Challenges to Caseload Management in Ryan White Part A funded NYC Care Coordination Programs

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Hello!

I am ***Scarlett Macias***

Quality Management Specialist

Agenda

- Welcome
- Workshop objectives
- NYC DOHMH Ryan White Part A programs
- Care Coordination Program (CCP) Model
- The CCP Learning Collaborative Caseload Manageability Project
- Caseload Manageability Activity
- Learning Collaborative Outcomes
- Lessons Learned

Learning Objectives

1. Describe RWPA-funded Care Coordination programs in the NYEMA and provider led Learning Collaborative.
2. Describe root causes for unmanageable caseloads in high intensity HIV medical case management programs.
3. Identify barriers to caseload manageability.
4. Outline potential solutions to caseload unmanageability.
5. Rank potential solutions to caseload unmanageability by level of impact and effort.

What is Ryan White Funding?

- 28 years of Ryan White HIV/AIDS Program
- Provides a comprehensive system of care for PLWH who are underinsured

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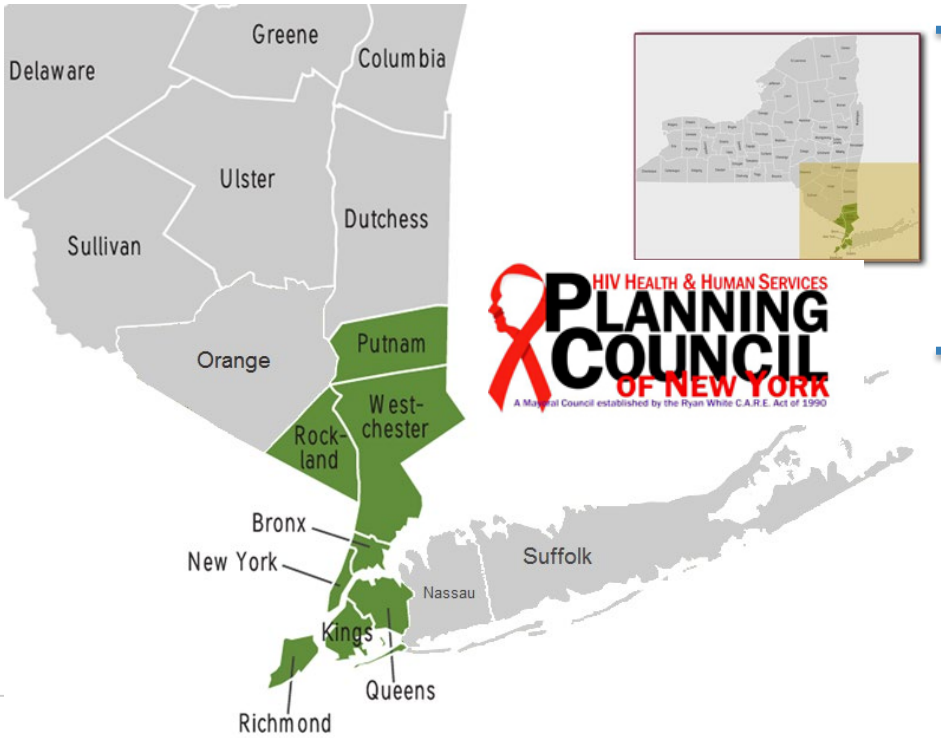
Ryan White Part A Program



HIV Health & Human Services
PLANNING COUNCIL
OF NEW YORK
A Municipal Council established by the Ryan White C.A.R.E. Act of 1990

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NY EMA and HIV Diagnoses/Prevalence by Region and County/Borough, 2016

	Population	HIV Diagnoses*	PLWH
New York City	8,537,673	2,279	123,877
Brooklyn (Kings County)	2,629,150	581	29,803
Bronx	1,455,720	520	29,803
Manhattan (New York)	1,643,734	468	32,476
Queens	2,333,054	415	18,307
Staten Island (Richmond)	476,015	61	2,398
Tri-County Region	1,400,222	122	4,023
Total	9,937,895	2,401	127,910

Sources: Population estimates: U.S. Census Bureau, American Fact Finder: Quick Facts –2016; New York, Kings, Queens, Bronx, and Richmond counties (NYC): NYC DOHMH, HIV Epidemiology and Field Services Program, data as of March 31, 2017; Putnam, Rockland, and Westchester counties: NYS Department of Health (NYS DOH), Bureau of HIV/AIDS Epidemiology, data as of September 3, 2017. *HIV diagnoses include those who were concurrently diagnosed with HIV and AIDS.

