY EMA includes
  - New York City
  - Three surrounding counties: Westchester, Rockland, and Putnam
- Grantee: NYC Department of Health and Mental Hygiene (DOHMH)
  - Bureau of HIV/AIDS Prevention and Control
    - Care, Treatment and Housing Program
- 2010 Part A award: \$121,088,606
  - Support 182 contracts (151 in NYC)
- Two master contractors to procure and administer subcontracts
  - Public Health Solutions – New York City programs
  - Westchester County Department of Health

# CTH Program Components

- Health Care Services
  - Ryan White Administration
  - Program Planning
  - Technical Assistance Unit
- Housing Services
- Research and Evaluation
- Planning Council Support
- Central Unit: Medical Director, Deputy Medical Director, Special Projects



# New York City has the 2<sup>nd</sup> Highest AIDS Case Rate in the US



**NYC's AIDS case rate is almost 3 times the US average, and nearly 37 times the Healthy People 2010 target.**

# HIV/AIDS in New York City, 2008

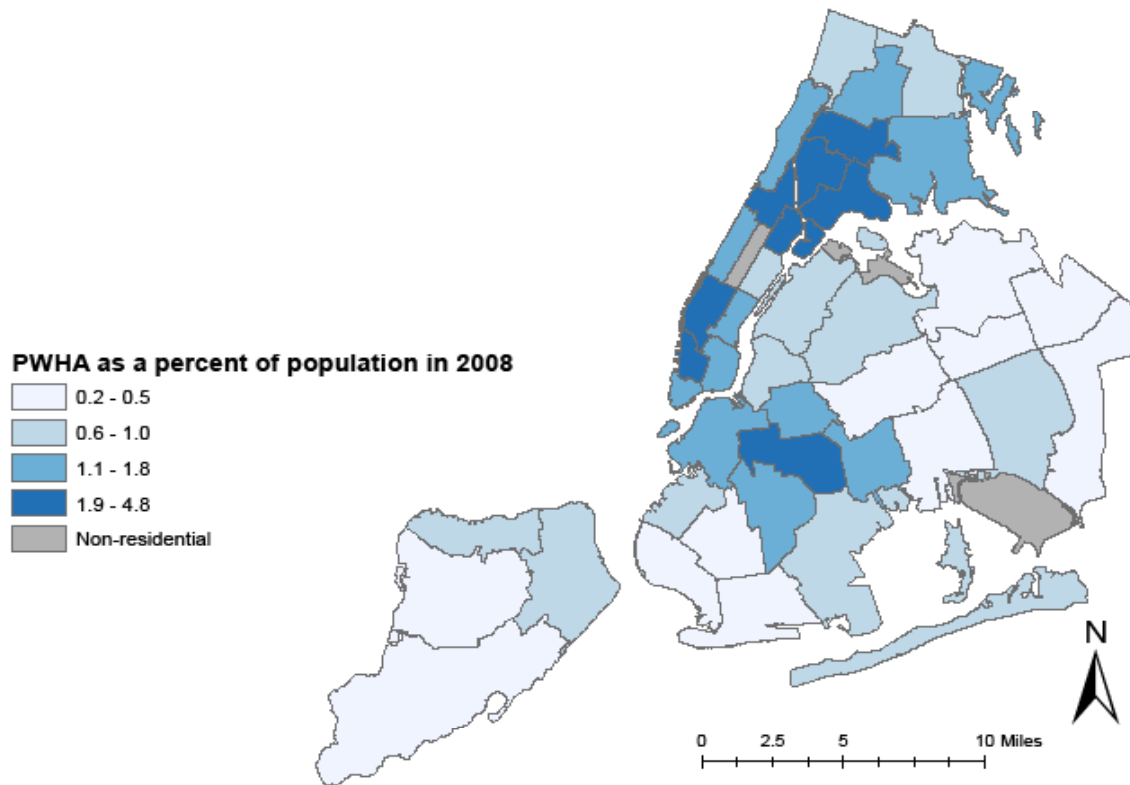
## Basic Statistics

- 3,809 new HIV diagnoses (47.6 diagnoses per 100,000 persons)
  - 2,871 HIV without AIDS
  - 938 HIV concurrent with AIDS (24.6%)
- 3,126 new AIDS diagnoses
  - Includes 938 concurrent HIV/AIDS diagnoses
- 105,633 persons living with HIV/AIDS
  - 1.3% of the population of NYC
- 1,920 deaths among persons with HIV/AIDS (17.9 deaths per 1,000 persons)
  - The death rate for NYC overall in 2008 was 6.5 per 1,000 persons

Death rate is age-adjusted to the city-wide population of PWHA at the end of 2008.  
As reported to the New York City Department of Health and Mental Hygiene by  
September 30, 2009.



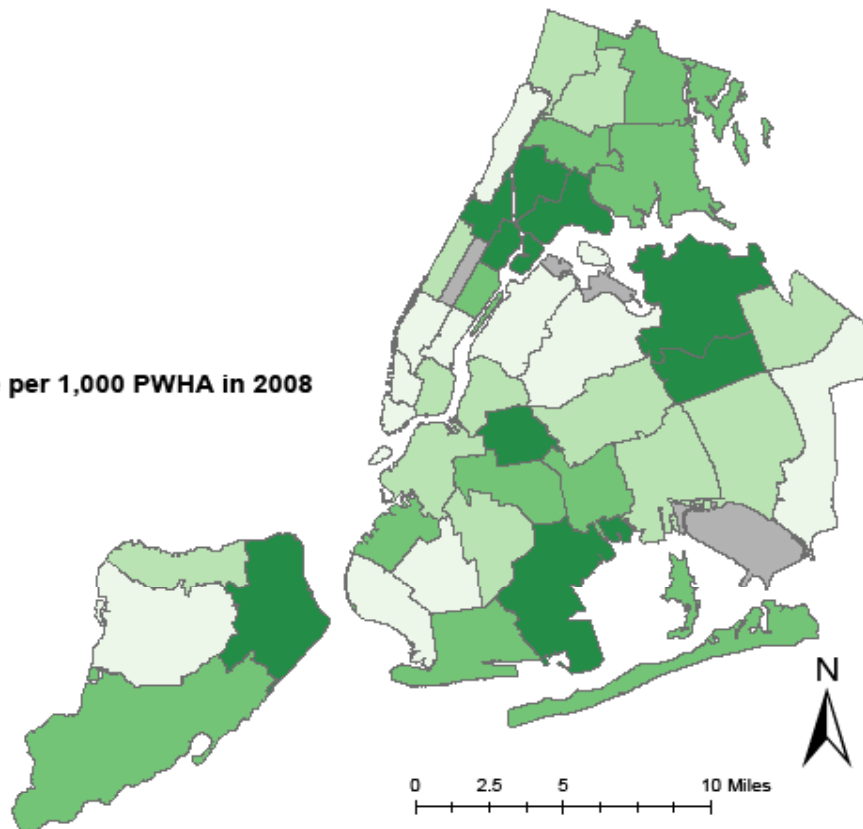
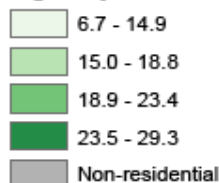
# Persons with HIV/AIDS by UHF Neighborhood New York City, 2008



