HIV HEALTH & HUMAN SERVICES PLANNING COUNCIL OF NEW YORK
Medical Case Management (MCM)/Care Coordination (CCP) Service Directive
Approved by the HIV Planning Council on July 27, 2017

Service Category Goals and Objectives	New York Integrated HIV Prevention And Care Plan 2017-2021 Plan[1] Goals	Program Directive & Service Model	Client and Agency Eligibility
Goals: To increase the proportion of newly diagnosed individuals who enter into primary care within three months of HIV diagnosis. To increase retention in HIV care and treatment. To increase the proportion of clients who have an optimal level of ART adherence. To increase the proportion of clients with an undetectable viral load and to improve immunological health. To reduce mortality	**GOAL #1 REDUCING NEW HIV INFECTIONS** B. By 2021, increase the percentage of persons newly diagnosed with HIV who are linked to HIV medical care to 85%. **GOAL #2 INCREASING ACCESS TO CARE AND IMPROVING HEALTH OUTCOMES FOR PEOPLE WITH HIV** A. By 2021, increase the percentage of individuals living with HIV infection with continuous care to 90%. B. By 2021, increase the percentage of individuals	Services should be client-centered[2], non-judgmental, guided by harm reduction principles, trauma-informed[3], culturally appropriate, sensitive to physical, behavioral, psychosocial, and sensory impairments, and tailored to the populations served. A variety of engagement strategies should be employed to ensure that client-specific needs are met. Patients should be included in decision making whenever possible. The utilization of peers in all applicable service areas is strongly encouraged. Services may include, but are not limited to the following: • **Clinical Care Navigation:** Coordinate all levels of medical and behavioral health. This includes, but is not limited to: logistics coordination, appointment scheduling, preparation and reminders, accompaniment, transportation assistance, return to care, and outreach activities. Ensure linkage and engagement in other needed medical or specialty care, mental health, and harm reduction and/or substance use services.	**Client Eligibility Criteria:** PLWHA who meet Ryan White eligibility requirements are eligible for Ryan White Part A-funded services, subject to payer of last resort requirements. Active substance use and/or criminal conviction history does not preclude client eligibility for and maintenance in services. Clients must meet at least one of the following to be medically eligible: • Newly diagnosed • Out of care • Previously diagnosed but new to care • Previously diagnosed but inconsistently engaged in care • Previously diagnosed and engaged in care but not on ART • Virally unsuppressed • Currently co-infected with hepatitis C

[1] https://www.health.ny.gov/diseases/aids/providers/reports/scsn/docs/integrated_hiv_prevention_plan.pdf
[2] The Eight Picker Principles of Patient-Centered Care state that all patients deserve high-quality healthcare, and that patients' views and experiences are integral to improvement efforts. These principles are: 1) Respect for patients' values, preferences and expressed needs; 2) Coordination and integration of care; 3) Information and education; 4) Attention to physical and environmental needs; 5) Emotional support, empathy, and alleviation of fear and anxiety; 6) Encouraged involvement of family and friends; 7) Continuity of care and smooth transitions (i.e. appropriate level of care or "track"); 8) Access to reliable care and trusted professionals. Modified from: http://www.picker.org/about-us/principles-of-patient-centred-care
[3] "A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings." Harris, M. & Fallot, R. (2001). Using trauma theory to design service systems, cited at https://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf ; https://www.researchandmarkets.com/reports/2239573/using_trauma_theory_to_design_service_systems.pdf

To reduce (and then maintain below significance) socio-demographic differences in: prompt linkage to HIV/AIDS care following HIV diagnosis, retention in primary medical care, and undetectable viral load and HIV related mortality. **Objectives** 1) Provide coordinated access to medically appropriate levels of health and support services and continuity of care. 2) Provide referrals and linkages to medical or supportive services that improve clients' physical and behavioral health. 3) Provide comprehensive treatment adherence services, promoting access to, and the	living with HIV infection with suppressed viral load to 80%. **GOAL #3 REDUCING HIV-RELATED DISPARITIES AND HEALTH INEQUITIES** A. By 2021, reduce HIV-related disparities in communities and specific populations at high risk for HIV infection. B. By 2021, reduce stigma and eliminate discrimination associated with HIV status. **GOAL #4 ACHIEVING A MORE COORDINATED RESPONSE TO THE HIV EPIDEMIC** A. By 2021, strengthen ongoing HIV-related collaborations with appropriate public and private sector partners. 1. Lead a coordinated effort to reduce new HIV and STD infections among gay men and MSM.	• **Patient Assessment:** Conduct an initial patient intake assessment and periodic reassessments to identify patient's unmet medical and social needs and to measure patient's capacity for self-management. The assessment findings, together with the patient's readiness and input, should determine level of service. The assessments must also inform client-centered goals as part of an individualized care plan. Encourage patient involvement and engagement through clear communication of patient progress, issues, and updates. **Note:** Agencies are allowed to provide services without a full assessment for a grace period of up to 45 days wherein they can charge for services retroactively once a full intake is completed. **Treatment adherence:** Ensure access to and consistent use of ART using motivational interviewing techniques and other adherence tools (e.g. pill box or blister packs). In addition to in-person delivery, video chat or other smart phone or internet based technologies are permitted. Self-reported adherence assessments may be conducted by phone/text check-ins. With a patient's permission, agencies may provide modified directly observed therapy (mDOT) to support adherence to HIV ART and medications used to treat Hepatitis C, opportunistic infections, behavioral health and other prescribed medications as necessary. mDOT may be delivered in the home/field, at the agency, or virtually using smart phone or other internet-based technologies.	• At high risk for falling out of medical care or becoming unsuppressed (e.g. experiencing viral rebound). • New to HIV treatment or change in ARV regimen • HIV-positive pregnant women **Agency Eligibility Criteria:** • Non-profit licensed community-based clinics/hospitals, governmental health organization, and non-profit community-based HIV/AIDS service organization (CBO) with established MOU with a clinical provider that allows for same day appointments and access to medical records. • Agencies must provide assessment and engagement into health insurance programs and assist eligible clients in accessing existing and future insurance programs, e.g., Medicaid, Medicare, and NYS Health Insurance Exchange. • Agencies must have the capacity to bill 3rd party payers for billable services. • Organizations must be able to address, either directly or through referral, the needs of clients with physical,