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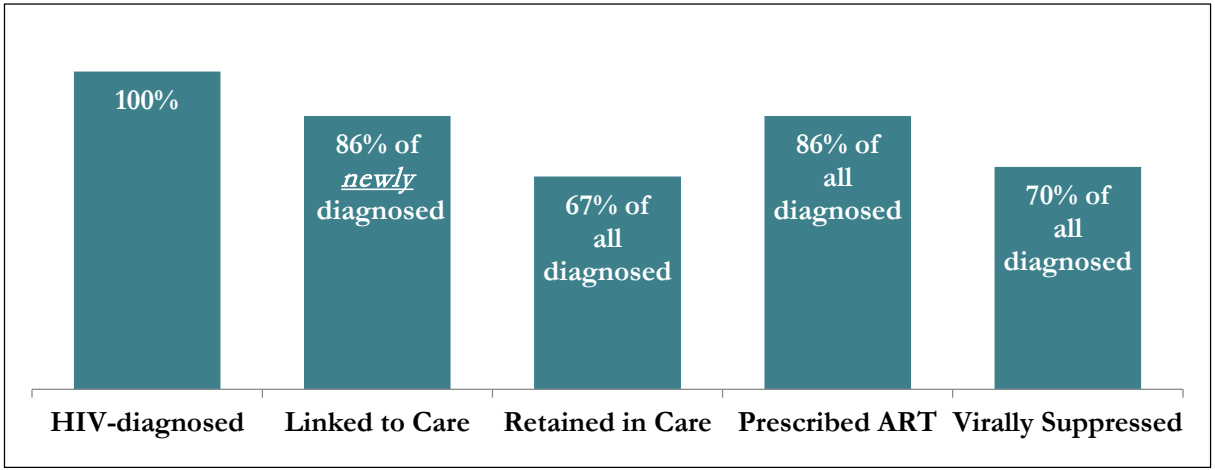
New York EMA -based HIV Care Continuum, 2016



Sources: Prescribed ART: NYC DOHMH, Medical Monitoring Project (MMP), 2016; All other: NYS DOH, Bureau of HIV/AIDS Epidemiology, data as of September 3, 2017.
Notes: "HIV-diagnosed" includes those diagnosed by 12/31/2015 and living and residing in NYC or the Tri-County region as of 12/31/2016; "Linked to care" includes those who were newly diagnosed with HIV in 2016 with one or more viral load or CD4 count within 91 days of diagnosis; "Retained in care" includes those among the HIV-diagnosed with at least two VL or CD4 counts in 2016 that were at least 91 days apart; "Prescribed ART" is defined as the proportion of NYC MMP participants who reported ART use during the 12 months prior to MMP interview date (interview date range June 3, 2015 - April 27, 2016); "Virally suppressed" includes those among the HIV-diagnosed whose most recent viral load in the year was <200 copies/mL.