**UHF neighborhoods with the highest proportions of PWHA are in the South Bronx, Central Brooklyn, lower Manhattan and Harlem.**

# Death Rate per 1,000 PWHA by UHF Neighborhood New York City, 2008

Age-adjusted death rate per 1,000 PWHA in 2008

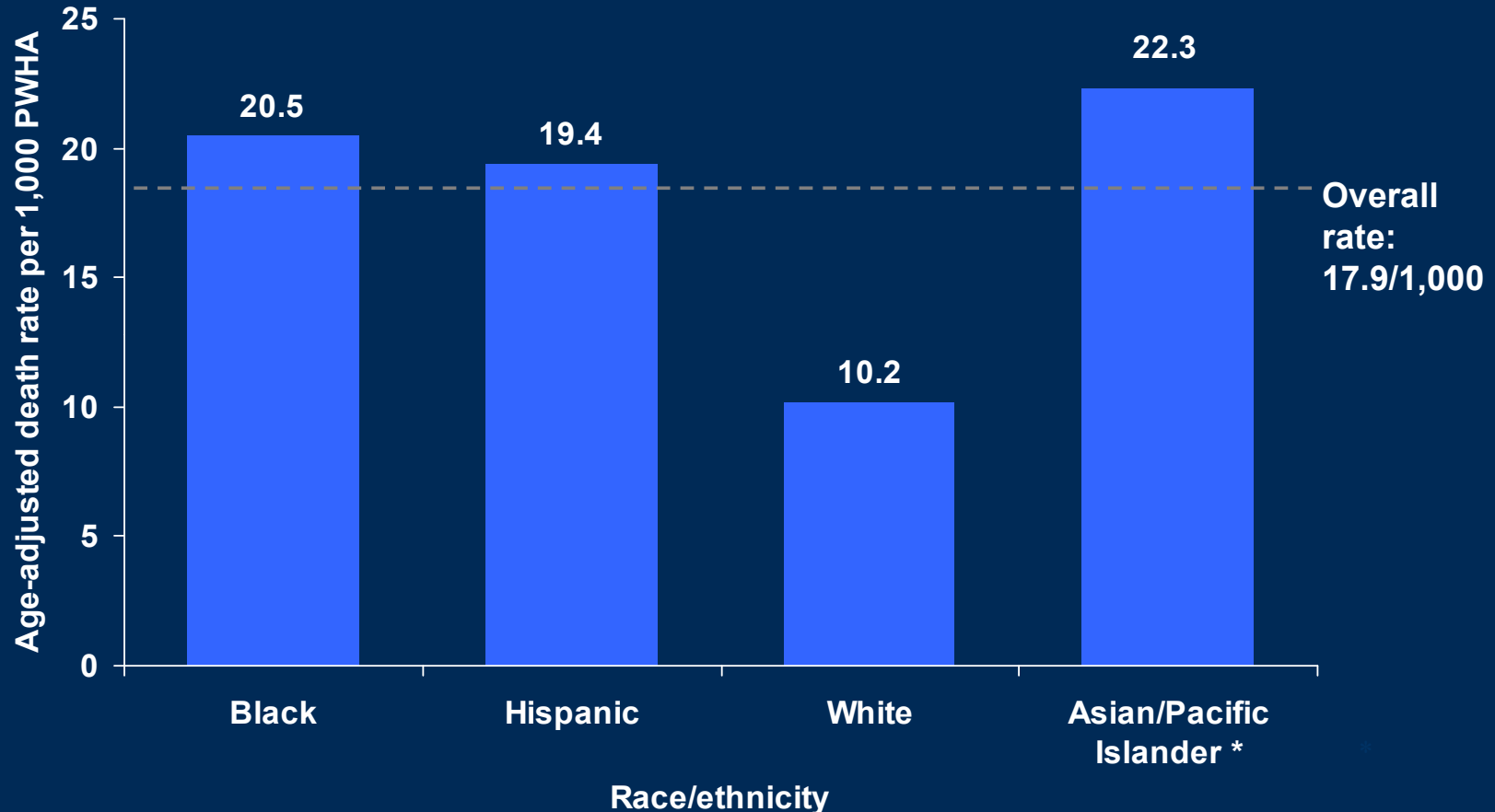


Most high-prevalence neighborhoods also have high mortality among PWHA. However, Chelsea-Clinton has the highest prevalence in the city but comparatively low mortality.



# Death Rates by Race/Ethnicity

## New York City, 2008



Among persons with HIV/AIDS, whites had the lowest death rates compared with other racial/ethnic groups.

# Epidemiology- Select Care Indicators

- Delays in care (2008) follow similar pattern as delays in diagnoses<sup>1</sup>
  - DPHO area delay in care = 30.1%
  - Chelsea-Clinton delay in care = 26.5%
- Patterns of care:
  - Interruptions: 9% one or more years
  - Discontinuous care: 8%

1. HIV Epidemiology and Field Services Program, unpublished data, Feb. 2008.

2. Prepared June 2008 with data reported Sept 31, 2007 to the HIV Epidemiology and Field Services Program at the NYC DOHMH.

# The Need for Care Coordination

- U.S. health care system suffers from widespread disparities and deficiencies in quality of care<sup>1,3</sup>
- Fragmented care is cited as a factor explaining poor quality of care, poor outcomes and delayed care<sup>1-2</sup>
- Care coordination is essential when the patient's health condition is chronic in nature rather than episodic<sup>2</sup>
- Care coordination is a priority for health care reform to improve medication adherence and optimize patient health outcomes<sup>4</sup>

1. McDonald KM et al. Care Coordination. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. AHRQ. June 2007.
2. Bodenheimer T. Coordinating care – a perilous journey through the health care system. *N Engl J Med* 2008. 358:10.
3. Institute of Medicine. Report Brief: Crossing the quality chasm: a new health system for the 21<sup>st</sup> century. IOM's Committee on the Quality of Health Care In America;2001. Accessed 8/26/08 at <http://www.iom.edu/CMS/8089/5432/27184.aspx>.
4. Cutler DM, Everett W. Thinking outside the pillbox—Medication adherence as a priority for health care reform. *N Engl J Med* 2010. 362:17.

