CARE COORDINATION

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Objectives

1. Establish planning timeline for developing updated CCP service directive
2. Provide HRSA definition of Medical Case Management
3. Define Medical Case Management models in NY EMA
4. Provide details non-Ryan White Part A case management services
5. Define current Care Coordination Program
6. Share current data on Care Coordination Program and outcomes

Planning Timeline

December 2016	January 2017	February 2017	March 2017	April 2017	May 2017
Present current model of services for Care Coordination.	Discussion of possible model revision begins. Process may include formal input from current providers.	Discussion of possible model revision continues. Process may include formal input from current providers.	Draft service directive presented and revisions begin.	Revision of service directives continues.	Finalize revisions to service directive.

HRSA Service Category Definition

Ryan White defines **medical case management (MCM), including treatment adherence**, as a range of client-centered services that link clients with health care, psychosocial, and other services provided by trained professionals, including both medically credentialed and other health care staff. Medical case management is considered to be a core medical service for purposes of Ryan White funding requirements.

Care Coordination Program

Program objectives:

1. Support clients to manage their medical and social service needs;
2. Provide linkage to care to clients in a coordinated manner;
3. Work together with patients to support treatment adherence; and
4. Provide clients with home-based navigation, coordination or medical and social services, and support

Currently funding:

- 10 community based organizations
- 17 hospital/clinical sites

Allocation and Prioritization (2015)

MCM rank: **5**

Total MCM allocation: **$24,479,855**

Proportion of portfolio: **27.92%**

Note: MCM includes Care Coordination Programs, Transitional Care Coordination and Case Management programs in Tri-County

NY EMA MCM Models

Care Coordination Program (NYC contracts): $21,272,362

- Comprehensive program (based on CCP manual) that includes treatment adherence, health promotion, patient navigation, accompaniment, modified Directly Observed Therapy (m-DOT), and assistance with entitlement and benefits.

Transitional Care Coordination (NYC contracts): $1,443,288

- Provides stabilizing case management for homeless and unstably housed individuals.

Case Management (Tri-County contracts): $1,764,205

- Coordinate all levels of medical care and social services support through an initial patient assessment and periodic reassessments, the development of individualized care plans, and patient monitoring.

Non-RWPA Case Management Programs

- HIV/AIDS Service Administration (HASA) offers case management and assistance in applying for public benefits and services

NYS Department of Health programs:

- Medicaid Health Homes*
- Medicaid Special needs plans (SNP) case management programs*
- Retention and adherence (RAP) programs
- Engagement and supportive services (ESS) initiative

Note: CCPs are specifically necessitated by HIV status, offer robust treatment adherence, and eligibility is based on medical need.