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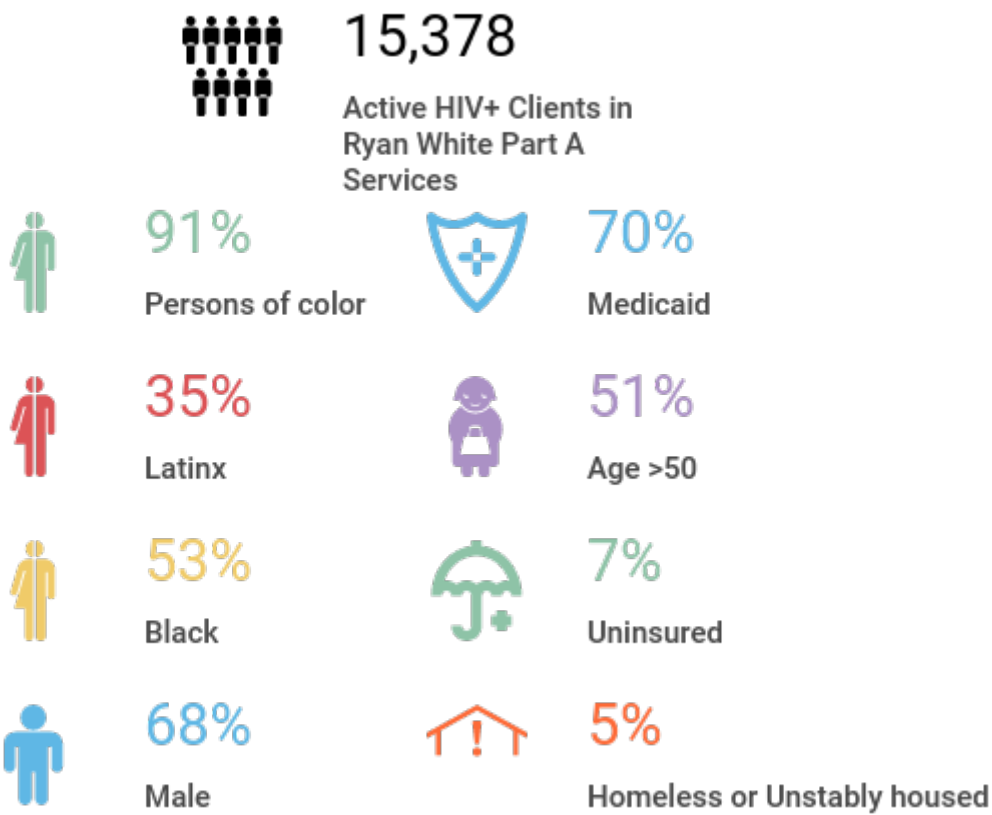
NY EMA Ryan White Part - A programs

Who do we serve?

NY EMA RWPA Program by the numbers, 2017



Data retrieved from the New York City Ryan White Part A (Base and MAI) Annual Enrollment Report: March 2016-February 2017—Active HIV Positive Clients

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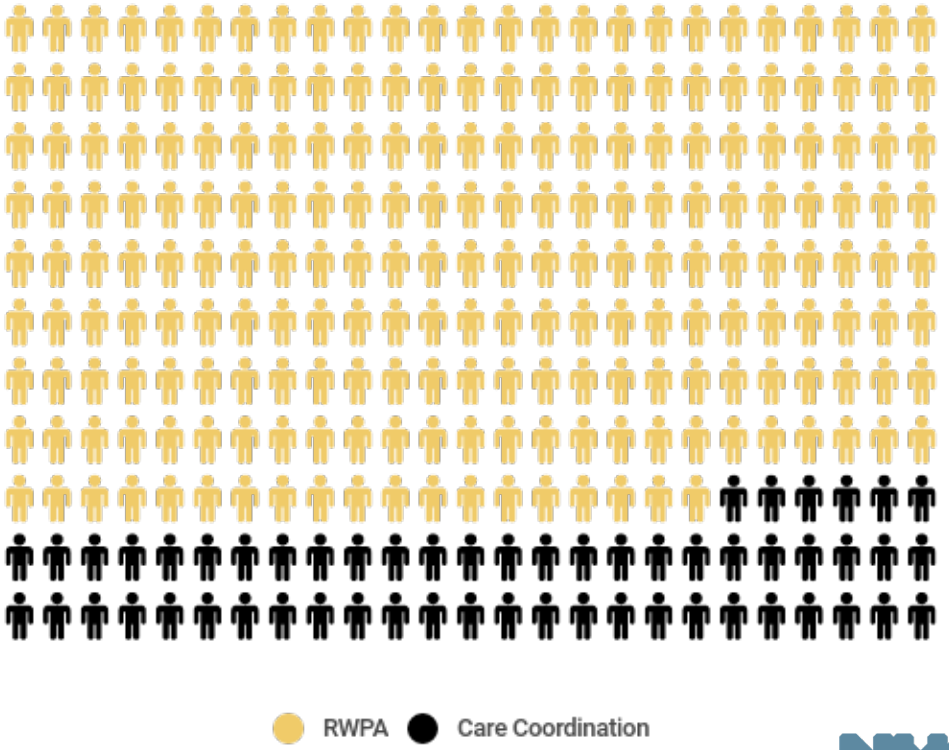
Active Clients in Care Coordination, 2017