# Closing the Quality Gap Care Coordination, 2007

- Agency for Healthcare Research & Quality report through the Stanford-UCSF Evidence-based Practice Center
- Final report in a series focused on quality improvement strategies
- Contributions include:
  - Developed working definition of care coordination
  - Summarized evidence of effectiveness of interventions
  - Presented frameworks for the development and evaluation of future interventions
- Intended to inform system-level policymakers, service-level decision makers, and patients

# Closing the Quality Gap

## Care Coordination Definition<sup>1</sup>

- The *deliberate* organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services.
- Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the *exchange of information* among participants responsible for different aspects of care.

1. McDonald et al. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. Technical Review 9. AHRQ. AHRQ Publication. June 2007. pg. 41.

# Benchmark HIV Interventions

- Bradford et al.<sup>1</sup> - **Navigation model** SPNS Outreach Initiative in 4 cities
  - Reduced barriers (i.e. no health insurance or no phone)
  - Improved health outcomes (i.e. quality of life or undetectable viral load)
- Behforouz, Farmer & Mukherjee<sup>2</sup> – PACT Project modified Haiti-designed intervention of **navigation, health promotion + DOT** to inner-city Boston
  - ART adherence rate 97%
  - Mean CD4 increase (12 mo) 123.7
  - Undetectable viral load 73%
  - CD4 maintained or increased – 82% at 12 mo; 100% at 24 mo
- Cabral et al.<sup>3</sup> - SPNS Outreach Initiative demonstrating that reasonably intense outreach and contact results in better retention in care

1. Bradford JB, Coleman S, Cunningham W. HIV system navigation: An emerging model to improve HIV care access. *AIDS Patient Care* 2007;21(Suppl1):S49-S58.
2. Behforouz HL, Farmer PE, Mukherjee JS. From directly observed therapy to accompagnateurs: Enhancing AIDS treatment outcomes in Haiti and in Boston. *CID* 2004;38(Suppl 5):S429-S436.
3. Cabral et al. Outreach program contacts: Do they increase the likelihood of engagement and retention in HIV primary care for hard-to-reach patients? *AIDS Patient Care* 2007;21(Suppl 1):S59-S67.





# Treatment Adherence

## PACT Overview

- PACT modeled on a Haitian DOT-HAART program launched in 1998 using *accompagnateurs* to educate and provide psychosocial support to HIV-infected patients via home visits
- In 2002, PACT Project started in inner-city Boston and adopted community health promoters & introduced DOT Specialists to increase ART adherence and promote self-sufficiency
- Basic principles
  - Curriculum-based skills building;
  - Intensive home-based weekly health promotion;
  - Home-based daily DOT; and
  - Accompaniment to medical visits by a Health Promoter to serve as a patient navigator, coach, and advocate

# PACT Health Promotion Curriculum

- Intro to HP
- Me and HIV
- What is HIV and how does it affect my body?
- Identifying and building social support networks
- Medical appointments and providers
- Wrap-up
- Health maintenance
- Handling your ART medications
- What is adherence?
- Adherence strengths and difficulties
- Using a pillbox
- Side effects
- Healthy living: diet and exercise
- Harm reduction – safety in relationships
- Harm reduction – substance abuse
- Harm reduction – sexual behavior

# The Chronic Care Model<sup>1</sup>

- Multidisciplinary primary care teams coordinate patient care, promote active patient participation and apply clinical practice guidelines to achieve optimal disease control
- Model delivers effective patient management by focusing on:
  - Health system design
  - Community resources
  - Decision support
  - Self-management support
  - Clinical information systems
- Goal is to promote self-sufficiency, reduce morbidity and improve quality of life

1. McDonald et al. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. AHRQ. June 2007.

# Medical Home Model

- A model of care that links patients to a primary care provider at the center of a complex healthcare system. The medical home model utilizes the chronic care model to promote self-sustaining health skills.
- The clinical provider is the patient's main point of entry to the healthcare system, who then interfaces with the care coordination program and the entire team of healthcare professionals to provide consistent integrated and appropriate medical care.<sup>1</sup>

1. American College of Physicians. The advanced medical home: a patient-centered, physician-guided model of health care. 2006 Jan 22.

# The Bottom Line

- Current treatments have great potential for impact on PLWHA health outcomes: viral load suppression
- Greatly increased life expectancy
- Complex nature of HIV requires specific interventions to maintain continuity of care



# Challenges

- Thousands not in care
- Adherence demands
- Ensuring equal access to care and treatment and reduce race and income disparities
- Supportive services must facilitate access to and maintenance in care
- The demand for cost efficiencies means that systems of care need better coordination

# Challenges

- How would you address these challenges within your EMA?



# Rationale for Integrating Care Coordination Services

- Case management is an effective intervention that links patients to and maintains them in care<sup>1-3</sup>
- Populations which face significant barriers to care can benefit from interventions to engage and retain them in regular HIV medical care and ART adherence<sup>1</sup>
- Relatively costly adherence interventions – such as DOT - are cost effective<sup>4</sup>

1. Tobias et al. Making the connection: the importance of engagement and retention in HIV medical care. *AIDS Patient Care and STs* 2007;21(suppl 1):S3-S8.
2. Lo W, MacGovern T, Bradford J. Association of ancillary services with primary care utilization and retention for patient with HIV/AIDS. *AIDS Care* 2002;14(Suppl1):S45-S57.
3. Katz MH et al. Effect of case management on unmet needs and utilization of medical care and medications among HIV-infected persons. *Ann Intern Med* 2001;135:557-565.
4. Goldie S et al, Projecting the Cost-effectiveness of Adherence Interventions in Persons with Human Immunodeficiency Virus Infection, *Am J Medicine* 2003;115: 632- 641.



