

Comprehensive Case Management for HIV in NYC

A PROPOSAL

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HIV Epidemiology, NYC, 2006

- As of June 30, 2006: 97,524 estimated PLWHA (data from the BHIV HIV/AIDS reporting system {HARS})
 - 36,313 with HIV only
 - 61,211 with AIDS
- Higher rate of concurrent HIV/AIDS diagnosis among blacks and Hispanics, and those reporting heterosexual and unknown transmission mode, many of whom are in the same category (HARS)

Delayed Initiation of Care and HIV-Related Mortality in NYC, 2004¹

	Number of new HIV diagnoses ⁷	% not in care within three months	Age-adjusted HIV-related death rate per 1,000 PWHA
Total	3,653	37.1	15.2
Neighborhood			
DPHO areas	1,275	40.6	22.6
Non-DPHO areas	2,378	35.2	12.0
Race/Ethnicity			
Black	1,955	41.6	19.2
Hispanic	1,046	34.8	15.4
White	542	25.2	7.8
Asian/Pacific Islander	82	41.4	6.3
Transmission category			
MSM	1,295	28.6	6.5
IDU history	340	44.1	23.6
Heterosexual	797	35.4	15.4

Case Management Need

- ~30,000 HIV infected persons not in care in NYC (from HARS-derived unmet need estimate)
- ~9,000 persons (unduplicated count) in NYC facilities that provide quality management data to the AIDS Institute have <2 visits/year (AIDS institute, personal communication)
- # receiving case management services in NYC (some individuals may be enrolled in more than one program type, ie. not unduplicated)
 - COBRA: ~11,000 (AIDS institute, personal communication)
 - SNP: ~2,400 (AIDS institute, personal communication)
 - Ryan White (Not mutually exclusive; Ryan White contracted agencies data in URS/AIRS):
 - Case management: ~3,500
 - Treatment adherence programs: ~4,800
 - Outpatient medical care: ~11,200

HIV Treatment and Care in New York City

- NYC Ryan White-funded services are fragmented and duplicative with multiple points of entry into overlapping programs
- Part A HRSA funds support over 110 agencies in 23 service categories with 236 separate contracts (Ryan White contracted agencies data in URS/AIRS)
 - 24 agencies provide case management
 - 13 agencies provide maintenance in care services
 - 27 agencies offer outpatient medical care
 - 22 agencies offer treatment adherence
- NYS provides services in NYC using both Part A and B funds

Qualitative Study Results, CTHP/REU, 2007 (1)

- Client-centered services address barriers and/or strengths
- However:
 - Goals are infrequently geared toward decreased hospitalization or improving clinical outcomes
 - Providers use varied standards (NYS AI, TTM, Medical CM, strengths-based model, or COBRA-like model) and there are few specific written protocols
 - The methods of coordination with other services providers are unclear

Qualitative Study Results, CTHP/REU, 2007 (2)

- It is unclear from the information received from CM agencies
 - What client-directed services are delivered to ensure engagement in primary medical care, eg. Navigation or escorting
 - How would program goals/objectives translate to improved clinical outcomes
 - What is the program logic model, and how does it shape program activities

AI Quality Management Results for Case Management Programs (2006)

- 46% of all enrollees had needs assessed within specified time frame
- 75% had an existing service plan
- 88% had a PCP visit within 6 months of prior visit
- 59% had anti-retroviral medications status assessed every 6 months
- Of those without a PCP visit, **none** had a documented referral to a PCP within 6 months of previous visit

AI QM Data for Treatment Adherence (2005)

- 89% had a PCP visit within 6 months of enrollment
- Of those without a PCP visit, none were referred
- 14% had treatment adherence education provided quarterly
- 16% had treatment adherence levels assessed every 4 months
- 25% were assessed for continuity of care with PCP (quarterly visits)
- 69% had ARV status assessed

Complexity of HIV Care (1)

- HIV infection is a chronic and complex disease
- Navigating the health care system is daunting
- Many PLWHA have multiple sources of stress in their lives, such as obtaining medical insurance, care, housing and food
- Needs such as housing and food take precedence over medical services

Complexity of HIV Care (2)

- High rate of concurrent drug use and mental health problems
- High rate of poverty and alienation
- Complex medical regimen
- Daily treatment necessary to sustain life
- Need for treatment adherence
- Need for assistance navigating the system to obtain needed services