(*) programs that are not based on HIV-related medical need

MCM Allocations in Other Jurisdictions

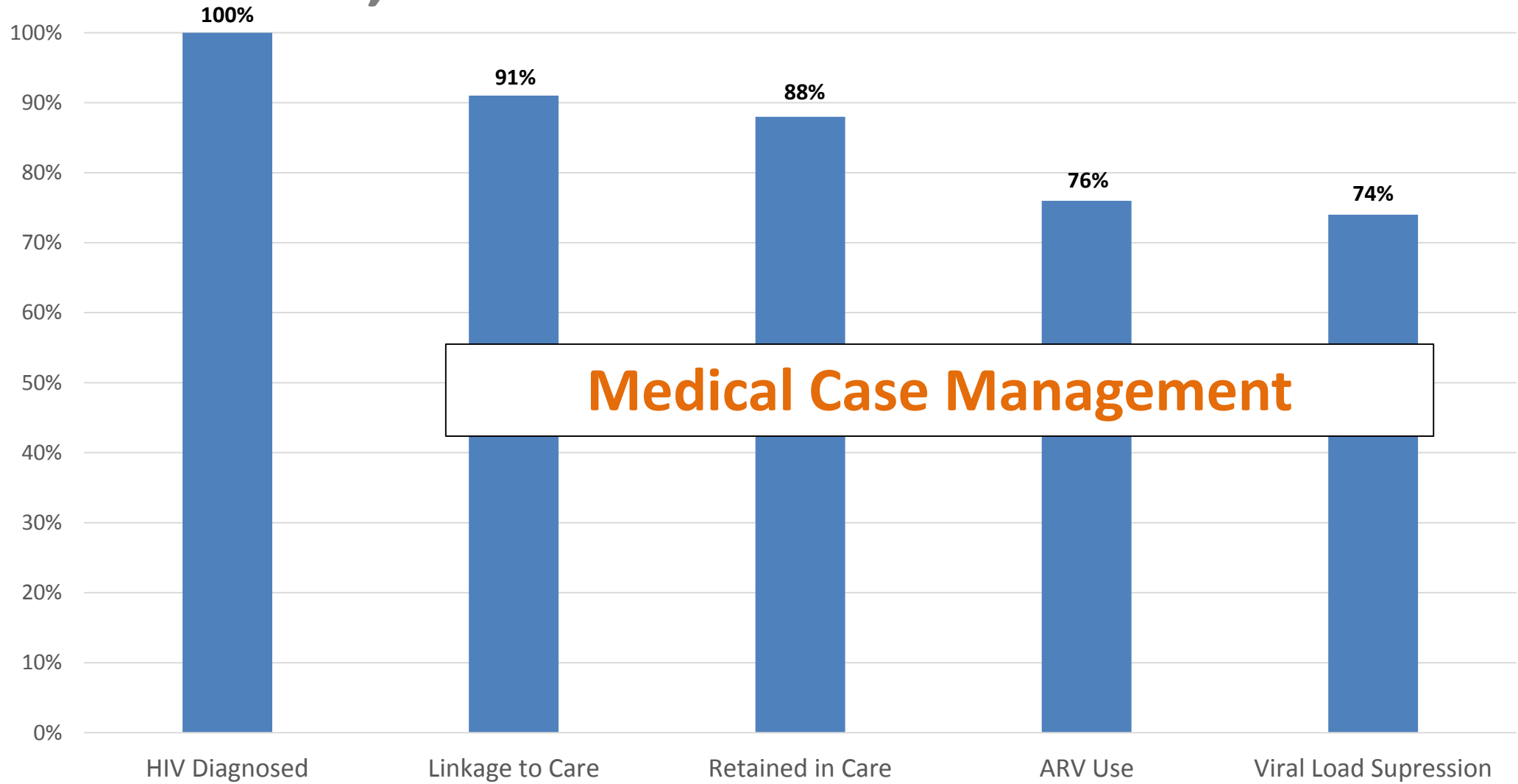
20% – 30%	Boston **31.9%**	New York **27.9%**	Newark **27.4%**	Nassau-Suffolk **26.7%**	Hartford **23.5%**
15% – 20%	Chicago **19.6%**	Washington **18.0%**	Philadelphia **16.9%**	Phoenix **16.1%**	
5% – 15%	San Francisco **12.3%**	Houston **10.8%**	Ft. Lauderdale **8.6%**	Atlanta **6.3%**	