3948

Active Care Coordination Clients

26%

Of RWPA Active Clients



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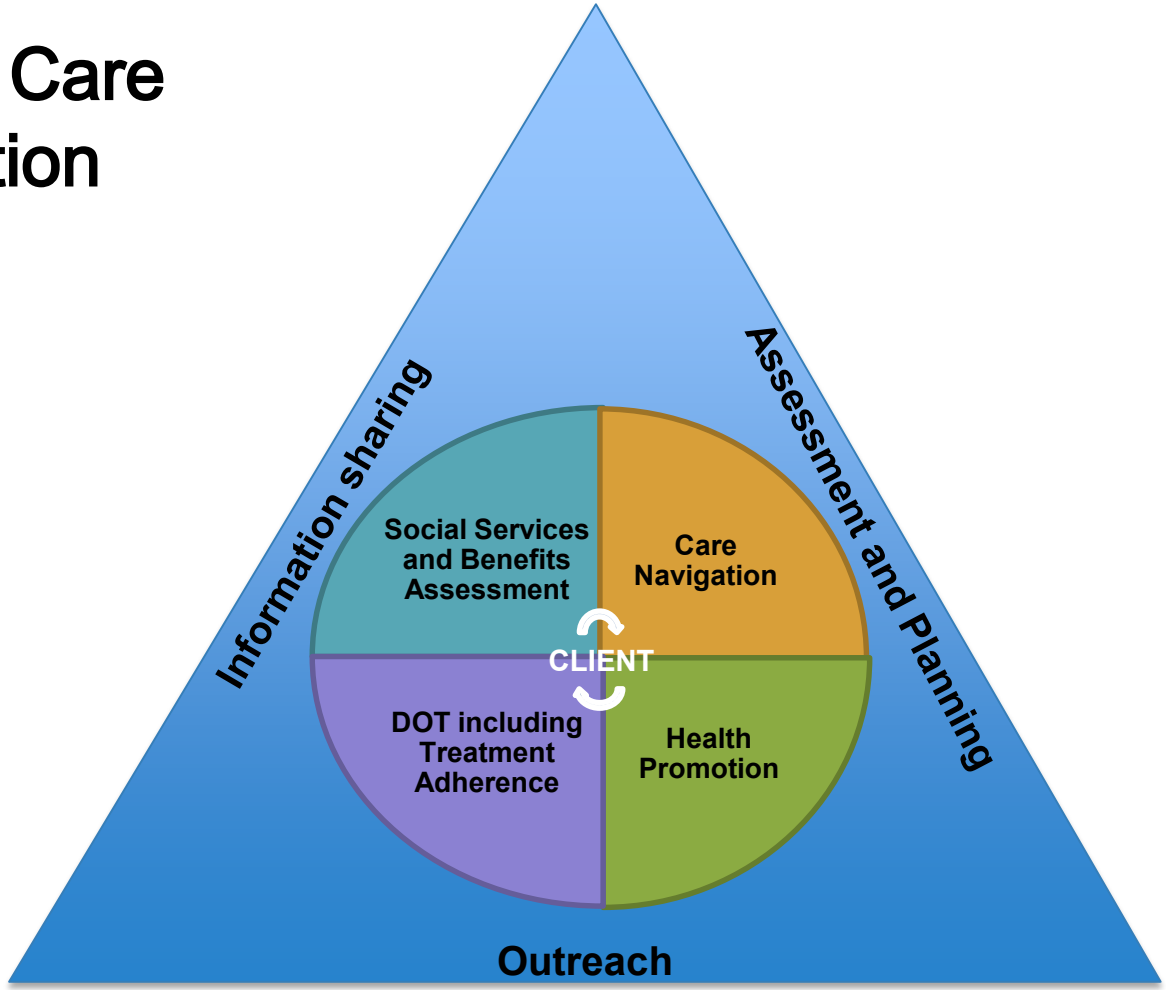
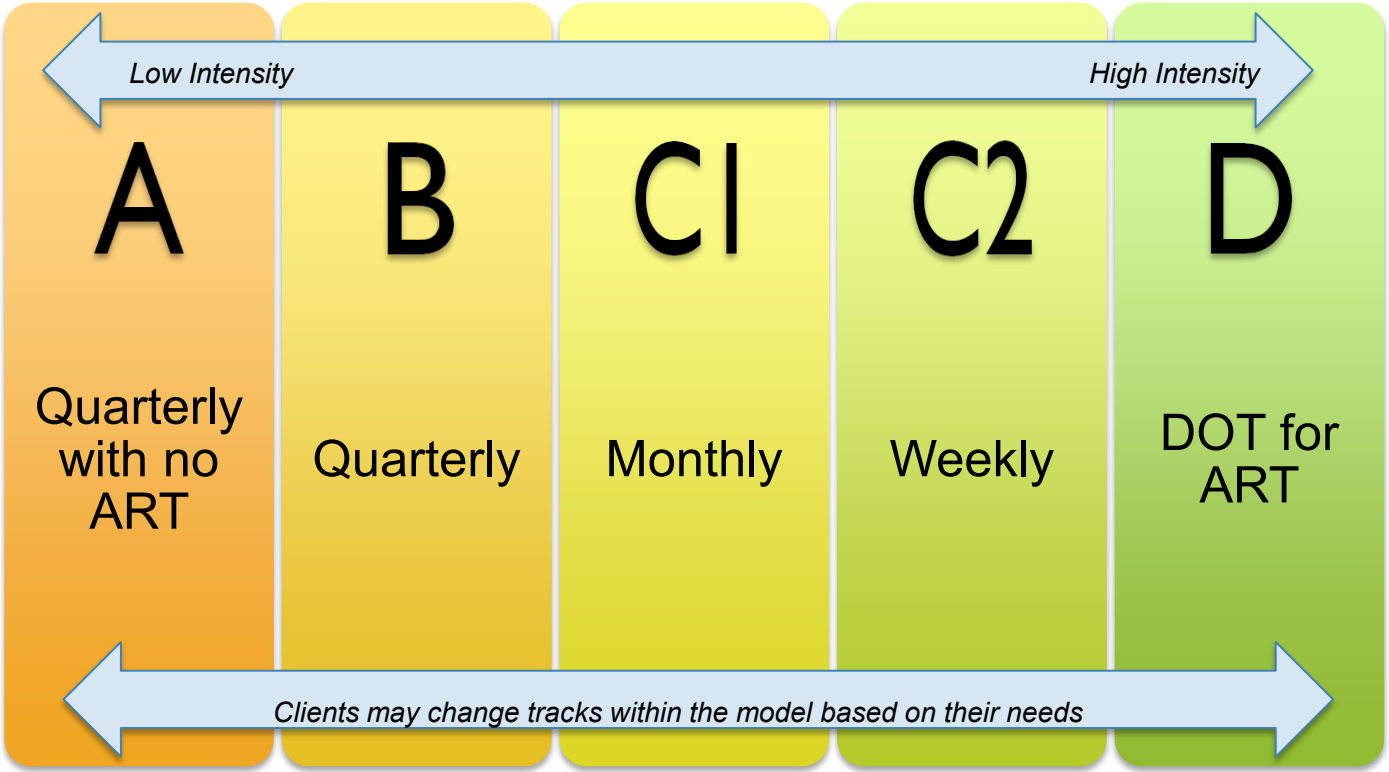
Care Coordination Program Model

The NYC Care Coordination Model



Service Delivery Tracks



The Care Team

Clinic Based

Vs

Community Based Organizations (CBO)

Vs

Hospitals

- 5 Clinic Based
- 6 CBOs
- 15 Hospitals
- 26 total programs

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Care Coordination Program Eligibility

Meet at least one of the following criteria:

- Newly diagnosed with HIV
- Out of care
- Previously diagnosed but new to care **OR** inconsistently in care
- Currently living with untreated Hepatitis C and HIV
- New to HIV treatment
- HIV+ and pregnant

3 The CCP Learning Collaborative

Caseload Manageability Project

What is the Care Coordination learning collaborative?