# NYC DOHMH Care Coordination Definition

- Combines elements of navigation and chronic care models to both train patients in becoming self-sufficient and to assist them in accessing needed care and services. The focus is on navigating the system to obtain services and coaching for self-sufficiency.
- Key strategies include multidisciplinary teams, care navigation, health education, medication adherence, social services and benefits assistance and directly observed therapy (DOT).
- Effective care management requires a concerted public health approach to maintain engagement in care and return those lost to follow-up.

# Departure from Previous Models...

- Streamlined information sharing
- Care Coordination Team leader assumes responsibility to execute the multi-disciplinary plan
- Hybrid approach – combines adherence counseling, DOT, navigation, social services and benefits assistance
- Assessments are shared – not repeated
- Medical home and chronic care models
- Service integration and increased efficiency

# HIV Care Coordination Patient-Oriented Policies

- All Persons diagnosed with HIV in NYC should:
  - Have a medical home;
  - Receive health education, health promotion and coaching to achieve self-sufficiency and optimal health status; and
  - Ultimately, most should achieve viral suppression
- As needed, persons diagnosed with HIV should:
  - Receive assistance from a Care Coordination Program;
  - Have access to logistical support to facilitate access to care;
  - Receive assistance enrolling in benefits including housing;
  - Benefit from an effective flow of health information between their primary care providers and the care coordination team; and
  - Obtain support to help achieve medication adherence

# Discussion

- Program objectives
- Practice Standards



# HIV Care Coordination Specific Objectives

- Ensure that persons enrolled in the program are linked to care in a timely and coordinated manner and maintain medical stability and a suppressed viral load;
- Maintain patients in care via navigation, coordination of medical and social services and provide support and coaching;
- Teach and support treatment (medications) adherence and reduced risky behaviors;
- Train patients to become self-sufficient so that they are able to manage their medical and social needs autonomously; and ultimately
- Ensure that patients maintain a stable health status and reduce HIV transmission

# Practice Standards

- Execute the treatment plan- appointments, referrals, and medication adherence and obtain benefits – creating a medical home
- Screen all patients for eligibility in the Program and duplicate enrollment in similar programs
- Address urgent needs and schedule follow-up medical care during intake
- Maintain up-to-date contact information for patients
- Perform a detailed assessment of social services & benefits and logistical needs to guide the comprehensive plan
- Provide education/health promotion
- Incorporate treatment adherence interventions as needed
- Effective coordination between and among medical care and support services

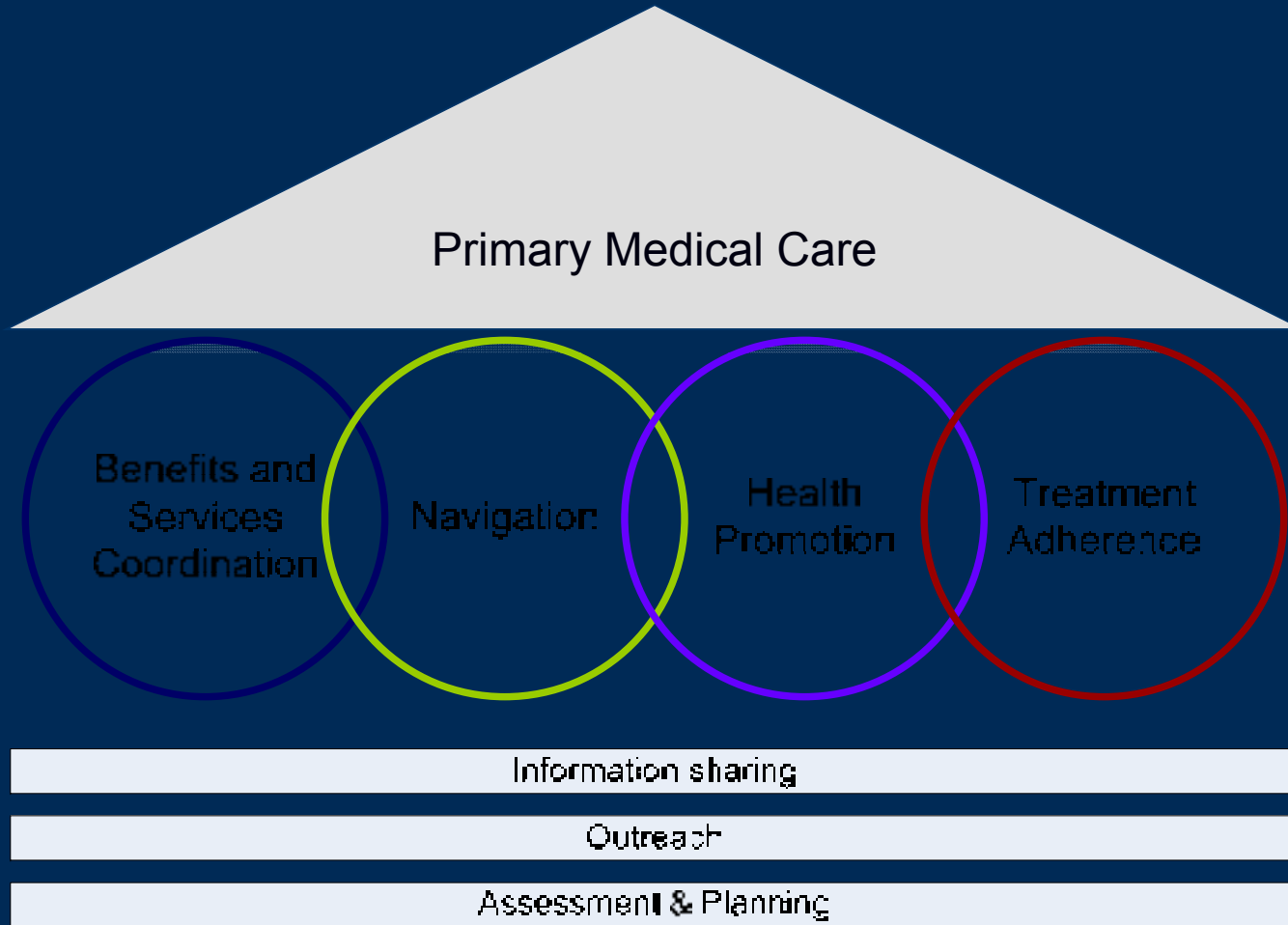


# HIV Care Coordination Protocol

## Purpose

- Requirement for Ryan White Part A funded care coordination Programs to ensure standard of care
- A reference for all case management or care coordination providers – although not required
- Provide detailed guidelines and standards