AVERAGE: 18.9%

SERVICE MODEL

An Overview

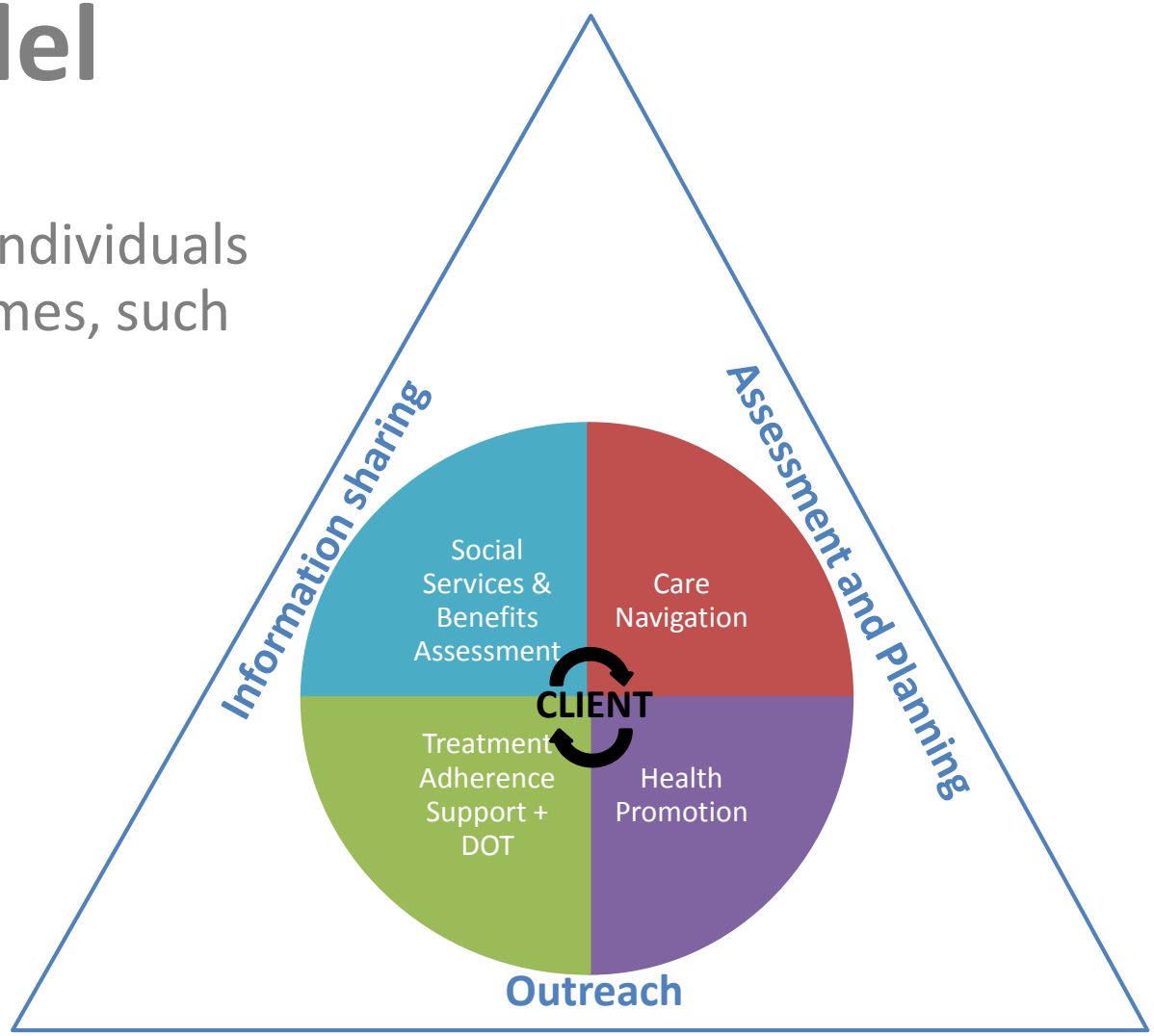
Ryan White Diagnosis-based HIV Care Continuum, 2014



CCP Program Model

Target population is RW-eligible individuals at risk for suboptimal care outcomes, such as:

- newly diagnosed
- irregularly in care
- lost to care, never in care
- starting new ART regimen
- with incomplete adherence/ response to ART



CCP Track Overview

NOTE
Track C2 is the induction phase (first 90 days for all clients)

INTENSITY	Low		High		
TRACK	A	B	C1	C2	D
Client type					
Not prescribed ART	●				
Prescribed ART		●	●	●	●
Health education/promotion					
Safer sex	quarterly		monthly	weekly	
HIV 101					
Harm Reduction	as needed				
Treatment adherence					
Medication adherence					
Adherence assessment		quarterly	monthly	weekly	
DOT					daily (M-F)

can be delivered at home or other suitable field site

CCP Funded Services

Services	Ryan White Only	Health Home Dually Enrolled
Intake assessment	●	●
Other assessment/reassessment	●	●
Care plan	●	●
Accompaniment	●	
Assistance with entitlements and benefits	●	
Assistance with social services	●	
Case conference	●	●
Health education/promotion (including group)	●	●
Outreach for client re-engagement	●	
DOT (ART & non-ART)	●	●

