

# CARE COORDINATION IN NEW YORK CITY

Department of  
Health and  
Mental Hygiene

Bureau of  
HIV/AIDS  
Prevention and  
Control

Care and  
Treatment Unit

# Funded Programs

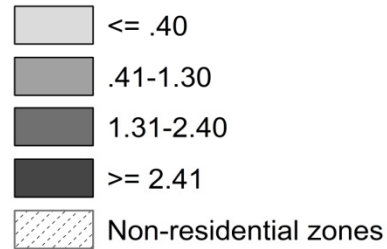
- **28 agencies providing CCP in New York City (NYC)**
  - 16 hospital-based agencies
  - 12 community-based agencies
- **Caseloads:**
  - Agency caseloads: 52 to 230 active clients
    - 9 small programs
    - 12 medium programs
    - 7 large programs
  - ~3,300 PLWH in the active portfolio caseload at any given time
  - 4,986 unique PLWH served from March 2012 – February 2013

# CCP Lead and Satellite Service Sites<sup>a</sup>

- ☆ Lead CCP Service Site
- Satellite CCP Service Site

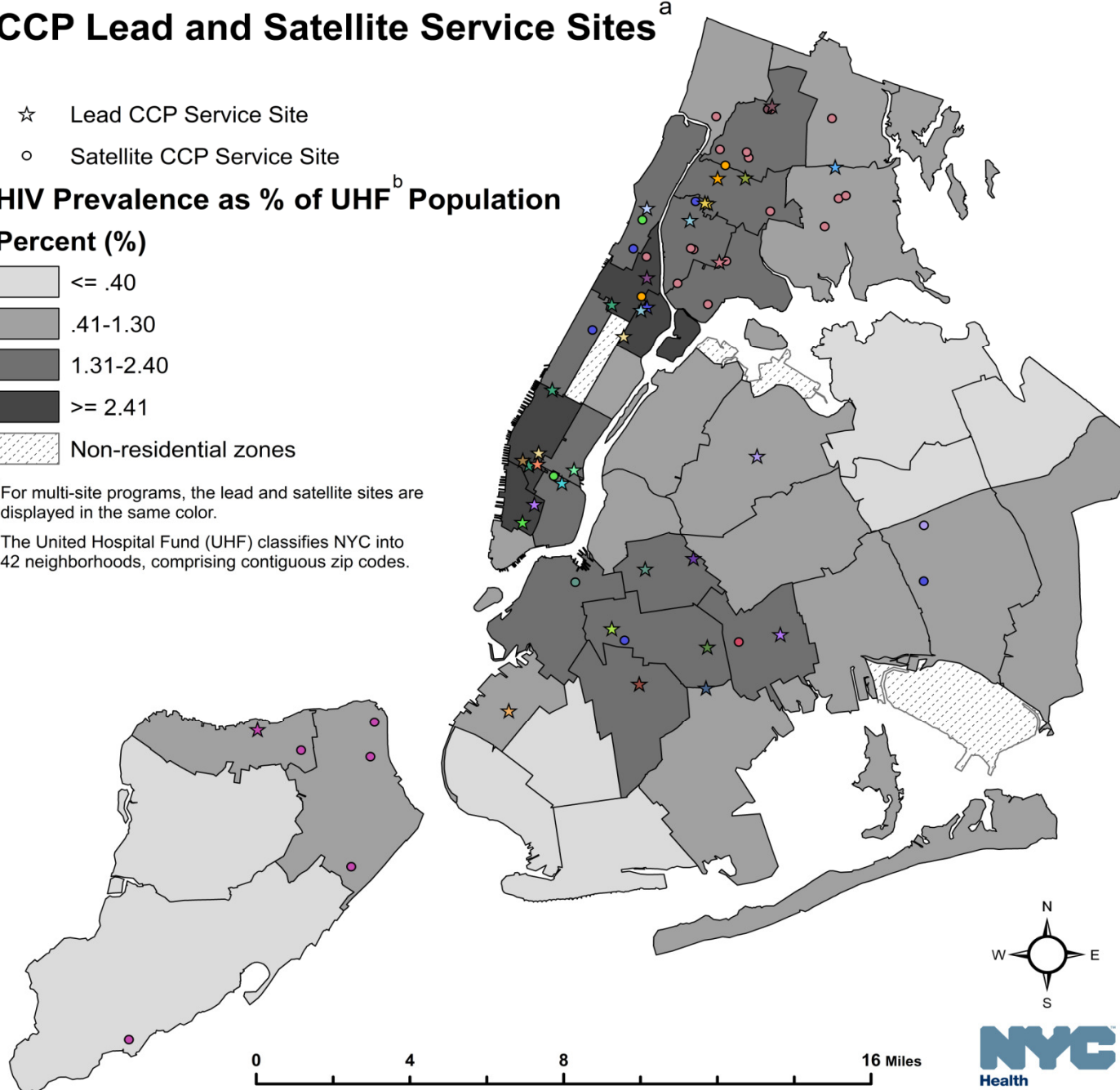
## HIV Prevalence as % of UHF<sup>b</sup> Population

### Percent (%)



<sup>a</sup> For multi-site programs, the lead and satellite sites are displayed in the same color.

<sup>b</sup> The United Hospital Fund (UHF) classifies NYC into 42 neighborhoods, comprising contiguous zip codes.