consistent utilization of, antiretroviral (ART) therapies.	2. Promote collaborations to improve the health of persons who inject drugs, including access to sterile syringes and overdose intervention. 3. Enhance statewide collaborations addressing Hepatitis C Virus (HCV) awareness, prevention, and treatment.	Agencies are encouraged to find ways to provide mDOT services during evenings and weekends, when needed, to expand adherence support. • **Health promotion:** Promote self-management and healthy decisions via delivery of high-quality, evidence-based health coaching sessions. Staff should be trained in health education, harm reduction, and motivational interviewing techniques. In addition to in-person delivery, video chat and other smart phone or internet-based technologies are permitted. • **Client assistance:** Coordinate all levels of social service support and benefits assistance including, but not limited to: housing, employment, education, health insurance, food and nutrition services, and other social services as needed. • **Outreach**: Outreach for client engagement should include review of the patient population to determine which patients have fallen out of care and to establish contact and reengage patients into care. • **Case Finding**: Program staff should look within their agency and in agencies they have established linkages with to identify and attempt enrollment for patients who meet the eligibility requirements but are not yet enrolled in Care Coordination. • **Formal Case Conference**: In order to ensure coordination of care and progress toward goals defined in the patient's care plan, case conferences	behavioral, psychosocial, or sensory impairments. • Agencies must either be co-located or have established linkages with programs providing early intervention services, medical care, mental health, alcohol and substance use services, housing programs, food and nutrition services, legal services, supportive counseling services, health education and risk reduction, employment related services and other unmet social needs and make referrals as appropriate. • Agencies must ensure that staff members are fully trained and in compliance with DOHMH requirements as well as culturally and linguistically competent for the populations served, and have knowledge and skills related to the needs of the populations served, including the use of people-first[4] language. Agencies must have the capacity to provide services in the languages spoken by the populations served. • Agencies must implement a plan or policy that ensures that staff across the

[4] http://www.inclusionproject.org/nip_userfiles/file/People%20First%20In%20Depth.pdf or https://s3.amazonaws.com/s3.sumofus.org/images/SUMOFUS_PROGRESSIVE-STYLEGUIDE.pdf

		should occur every 3 months at a minimum. Formal case conferences must include the Primary Care Provider **or** HIV Specialist and at least one member of the CCP Program. Additional service providers, such as the pharmacist(s), patient navigators, mental health/substance use providers, and other members of the care team can also be included. Inclusion of the patient is strongly encouraged, but sensitivity to patient readiness is recommended. Conferences can be conducted in person, over the phone, or virtually via smart phone or other internet-based technologies. Patients must be informed of and agree to any changes to their primary care or Coordinated Care Program level of service. • **Staffing Model:** Agencies should engage in outreach, recruitment and employment practices that attract staff with life experience and expertise that is shared by the agency's target population in order to improve access to and ensure appropriate utilization of health care services. Value should not be placed solely on level of education. This includes but is not limited to: age, socio-economic status, sexual orientation, gender identity and expression, race/ethnicity, substance use history, history of incarceration, immigration status, and HIV status.	program, including clinical and non-clinical partners, affirms and respects gender identity and expression. Programs must ensure that staff are/will be able to provide care according to current best practices in care of transgender and gender non-binary persons, and can engage trans/gender non-binary persons in evaluations of and satisfaction with program services.[5] • Programs should be distributed throughout NYC to ensure that the areas and populations of highest need have appropriate access to care.

[5] Possible references include: The Center of Excellence for Transgender Health: Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People http://transhealth.ucsf.edu/protocols
WPATH Standards of Care - https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20(2)(1).pdf