SERVICE UTILIZATION

March 1, 2015 – February 29, 2016

Service Utilization

4,225

clients enrolled in CCP for at least one day

363 days

median length of enrollment

28%

clients with new enrollments during the grant year

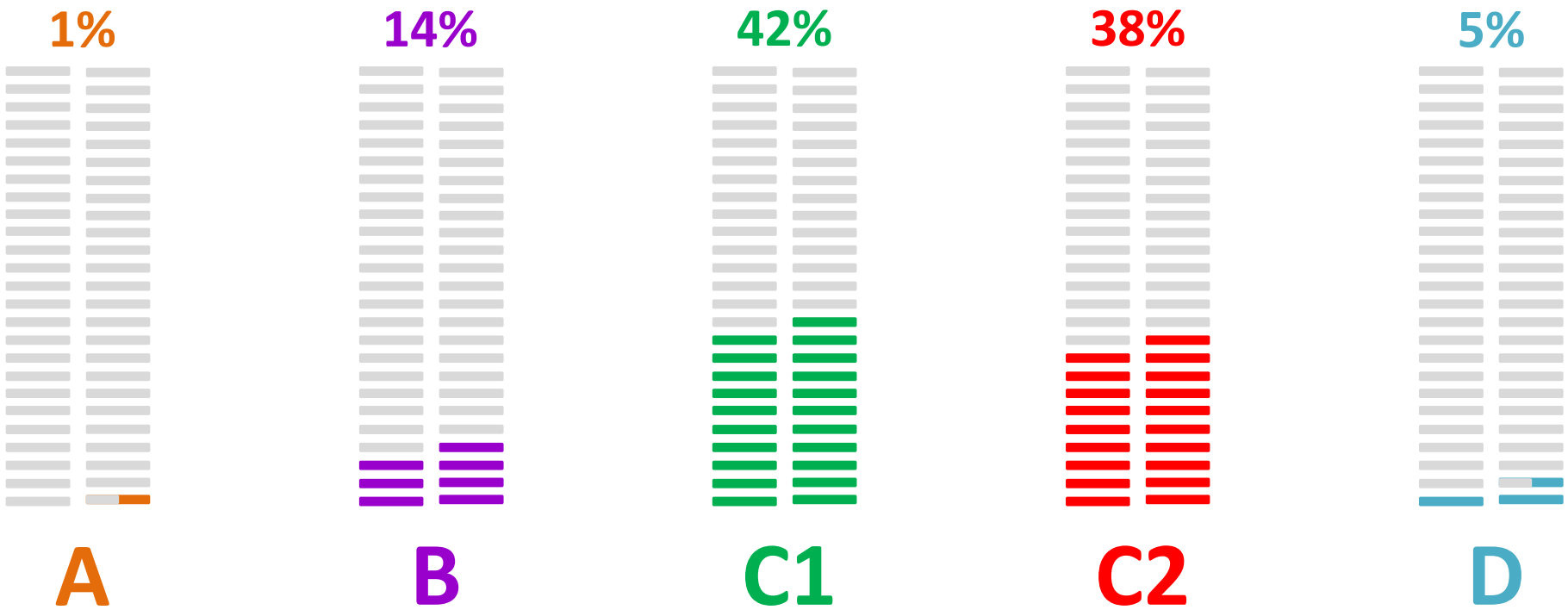
4%

clients in dually enrolled track enrolled in Medicaid Health Homes

[March 1, 2015 – February 29, 2016]

Track Enrollment: Existing Clients

Track enrollments below represent clients enrolled in the previous grant year (Mar. 2015 – Feb. 2016)



N = 3,042 existing clients

OUTCOMES

Evaluation of Outcomes

- **CHORDS** (Costs, Health Outcomes & Real-world Determinants of Success in HIV Care Coordination) **Study**
- Supported through a grant from NIMH (1R01MH101028)
- NYC DOHMH collaboration with CUNY Institute for Implementation Science in Population Health, Graduate School of Public Health and Health Policy

Comparison Group Analysis Approach

Step 1. Select from the NYC HIV Surveillance Registry a group of people in HIV care, who:

- Met CCP criteria for medical eligibility and were not enrolled in the CCP

Step 2. Assign each non-CCP PLWH a start month (for 12-month follow-up) that:

- Falls within a period when the individual appeared to be medically eligible for the CCP