# Components of the Program





# Information Sharing between PCPs and Case Management

- RW Part A quality management performance reports – rates of information sharing (referrals, appointment dispositions, key health indicators) remain low despite efforts at promoting standards of care
- Despite technologic advances, remote access by case managers to EHRs is rare
- Anecdotal information suggests challenged communication between providers and provider types

# Patient Eligibility

- Newly diagnosed with HIV, or
- Lost to care, or
- Sporadic/irregular care or difficulty keeping appointments, or
- History of non-adherence to ART or
- First time on an ART regimen or recent change in regimen, or
- ART experienced with:
  - **Prior treatment failure and drug resistance, or**
  - **Recurrent virologic rebound after successful suppression**

# Outreach

## *Initially*

- Primary care roster reviewed at Program onset to identify patients with lapsed care
- Patients prioritized for Program outreach:
  - Had at least 1 visit in the past 2 years at the medical facility AND
  - No visit in the past 9 months or more

# Multidisciplinary Comprehensive Assessment Exercise

- Medical assessment - history and physical, including mental health and substance abuse treatment needs
  - Primary care provider +/- behavioral health provider
- Social needs & benefits assessment - health insurance benefits, housing, etc
  - Can be done by nurse, social worker in the primary care team, or care coordination team leader
- Care coordination assessment (logistics)
  - Care coordination team leader



# Multidisciplinary Comprehensive Plan

- Care coordination team leader creates the comprehensive plan via a case conference – an in-person hand-off- and
  - Summarizes the medical plan in the patient's medical record
  - Summarizes the social worker's plan, if available
  - Adds the support services plan
- Creates a timeline and goals for each element of the plan



# Benefits and Service Coordination

Assist with obtaining and coordinating services including social support, peer groups, and access to food/nutrition services.

- Evaluate for eligibility, assist with applications and ensure *housing, health insurance and other benefits*
- Maintain formal relationships with community service agencies

# Navigation (1)

Ensure that every patient knows where, when, and how to access all health (including primary care, mental health and substance abuse services) and related services. Follow up with the service provider the same day. Ensure confidentiality of personal health information.

- Review the comprehensive treatment plan with the patient and provider at every primary care visit
- Remind the patient of upcoming appointments or plans

# Navigation (2)

*To ensure patient has the requisite resources for appointments and services:*

- Scheduling of appointments
- Accompaniment to appointments
- Assistance with:
  - Transportation
  - Translation
  - Childcare services



# Health Promotion

Provide basic or expanded (for those on anti-retroviral medications) HIV education, coaching and counseling.

**Provide education with practical application on:**

- **HIV 101**
- **Disease management**
- **Communication with providers**
- **Harm reduction and**
- **Healthy behavior**

# Home Visits

- Patient Navigator is the main team member working in the field
- Home visits:
  - Treatment adherence and education in environment where client is comfortable and where they take their meds
  - One staff member should always be accessible in the office when a staff member is working in the field
  - Safety in the field
  - Discussing home visits with clients
  - Confidentiality and disclosure
  - Scheduling: Days, nights, weekends?
  - Mapping and routing visits for time efficiency
  - Travel plans



# Treatment Adherence (1)

Build patients' medical adherence skills.

- **Teach methods of adherence to patients**
  - **Methods may include self-reporting, pill counting, or directly-observed therapy (DOT).**
- **Educate and demonstrate to all patients how to:**
  - **create a medication list;**
  - **read a pill bottle and fill a pill box;**
  - **communicate with the pharmacy to refill medications;**
  - **integrate a medication regimen into a daily routine; and,**
  - **manage side effects.**

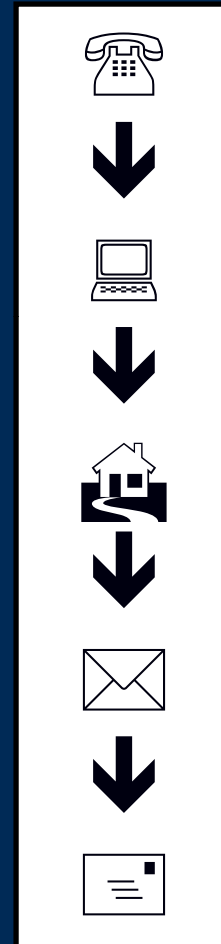
# Treatment Adherence (2)

Provide directly observed therapy (DOT) for cannot adhere to ART independently.

- **Obtain consent to perform DOT**
- **Provide intensive health education**
- **Serve patients in the setting most likely to yield clinical success**
- **Document medication compliance on the log form**