THERE ARE 28  
CCP AGENCIES  
IN NYC

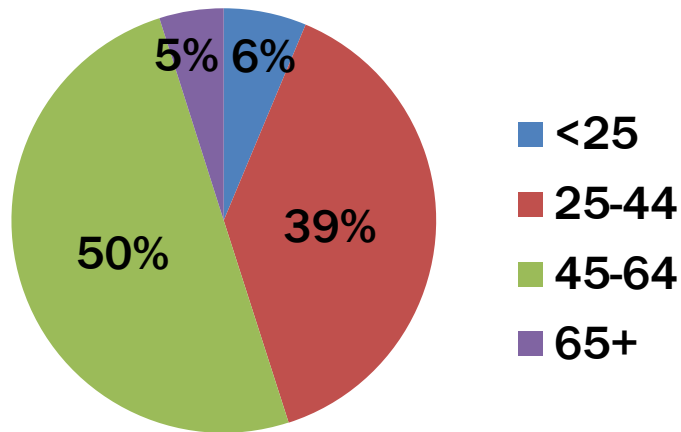


# BACKGROUND: Target Population

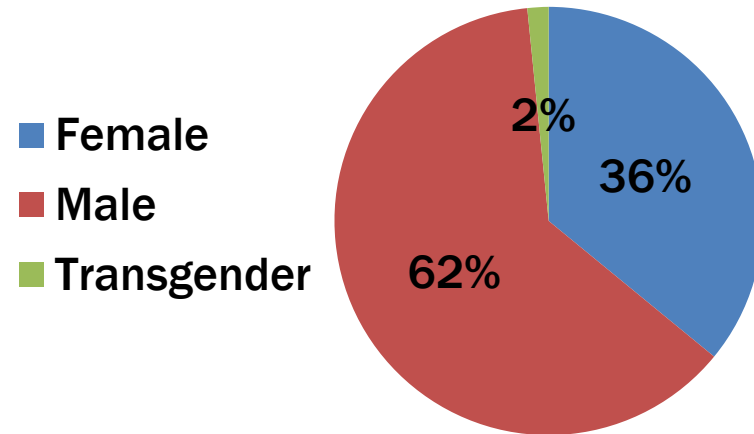
- **Persons at high risk for suboptimal health care outcomes:**
  - newly diagnosed
  - previously lost to care/never in care
  - irregularly in care
  - with recent adherence issues (e.g., viral rebound, resistance)