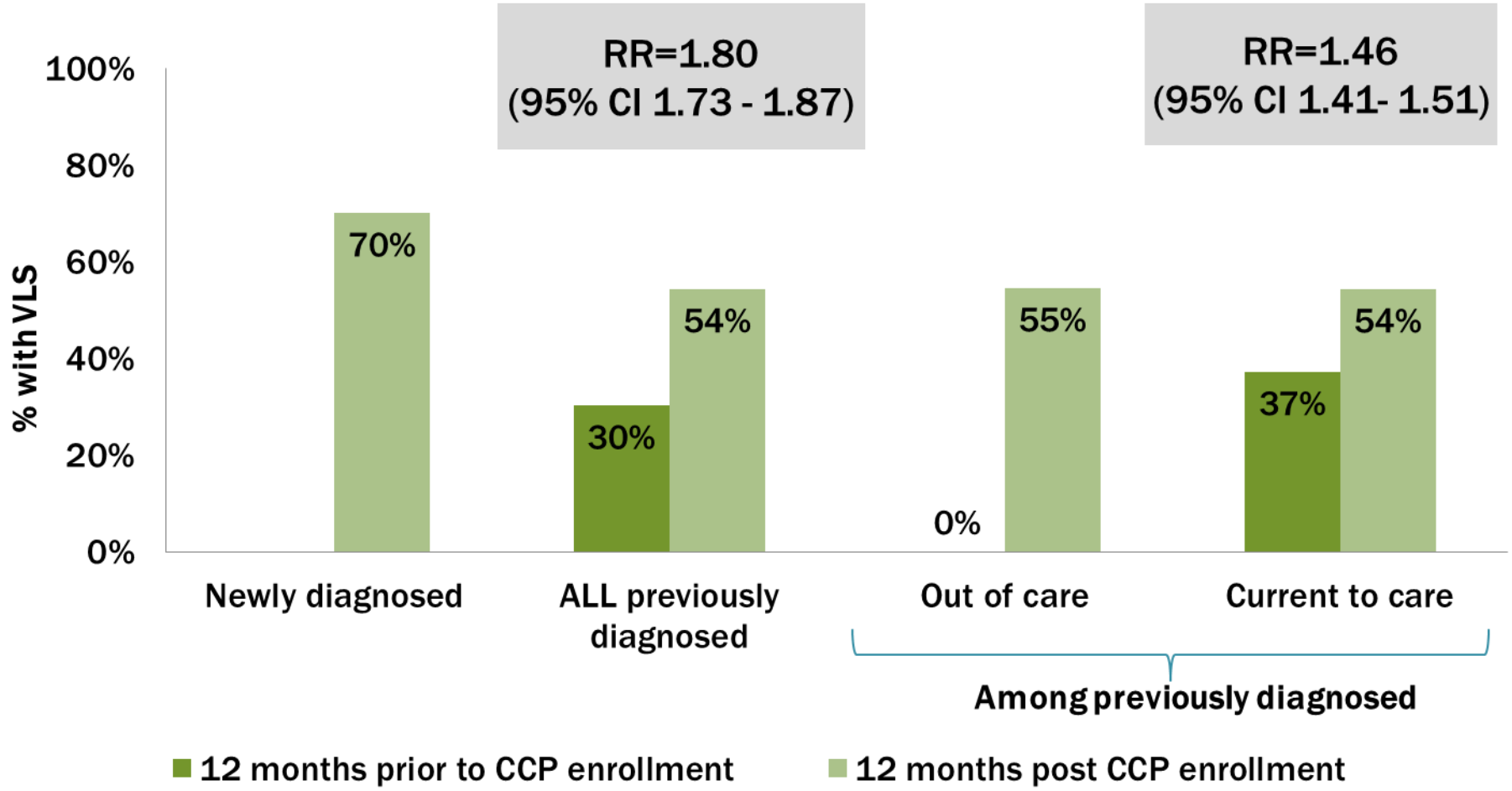
Step 3. Match each CCP client to one eligible non-CCP individual, based on :

- Similarity on clinical and demographic characteristics

Step 4. Estimate effect: CCP vs. non-CCP viral load suppression (VLS) at 12-month follow-up

- Using relative risks (RRs), for which values >1.0 suggest a positive program effect, i.e., greater chance of VLS at 12-month follow-up among CCP clients vs. other, similar PLWH