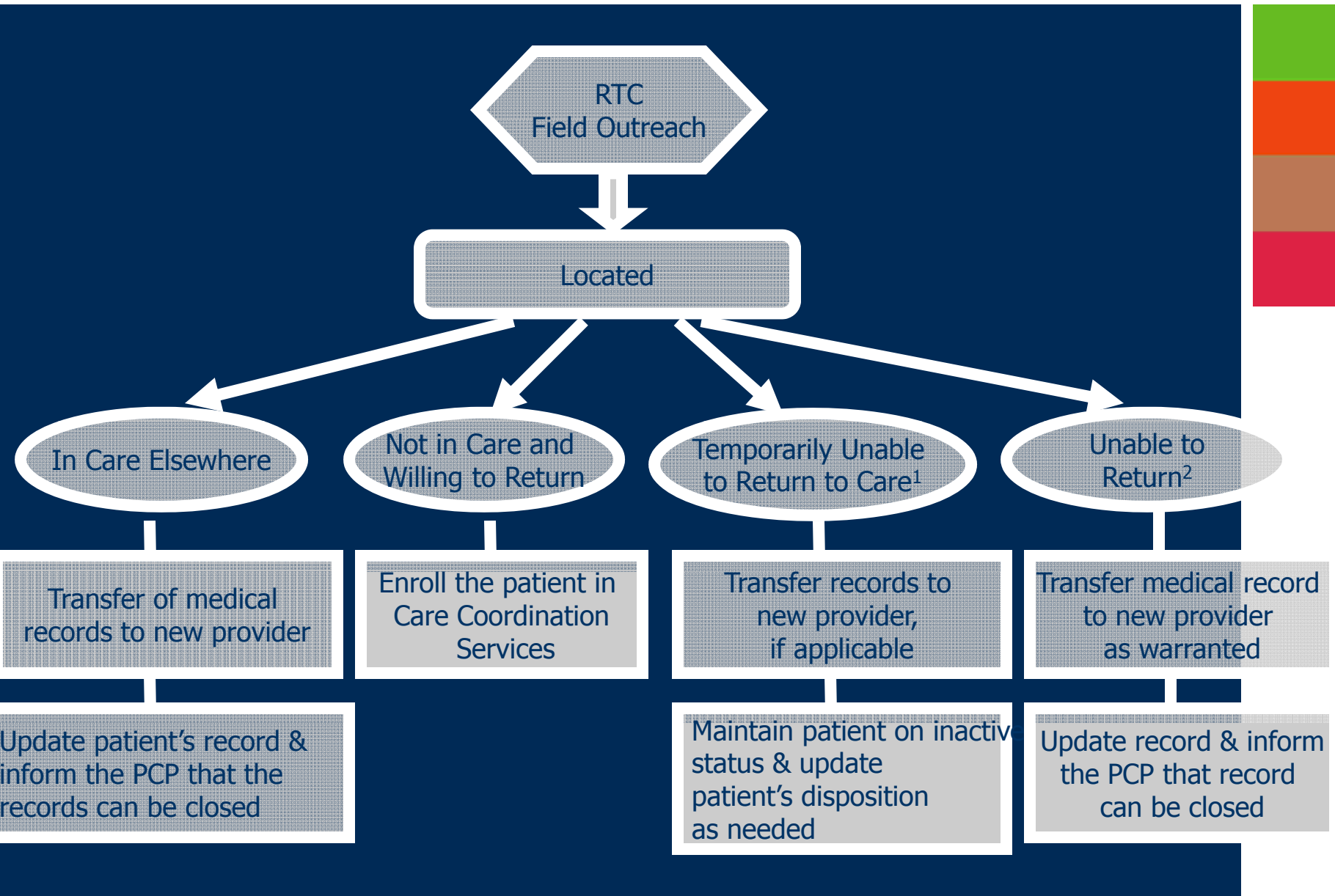
# Missed Appointments Procedure

- Missed appointment noted right away and intervention started the same day
- Notify supervisor
- Phone outreach
- Internet search
- Field Outreach
- Letter
- Certified letter
- Document process on outreach log
- Close case at 2 months if efforts fail



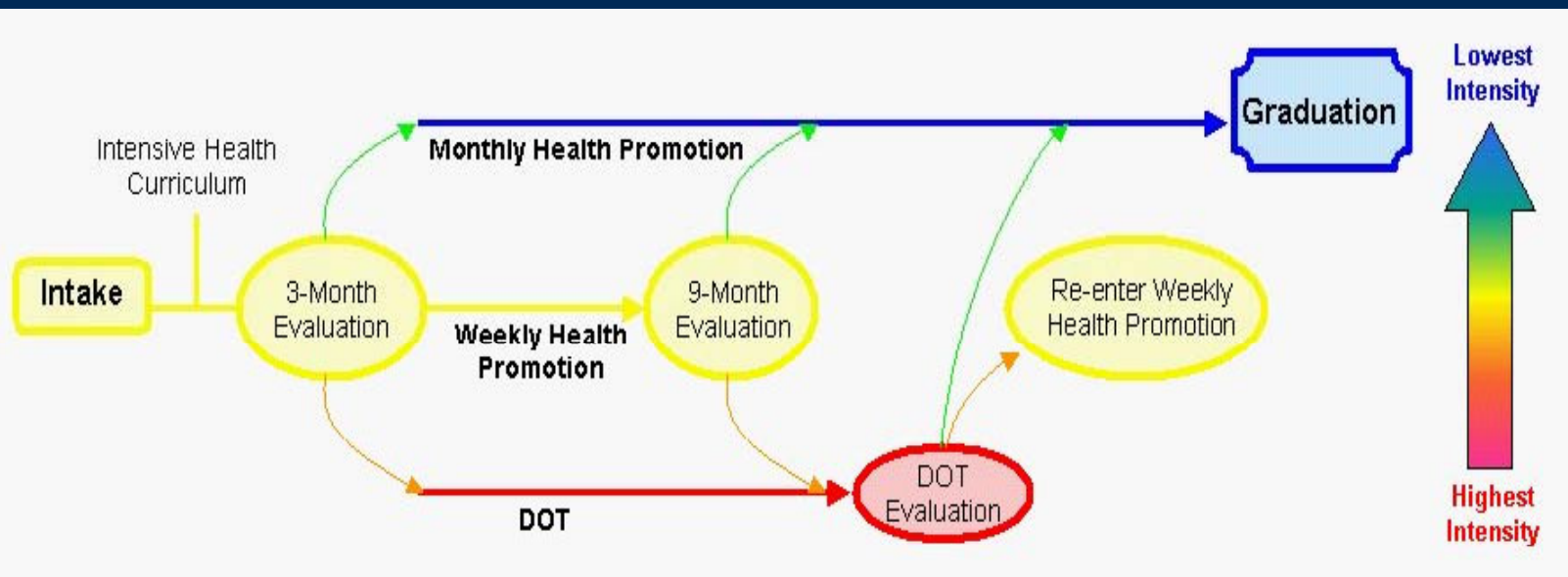
# Return to Care Procedure

- Review the patient roster or EMR quarterly to ensure no patients have been lost in the intervening quarter despite the missed appointment procedure
- Phone calls
- Internet search
- Home visit
- Certified letter



1. For example, travel, short-term incarceration, hospitalization
2. For example, long-term incarceration, permanent move, or death

# Program Design



Courtesy PACT



# Induction Phase (1)

- First 3 months of service
- Allows Program staff to evaluate the patient's needs and abilities in adherence and health education
- Includes:
  - Care Navigation
  - Weekly Health Promotion
  - Social Services and Benefits Assistance
- Patients prescribed ART are guided as per the curriculum to use a pill box as early as possible



# Induction Phase (2)

- Navigation activities include:
  - Health promotion interventions once per week (basic, HIV 101, appointments management)
  - Accompanied to ALL primary care appointments
    - Accompaniment to medical specialist, social services agencies and programs is beneficial
  - Care Coordinator tailors approach based on patient successes and challenges



# On-Going Phase

- Re-assessments
- Movement between phases
- Graduation or case closure for other reasons



# Levels of Care – Low Intensity A

- Limited to persons with **no indication for ART**
- Education: Delivered **quarterly** in conjunction with primary care visits and at any home visits
  - Biology of HIV - What is HIV?
  - Me and HIV - Healthy Living
  - Identifying resources and supports
  - Medical appointments and providers
  - Social context and healthy habits
  - Harm Reduction: sexual
  - Harm Reduction: substance use
  - Harm Reduction: safety in relationships
- Accompaniment to PCP appointments
- Medication Adherence: **None**