# CLIENT DEMOGRAPHICS: GRANT YEAR (GY) 2013, CARE COORDINATION PROGRAM (ALL AGENCIES), N = 4,752

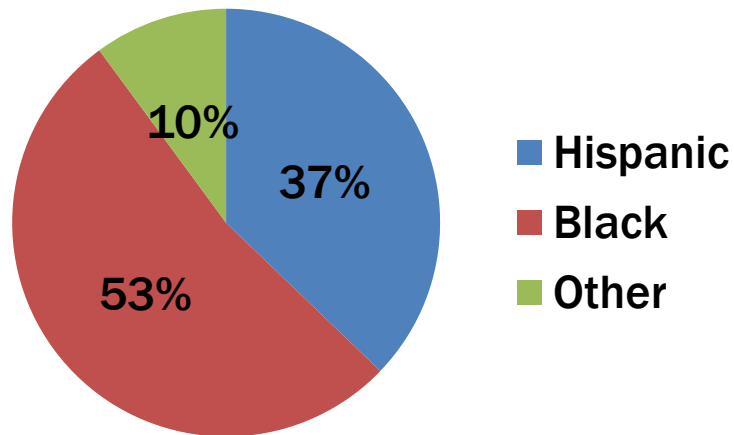
## AGE GROUP



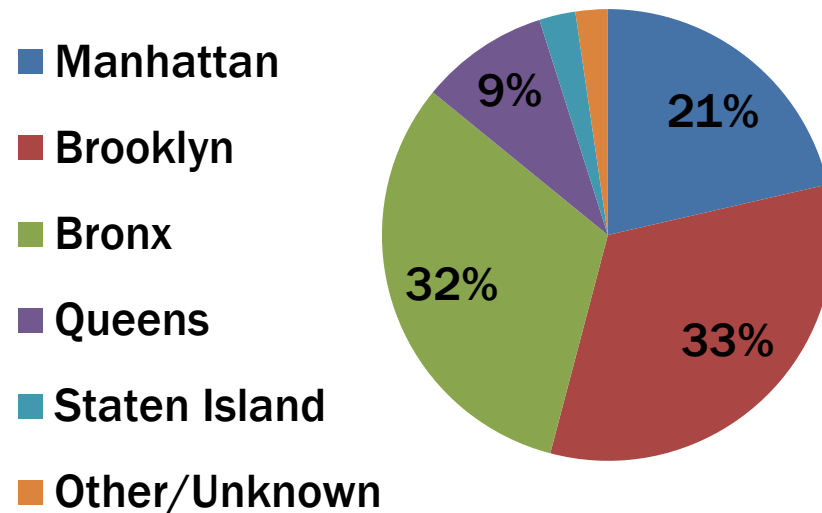
## GENDER



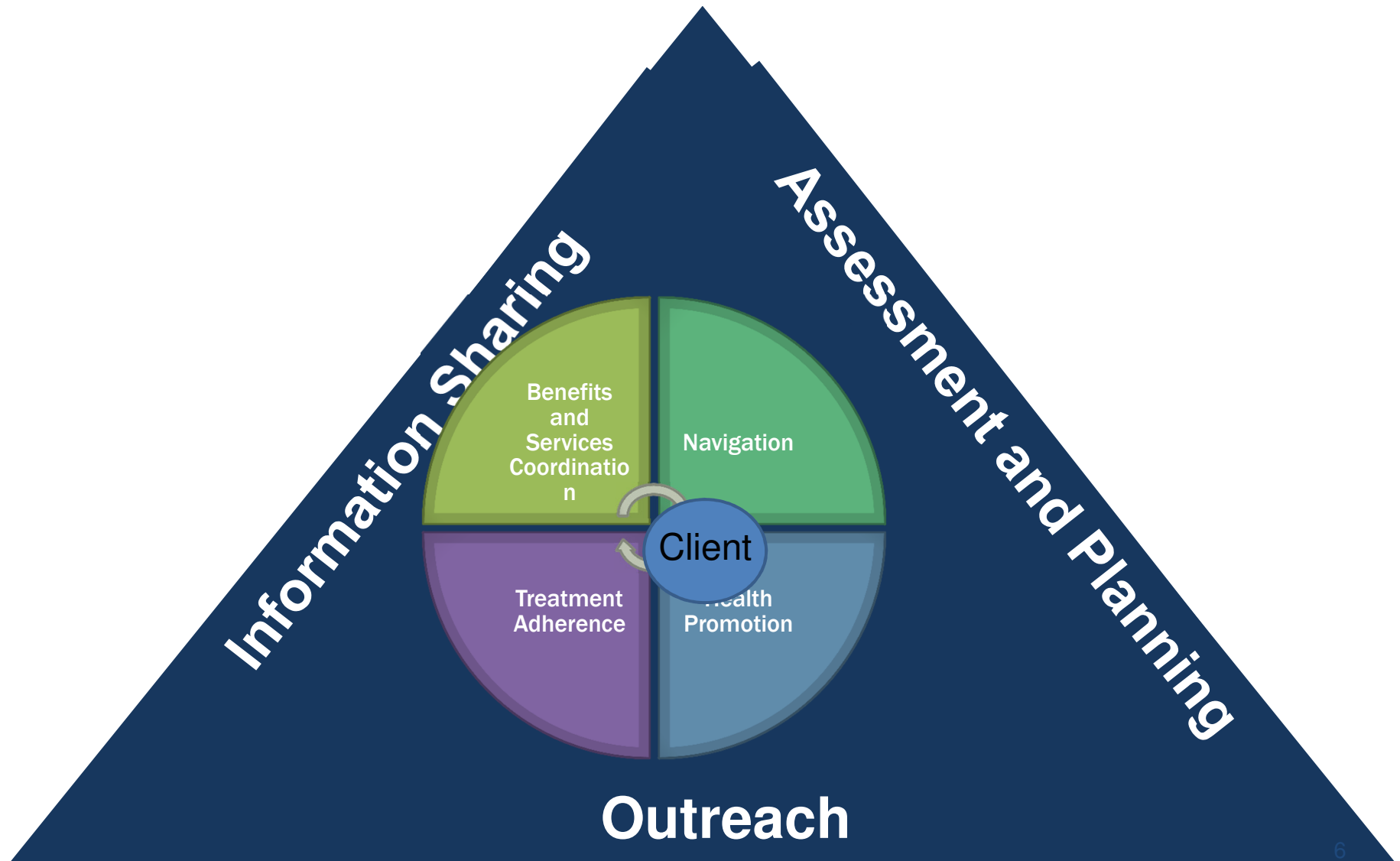
## RACE/ETHNICITY



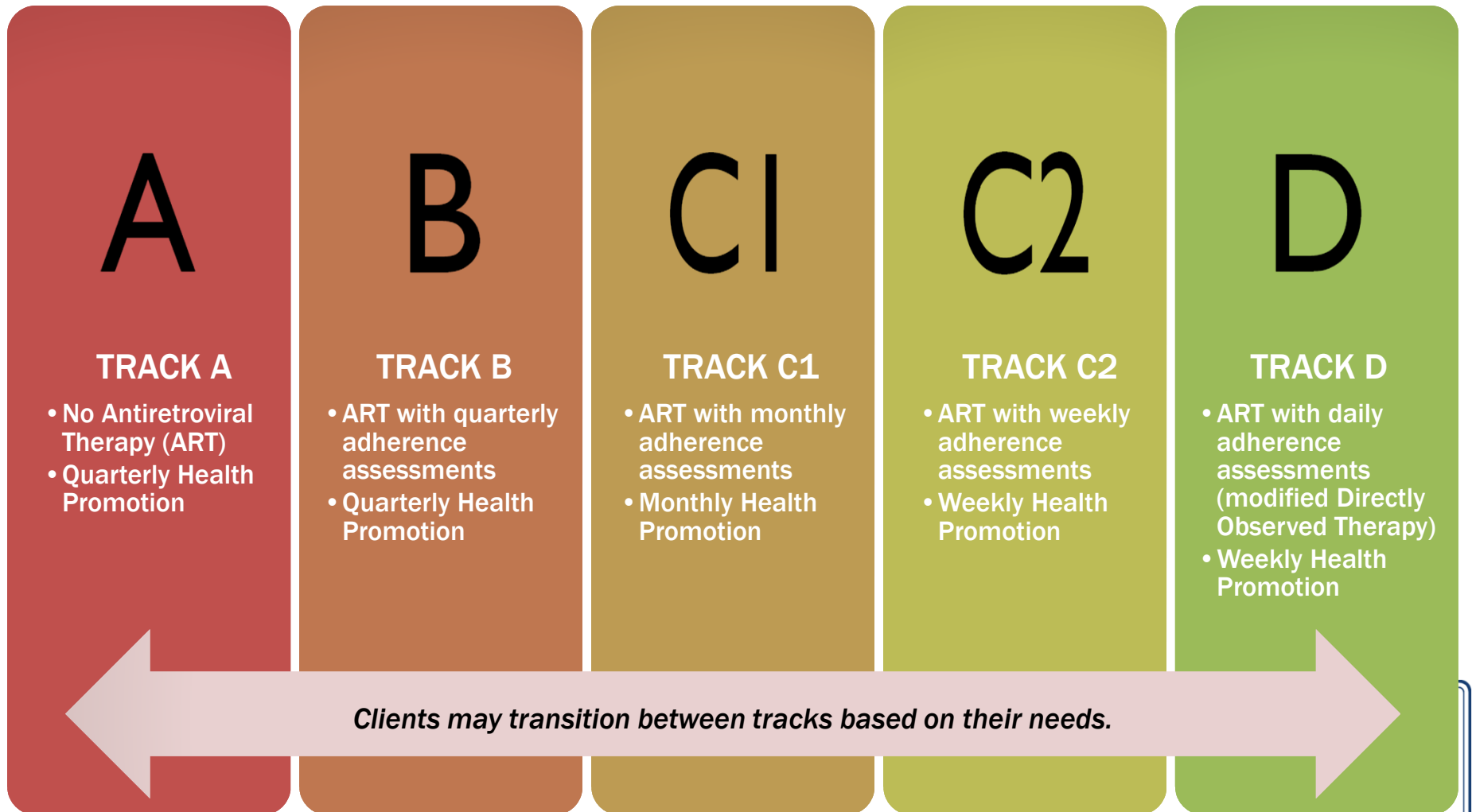
## BOROUGH



# Background: The CCP Model



# BACKGROUND: Service Delivery Tracks



\*Home visits are an integral component of all tracks in the model

# BACKGROUND: INTERVENTION DESCRIPTION

- **CCP model provides:**
  - Outreach and re-engagement
  - case management:
    - assessment and planning
    - case conferencing
  - patient navigation, including accompaniment
  - adherence support, including directly observed therapy (DOT)
  - health promotion in home visits
  - assistance with medical/social services