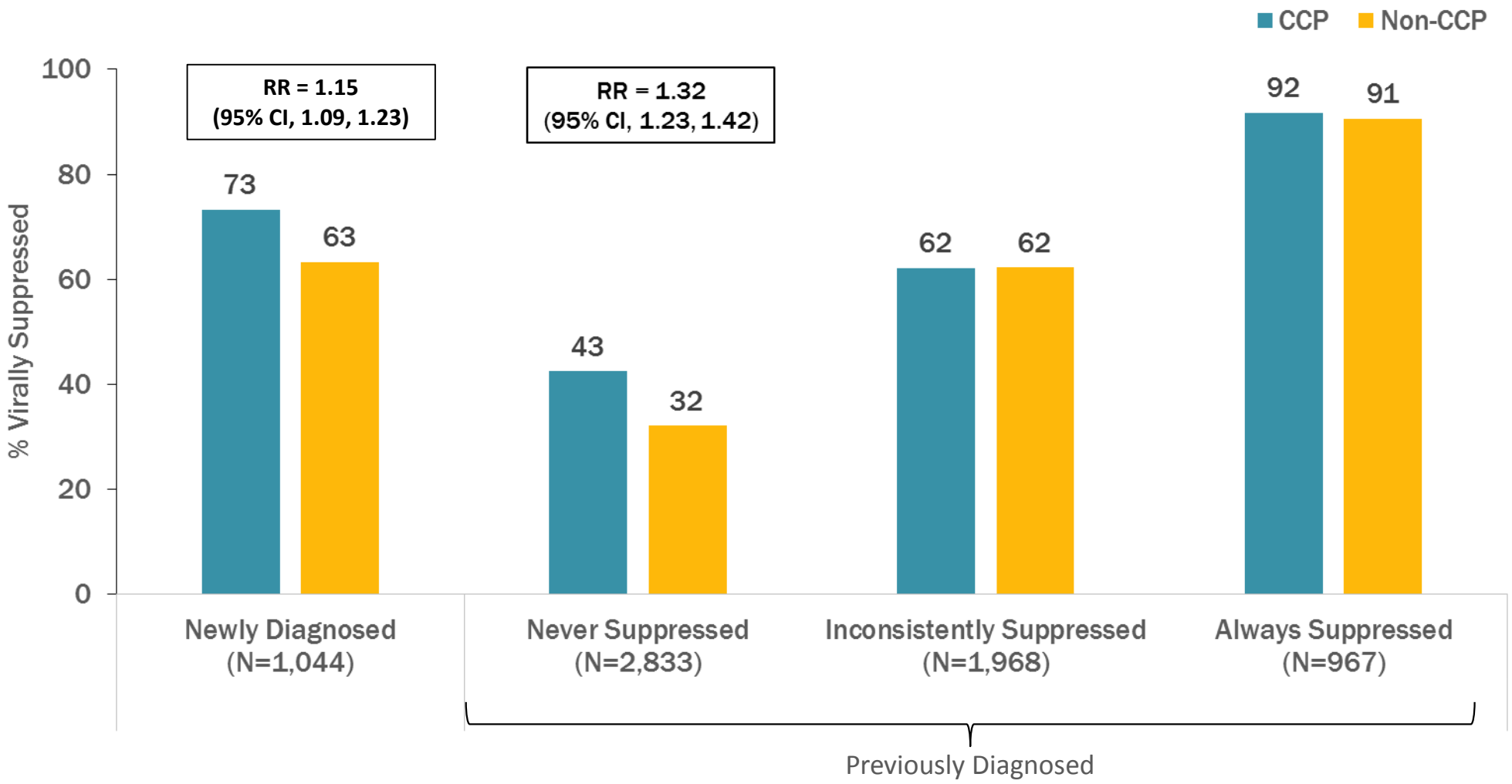
Viral Load Suppression, Pre and Post



Viral Load Suppression: Pre and Post

- The pre-post analyses, **significant VLS increases are apparent in all subgroups**
- Including all demographic, clinical and psychosocial subgroups we could measure
- VLS increases seen in even those with housing, mental health and/or substance-related barriers at the time of enrollment
- In fact, clients with unstable housing or hard drug use show greater improvements in VLS than clients enrolling without those barriers (due in part to starting with lower levels of VLS)

Viral Load Suppression



Effectiveness Summary

- Pre-post analyses show substantial improvement in VLS among previously diagnosed clients as well as high post-enrollment levels of VLS (70%) among newly diagnosed individuals
- In the pre-post analyses, significant VLS increases are apparent in all subgroups analyzed
- A significant positive program effect is demonstrated for both newly diagnosed individuals and individuals who were unsuppressed for the full year prior to enrollment
- In short, the CCP shows evidence of effectiveness for those at the highest risk of suboptimal health outcomes, even when we control for citywide improvements in VLS

In the next few months, we will be reviewing components of the Care Coordination Program and developing guidance for a new, updated service directive.

What additional information or data could the DOHMH provide that would be helpful in the process of developing a new service directive?

THANK YOU!

Questions?