# Levels of Care – Low Intensity B

- Limited to persons **prescribed** ART
- Education: Delivered **quarterly** in conjunction with primary care visits and at any home visits
- All of the modules listed for Low Intensity A, plus
  - What is adherence - Using a pillbox
  - Handling your ART medications
  - Side effects - Difficult days
  - Adherence strengths and difficulties
- Accompaniment to PCP appointments
- Medication Adherence: Quantitative measurement of adherence by self report **in conjunction with PCP and home visits**

# Levels of Care – High Intensity C 1-2

- Limited to persons **prescribed ART**
- Level C1=MONTHLY
  - Education: All of the modules listed for Low B delivered **monthly**, generally in the patient's home or other suitable site in the field
  - Accompaniment to PCP appointments
  - Medication Adherence: Pill counting **monthly**
- Level C2=WEEKLY
  - Education: All of the modules listed for Low B delivered **weekly**, generally in the patient's home or other suitable site in the field
  - Accompaniment to PCP appointments
  - Medication Adherence: Pill counting **weekly**

# Levels of Care – High Intensity D

- Limited to persons **prescribed** ART
- Education: All of the modules listed for Low B delivered **weekly**, generally in the patient's home or other suitable site in the field
- Accompaniment to PCP appointments
- Medication Adherence: Directly-Observed Therapy (DOT) Daily (Mon – Fri)

# Case Study

- Mary only takes her medications when pregnant with poor follow-up with PCP; she discontinued after miscarrying her last pregnancy. She also had difficulty obtaining medications and never applied for ADAP. Baseline CD4 174 and VL 34,070.
  - Now Mary keeps her appointments and is adherent to ART
  - Last CD4 230, VL 11,480



# Case Study

- Jane, recently diagnosed with AIDS. Worried about deportation because of her immigration status, she does not keep appointments. Depressed. Baseline CD4 170 and VL 5,450
  - CC team alleviated her concerns
  - She is seeing a PCP regularly and is on ARV
  - Last CD4 230
  - Last VL 70

# Case Study

- Tomas, 29 year old from Columbia, HIV+ since 2002, only comes for care when he is ill. He otherwise misses appointments and does not take ARV regularly. CD4 nadir 11 and VL196,000
  - Since enrollment in CC, Tomas has kept all appointments, is 100% adherent
  - Last CD4 80, last VL undetectable
  - Obtained rental assistance and is moving out of a friend's apartment

# Case Conferences

- Ongoing communication between Care Coordination staff and medical providers concerning:
  - Patient progress
  - Health concerns
  - Changes in treatment plans
  - Barriers to care
  
- All those with direct patient contact should attend:
  - Patient Navigator
  - Care Coordinator
  - PCP
  - Care Coordination Program Director



# Case Review

- Regular Case Review
  - Internal program review to ensure navigation and health promotion are occurring
  - Complex and active cases reviewed weekly
  - Every case reviewed at least once per quarter
  
- Quarterly review for QA



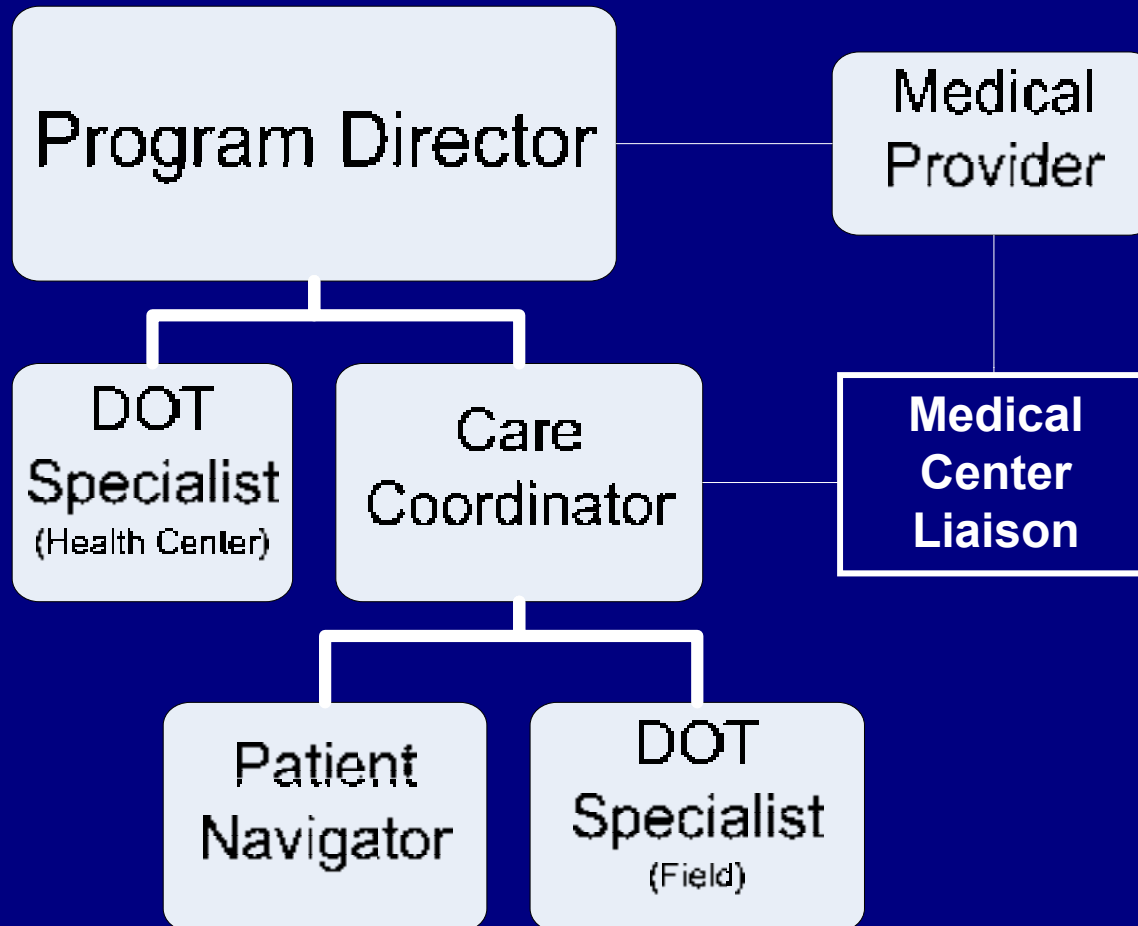
# Case Closure

- Patient has become self-sufficient: graduation
- Patient is lost, moved, deceased: close case
- Patient wishes to transfer to another program
- Refuses services: attempt to convince patient to remain with care coordination program; and if not possible, close as refused
- Patient is not benefiting from program, not improving, not adherent with plan: refer to more appropriate program, such as drug treatment, residential care, adult day care