# HEALTH HOMES VS. CARE COORDINATION

## CCP Complete

- Full CCP Services
- Full RW Reimbursement

## Health Homes ONLY

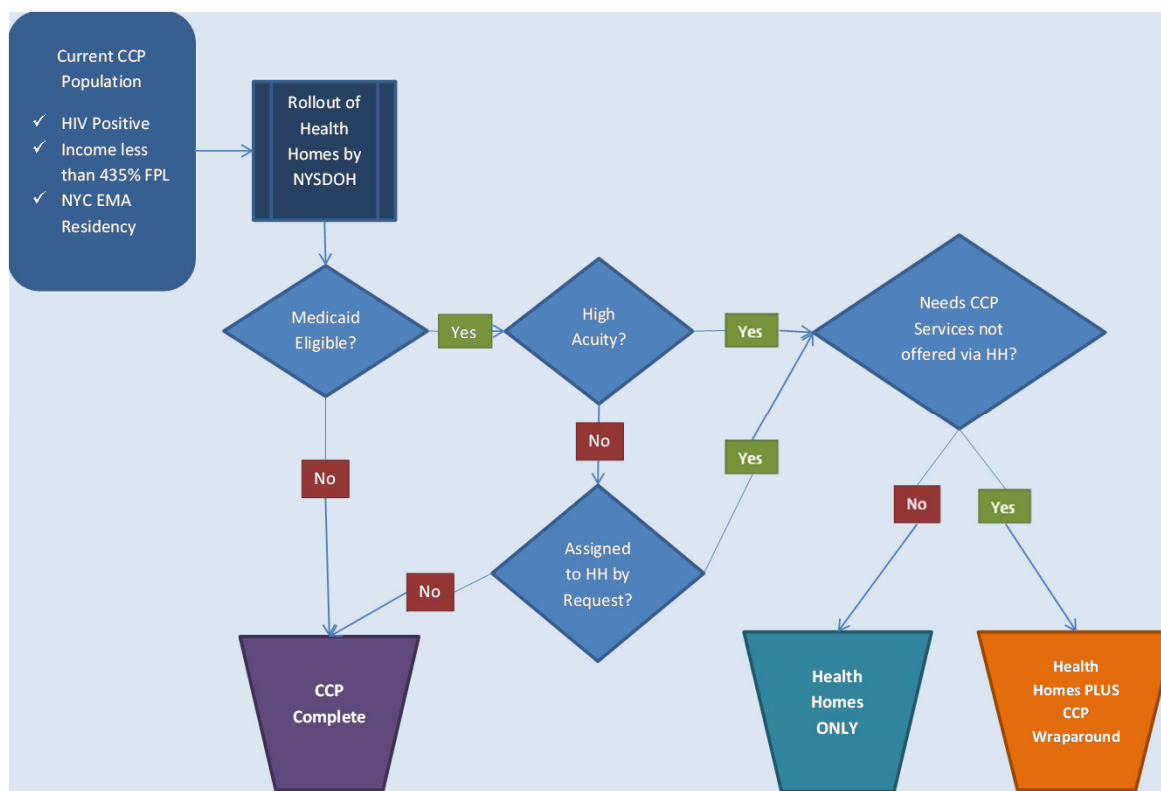
- No CCP Services
- No RW Reimbursement

## Health Homes PLUS CCP Care Completion

- Partial CCP Services
  - Treatment Adherence Support and Readiness
  - DOT
  - HIV-Specific Health Promotion
- Partial RW Reimbursement (COBRA Rate)

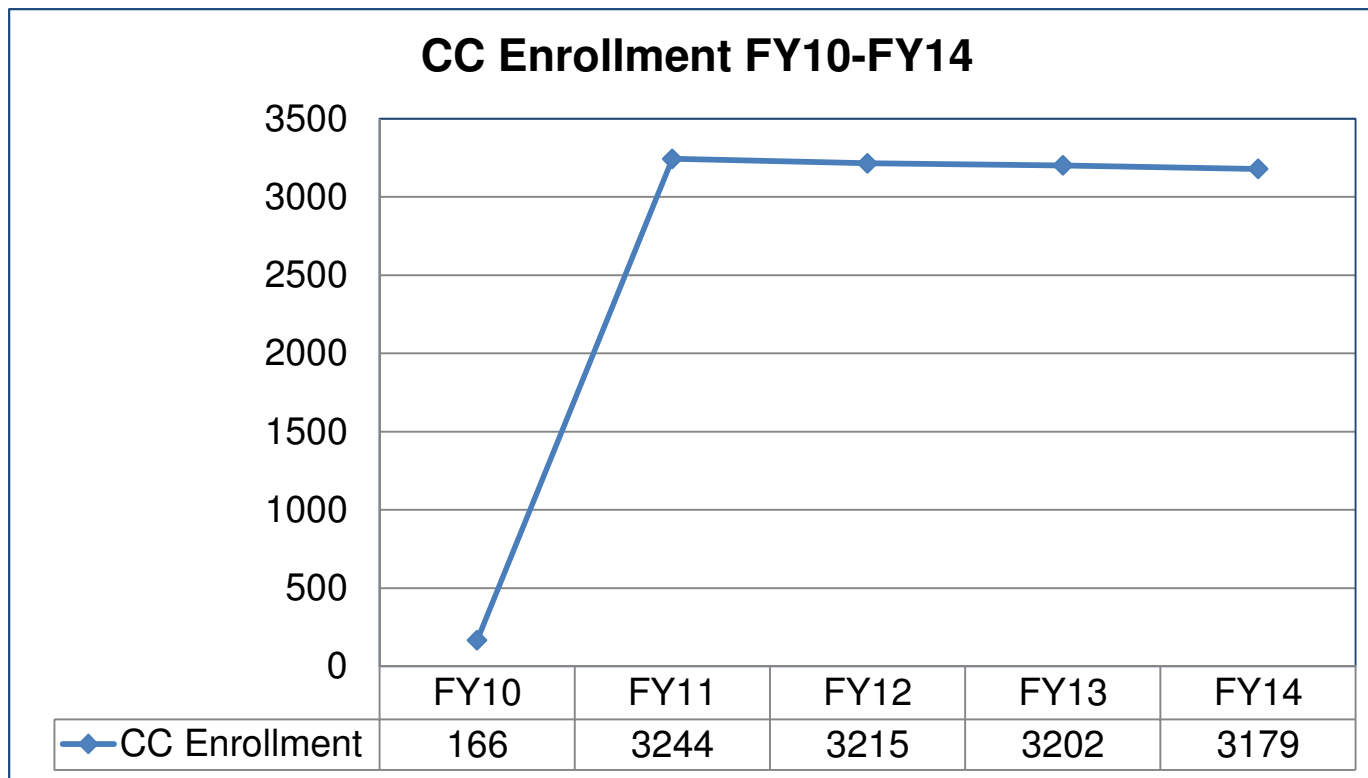
# HEALTH HOMES VS. CARE COORDINATION

All contracting agencies were given guidance regarding how to enroll and serve clients who are also enrolled in Health Homes.