- Quality Improvement group
- 14 programs in the group
- Past projects:
  - Increasing DOT enrollment
- Current project:
  - Developing Quality Indicators for new iteration of the model

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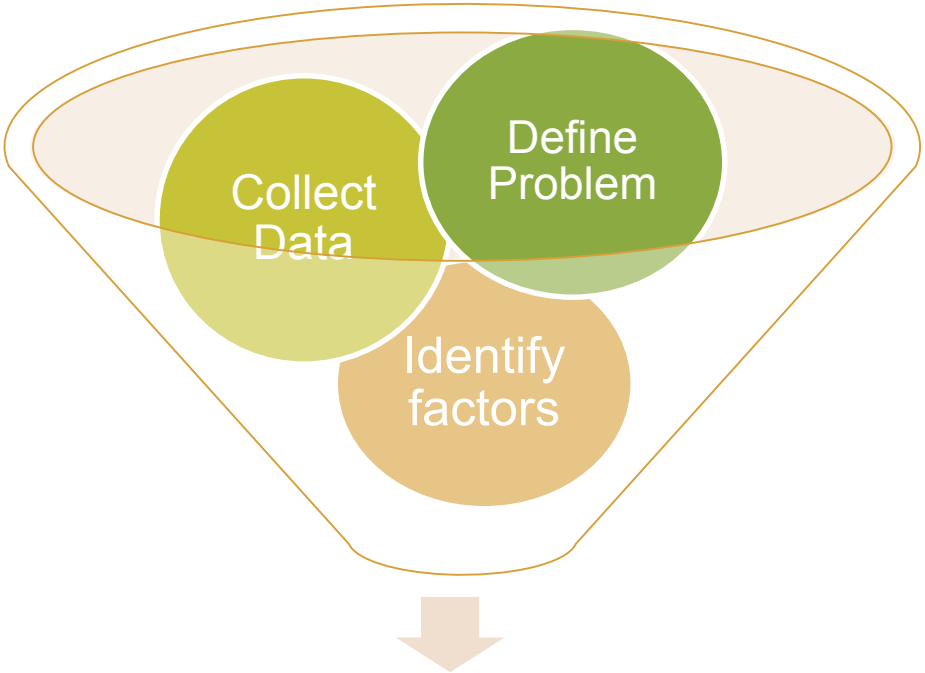
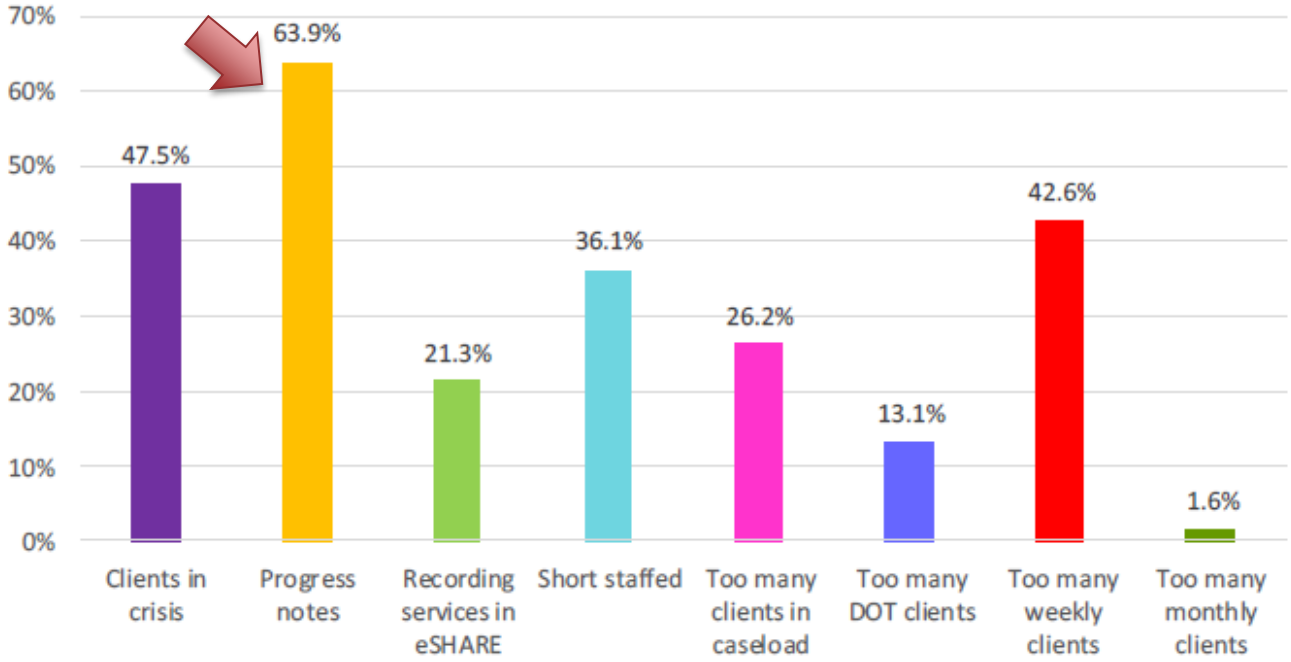
How do we find the root causes of a problem?