# Role of Staff Exercise



# Program Staff Roles



# Program Director

- Recruit, hire, and supervise all staff
- Ensure staff training
- Generate relevant protocols
- Act as a liaison between the Program and NYC DOHMH
- Liaise with Medical Providers
- Attend case conferences
- Review all program enrollments and case disposition actions
- Oversee monitoring, reporting and quality management





# Care Coordinator

- Programmatic supervision of Patient Navigators and Field DOT Specialists
- Oversee implementation of plan
- Facilitate communication with all clients' care providers
- Case Management Responsibilities for referrals and entitlement applications
- Complete client enrollment
- Perform Intake/Assessment and develop Client Care Plan
- Meet with patient after every PCP appointment
- Provide clinic-based education
- Participate in case conferences



# Medical Center Liaison

- Staff at partner agency medical facility, as proxy for Care Coordinator
- Act as liaison between medical facility and Care Coordination program
- Supervise Center-based DOT
- May perform: enrollment, intake/assessment, in lieu of the care coordinator
- Participates in development of Comprehensive Care Plan
- Forwards reports to Care Coordinator
- May conduct center-based health education for low intensity clients



# Patient Navigator

- Client's primary contact
- Build rapport and foster relationship
- Provide field-based education: monthly or weekly
  - Facilitate topics in Care Coordination Curriculum
  - Curriculum Coverage Log
- Treatment Adherence
  - Monthly Pill Box Log
- Navigation: logistical support, reminder calls, coordinate transportation, assist arranging childcare
- Accompany clients to appointments
- Conduct social service and benefit reassessment
- May perform duties of DOT-Field Specialists



# DOT Specialist

- Center-Based
  - Distribute medication
  - Observe and record
    - Patient self-administration of ART
    - DOT Log
  - Assess and report side effects to Care Coordinator and medical provider
- Field Based
  - Do not touch medication
  - Observe and record
    - Patient self-administration of ART
    - DOT Log
  - Assess and report side effects to Care Coordinator and medical provider



# Medical Provider

**A crucial partner in the program, the engagement of the medical provider is essential for program success**

- Primary Care Provider must be within Care Coordination network
- Role includes:
  - Encourage client enrollment
  - Refer eligible and interested clients
  - Attend or initiate the initial case conference
  - Produce the medical treatment plan
  - Routinely communicates with Care Coordination team
  - Share medical information with the team
  - Participates in case conferences
  - Reviews each client at least once per quarter
  - Relay clinical concerns and events to CC team

# Clinical Supervision

- An opportunity for staff to talk about their emotional reactions to their work
- Should be provided by a licensed therapist
- 30-40 minutes at least once every two weeks
- Individually or in a group
- Strongly recommend that Clinical Supervision NOT be provided to a staff person by his/her non-clinical supervisor



# Program Innovations

- Leverages Ryan White funds to implement a public health-focused evidence-based intervention
- Uses surveillance data for program planning, implementation and monitoring
- Uses medical records data for patient recruitment and follow-up
- Establishes formal relationship and communication between the HIV care providers and the care coordination team
- Uses a program protocol and patient health promotion curriculum
- Includes the principles of the medical home and the chronic care models

# Implementation

- \$25 Million allocation (25% of portfolio)
- RFP released January 2009
- Contracts started December 1, 2009
- 28 Agencies and networks funded citywide
- Aiming to serve 4-5,000 patients





# Technical Assistance and Program Monitoring - DOHMH

- Two-week training on program and related topics
- Guidance from PACT staff
- Technical assistance specialist team
- Technical assistance assessment, site visits and feedback
- Tailored assistance and on-going training based on needs
- Data-driven TA using evaluation and quality management data

# Current Status Implementation (1)

- Programs funded
  - 28 Care Coordination providers currently funded
    - 16 Medical Providers implementing program alone
      - Three network with a CBO
    - 12 Community-Based Organizations
      - Seven multi-service centers with HIV primary care
      - Five are non-clinical CBOs providing care coordination for one or more medical providers
- Enrollment
  - Target patient goal
    - Approximately 4,000-4,500 per year
  - Start-Up built into year 1 deliverables
  - Six (6) months into year 1
    - Per self-report: 963 (24%) current patients (goal was 25%)

# Current Status Implementation (2)

- Training
  - 10-day Care Coordination training required
    - National Development and Research Institutes, Inc. (NDRI)
  - 15 10-day trainings scheduled
    - Program Directors, Care Coordinators, Patient Navigators
    - Approximately 320 total staff members to be trained
      - Ten (10) trainings completed; 234 (73%) people trained

# Current Status Implementation (3)

- Technical Assistance Provided
  - Initial Meet and Greet
    - Conducted with Master Contractor
  - Second site visit
  - Forms presentations
  - Presentations for Medical Providers
  - Care Coordination Chronicle
    - Quarterly Newsletter
  - Provider Meeting
  - Referral Resource Guide



# Current Status

## Program Evaluation

- Rollout of eSHARE database
- Evaluation of the fidelity of model implementation
- Frequent data analysis and review
- Continued work with the AIDS Institute and use of Quality Learning Networks
- Feedback to providers
- Health department oversight and internal quality management
- Special evaluation studies
  - Continue to study collaboration among the care coordination team (HIV PCP, Care Coordinator & Patient) and examine its impact on patient health outcomes



# Program Evaluation

## Examples of Measures

- Process measures:
  - Appointments kept
  - Referrals made
- Outcome measures:
  - Proportion with undetectable viral load
  - Proportion with increasing or stable CD4 counts
  - Progression to AIDS
  - Hospitalizations or ER visits



# Benefits for Patients

- Assistance with applications and follow-up
- Health promotion, coaching and support
- Personal goal setting and follow-up
- Medication adherence skills education
- Reminders and logistical assistance for appointments
- Better clinical outcomes as a result

# Benefits for the Medical Provider

- Better-managed patients
- Stable patients
- Reliable follow-up
- Readily available information
- Opportunity to participate in decisions concerning patient interventions
- Easy access to staff
- Simple referral process



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