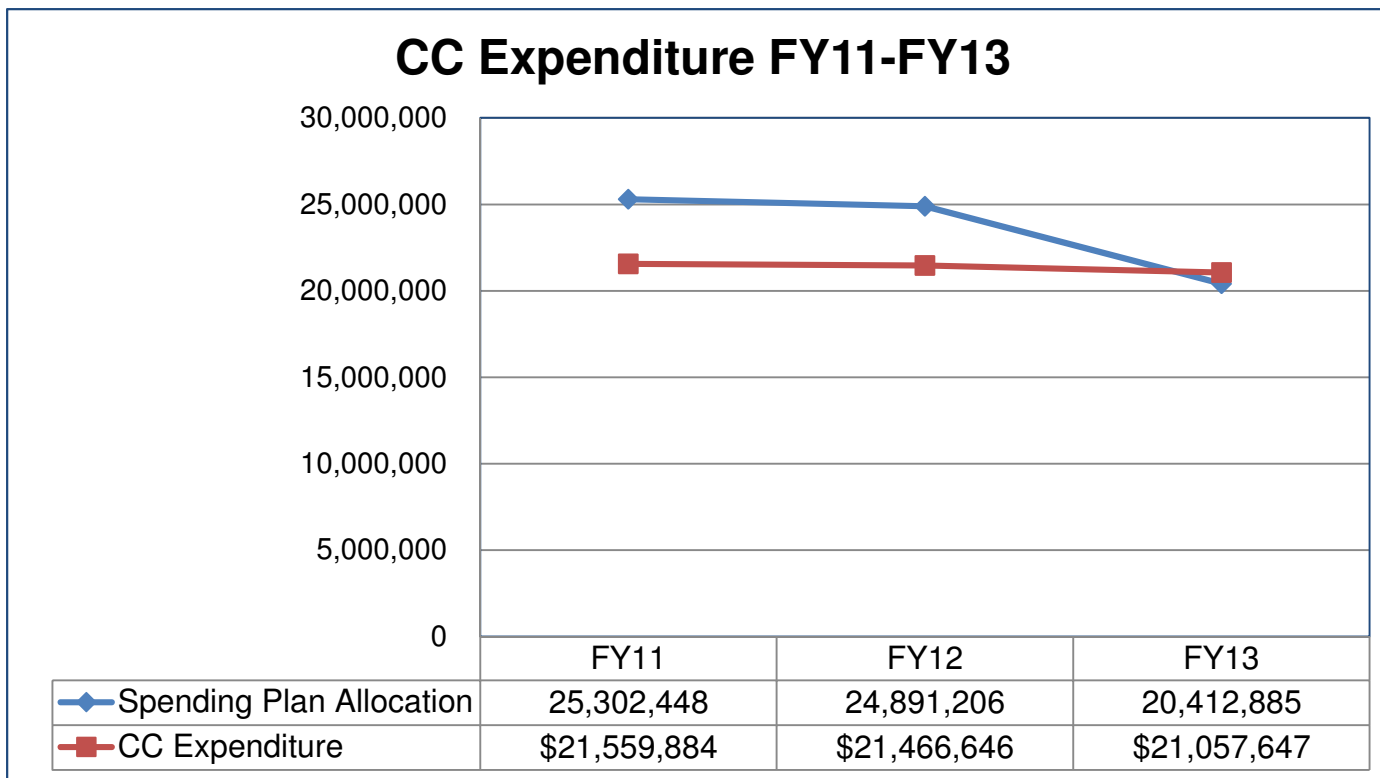
# ENROLLMENT

From FY11 to Present, Care Coordination enrollment has remained relatively stable, with a reduction of 65 clients from a high of 3,244 in FY11.



# EXPENDITURES

From FY11 to present, Care Coordination expenditures have decreased by \$502,237.



**SHORT-TERM OUTCOMES  
IN THE NYC RW PART A  
CARE COORDINATION  
PROGRAM**

# SHORT-TERM OUTCOMES IN THE NYC RW PART A CARE COORDINATION PROGRAM

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- Stephanie Chamberlin<sup>1</sup>
- Rebekkah Robbins<sup>1</sup>
- Julie Myers<sup>1</sup>
- Graham Harriman <sup>1</sup>
- Sarah Braunstein<sup>1</sup>
- Beau Mitts<sup>1</sup>
- Sarah Gorrell-Kulkarni<sup>2</sup>
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## Acknowledgements:

Data shared with gratitude to the Care Coordination Program Service Providers  
Effectiveness analysis funded under an NIMH grant: NIH R01 MH101028-01A1



# METHODS: ELIGIBLE SAMPLE AND CARE STATUS GROUPS

## ■ Clients Eligible for Analysis (N=3,641)

- Eligibility: enrolled by 3/31/11, matched to Registry, and alive for  $\geq 1$  year of follow-up.

## ■ Key Terms:

- Newly Diagnosed: HIV diagnosis date in 12 months before enrollment
- Current to Care (Baseline): Any CD4 or VL test date in 6 months before enrollment\*
- Out of Care (Baseline): No CD4 or VL test date in 6 months before enrollment\*