Consequences of Advances in HIV Treatment

- Lower mortality and longer life expectancy lead to growing number of PLWHA & greater demand for HIV-related services
- Evolution of HIV/AIDS into a chronic illness means a broader range of services is required over a lifetime
- Addressing disparities in HIV/AIDS calls for an array of services

Assistance in Securing and Maintaining Care

- Certain services increase the likelihood that PLWHA will obtain quality care and remain in care
 - Patient management and navigation
 - Housing, transportation and food and assistance obtaining these services
 - Mental health and substance abuse treatment
 - Medical care at medical centers where HIV experts are available
 - Coordination between medical provider and non-medical providers

The Role of Case Management in HIV Care

- Adherence to medical treatment plan:
 - Assistance keeping primary care and other clinical appointments
 - Assistance with benefits and support services
- Coordination of services
- Goal: Improve the health of PLWHA by ensuring that all required health and related services are delivered

The Role of Treatment Adherence in HIV Care

- For patients on anti-retroviral (ARV) medications or about to start
- Assistance with taking medications, including
 - Adherence-specific education
 - Pill boxes, beepers, etc.
 - Adherence measurement
 - Regular contact with patients and, if necessary, DOT
- Goal: Improve the health of PLWHA by helping them take their ARV medications

Ryan White Funded OMC Services - 2008

- Limited need for clinical care for RW-eligible persons because of Medicaid and ADAP+
- \$7,016,962 in ADAP
- \$7,136,180 in ADAP +
- Of OMC funds [\$13,508,067], services were as follows
 - **22% clinical services**
 - **34% behavioral interventions**
 - **23% support services or CM**
 - **21% adherence support**
- About half of OMC funds go to NYS AI for contracting in NYC (~\$6.5 million)

OMC Behavioral Services Examples (34% of the OMC category, 2007)

- Family counseling
- Group counseling
- Group treatment education
- Individual counseling
- Support groups
- Peer counseling
- Education
- Substance abuse services

OMC Support Services Examples (23% of the OMC category, 2007)

- Care coordination
- Referral for care
- Case conference
- Entitlements
- Crisis intervention
- Escort
- Outreach
- Translation

NYC HIV Care Coordination Plan

- Outcomes oriented
- Goal is to ensure patients/clients are in care and remain stable
- Provide access to all needed services, from health care to housing and other services and entitlements
- Ensure coordination between medical care and support services
- Coordinate with HOPWA to ensure that supportive housing reaches those who need the highest level of integration

NYC DOHMH BHIV CTHP Care Coordination Proposal

- Comprehensive system covering the city ensuring access to varied services
- Close relationship between medical providers and case management providers
- Guidelines dissemination via written protocols
- Technical assistance and program monitoring
- Data collection and outcome monitoring

Consolidation of OMC and CM

- Funds needed for clinical care = ~\$3 million, based on prior utilization
- Funds needed for medical case management (linkage to care, care coordination and treatment adherence) = a minimum of \$25-30 million to reach the highest need PLWHA (based on unmet need and CM by other providers)

Issue to Consider

- Approximately \$6 million in OMC funds (distinct from ADAP and ADAP+) are contracted via the state

Consolidation with Other Services

- Integrate transportation into care coordination in each contract, thereby eliminating transportation as a separately contracted service
- Provide transportation to all clients who need it, via metrocards, Access-a-Ride or cab fares

Consequences of Integration

- Key support services accessible through one provider group/team
- One case manager
- Increase efficiency and accountability
- Decrease duplication
- Larger grants, streamlined administration
- Better coordination of services

Enhancing the Current System of HIV Care (1)

- De-duplicating service delivery with a patient management database
- Creating clinical provider-case management teams and mandating formal linkages and information exchange via contracts
- Disseminating standard case management and treatment adherence guidelines
- Staff training and continuing education

Enhancing the Current System of HIV Care (2)

- Improving and facilitating data reporting
- Evaluating services via outcome measures
- Using evaluation and quality management findings to directly improve services

BHIV CTH Program Role

- Write detailed care coordination RFP
- Write care coordination guidelines
- Provide technical assistance
- Conduct program and outcome monitoring

Discussion/ Questions