\*Among the previously diagnosed



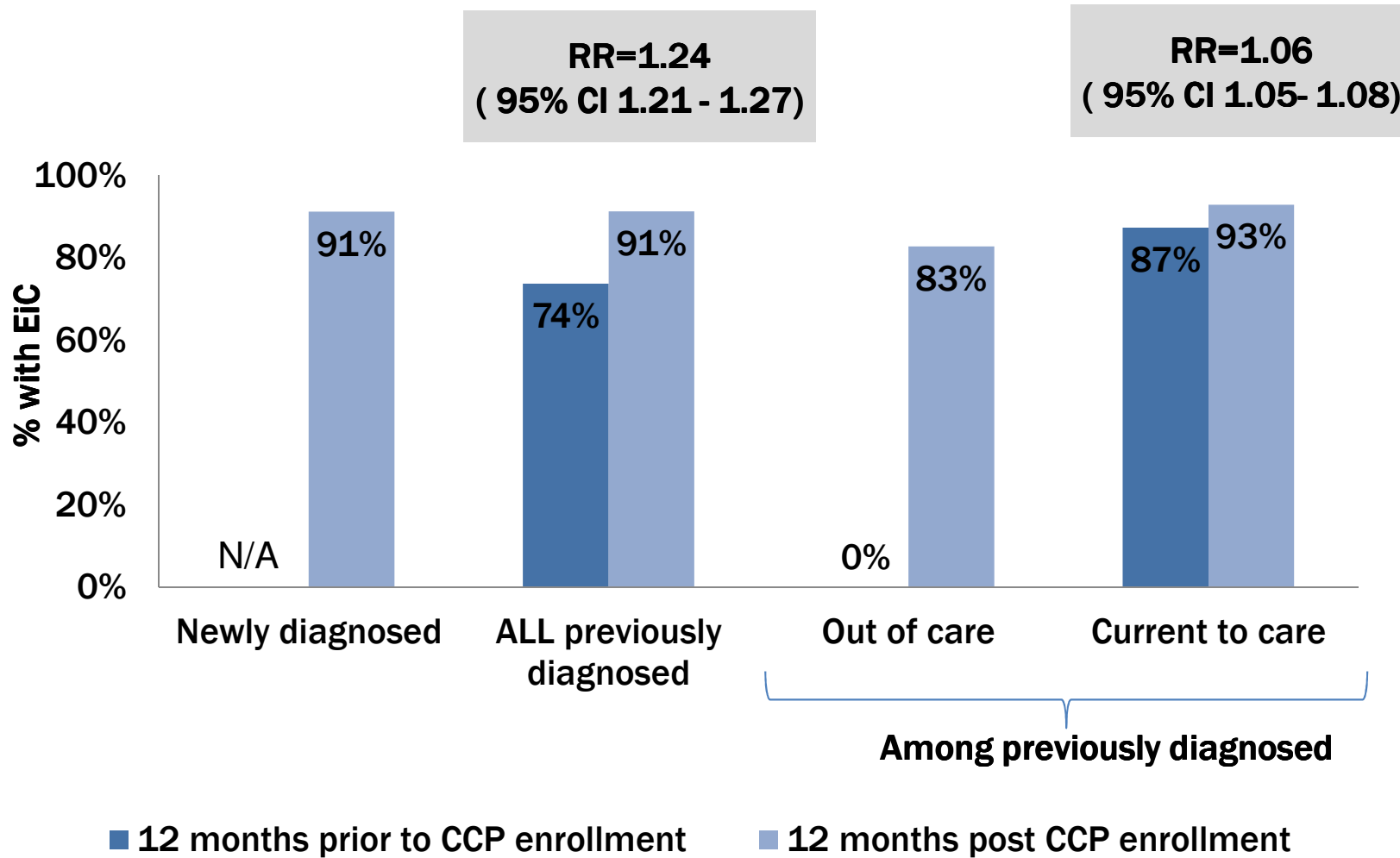
# METHODS: PRE- VS. POST- ENROLLMENT COMPARISON

- Matched programmatic (eSHARE) data with NYC HIV Registry data
- Estimated relative risks (RRs) using GEE, a method for handling correlated data
- **Outcome Measures:**
  - Engagement in Care (EiC):  $\geq 2$  CD4 or VL tests  $\geq 90$  days apart, with  $\geq 1$  in each half of 12-month period
  - Viral Load Suppression (VLS): VL  $\leq 200$  copies/ $\mu$ L on most recent test in second half of 12-month period\*

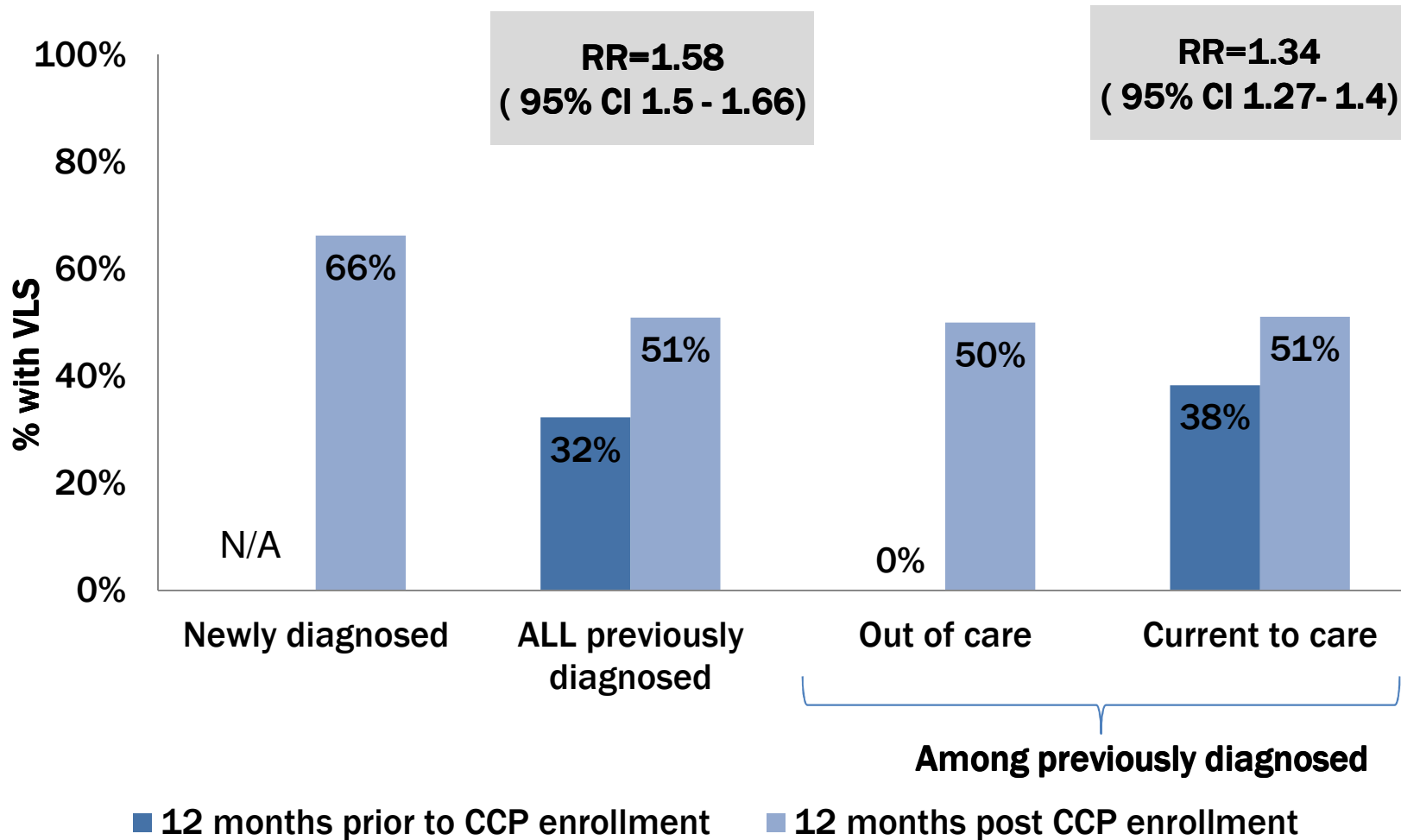
\* Missing VL in 2nd half of 12-month period was considered evidence of lack of care and treated as=to unsuppressed VL.



# PRELIMINARY RESULTS: ENGAGEMENT PRE- & POST-CCP



# PRELIMINARY RESULTS: VL SUPPRESSION PRE- & POST-CCP



# PRELIMINARY RESULTS: SIGNIFICANCE OF FINDINGS, BY SUBGROUP

## ■ Significant improvements held across subgroups...

- Sex
- Race/Ethnicity
- Age
- Primary Language
- Insurance Status
- Housing Status
- Household Income
- ART Status
- Year of HIV Diagnosis
- Viral Load Suppression
- CD4 Count

...with two exceptions:

→ × “other/unknown” race (VLS only)

→ ×  $\geq 500$  (EiC only)

# PRELIMINARY RESULTS: RELATIVE IMPROVEMENTS, BY SUBGROUP

✓ = Greatest improvement in the subgroup breakdown, as determined by Relative Risk

## ■ Subgroup Improvement in EiC:

- Sex
  - ✓ Male
- Race/Ethnicity
- Age
  - ✓ <45
- Primary Language
- Insurance Status
  - ✓ Uninsured
- Housing Status
  - ✓ Homeless
- Household Income
  - ✓ <\$9,000
- ART Status
  - ✓ No ARV prescription
- Year of HIV Diagnosis
  - ✓ Dx after 2004
- Viral Load Suppression
  - ✓ Unsuppressed
- CD4 Count

## ■ Subgroup Improvement in VLS:

- Sex
- Race/Ethnicity
- Age
  - ✓ <45
- Primary Language
- Insurance Status
- Housing Status
- Household Income
- ART Status
  - ✓ No ARV prescription
- Year of HIV Diagnosis
  - ✓ Dx after 2004
- Viral Load Suppression
- CD4 Count
  - ✓ <200

# KEY FINDINGS

- Short-term EiC and VLS improvements were robust across most subgroups examined, among the previously diagnosed.
- Newly diagnosed clients also fared well.
- Improvements were observed for EiC at 25 (89%) and VLS at 21 (75%) of 28 agencies.
  - Results not just driven by a few large programs

# LIMITATIONS AND CONSIDERATIONS

- Labs are an imperfect proxy for primary care
  - May overstate care engagement to the extent that some labs reflect acute care vs. primary care visits
  - Not all primary care visits produce lab data
- Ceiling effects may explain some subgroup findings
  - Certain groups have very little room for improvement
- Contribution vs. attribution – can't credit all to CCP
  - Next analyses to include contemporaneous comparison groups
- Evolving HIV service and policy landscape

# FOR MORE INFORMATION

- NYC DOHMH Care Coordination website

<http://www.nyc.gov/html/doh/html/living/hiv-care-coord.shtml>

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