What are the top 3 reasons your caseload is unmanageable?



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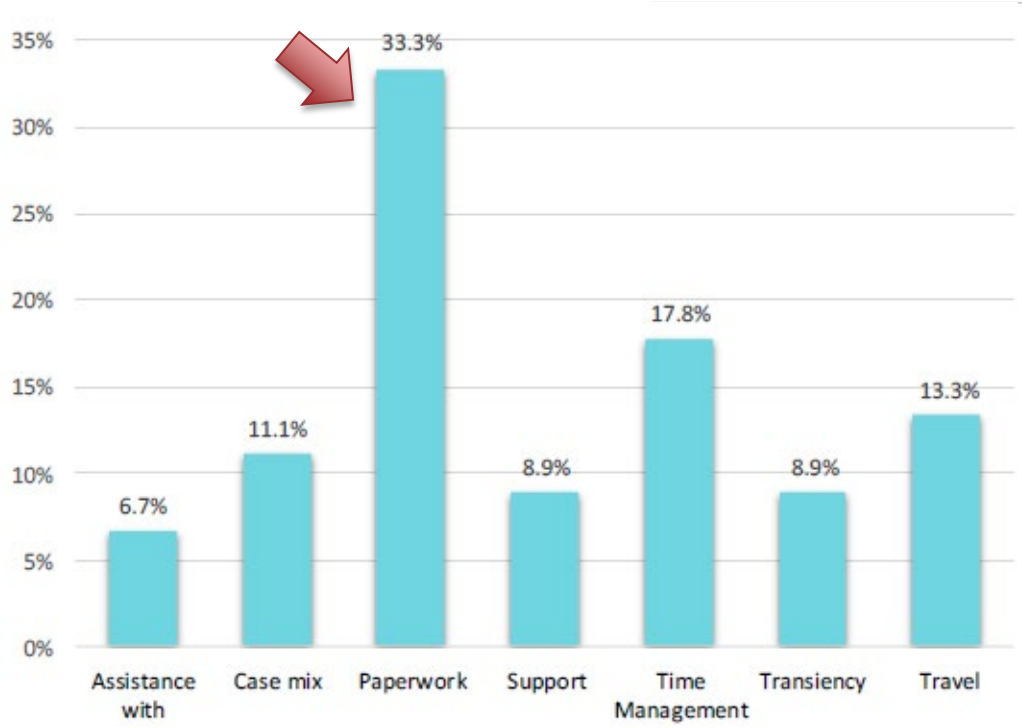
If there are other reasons that are not listed…



Getting at the Root Causes

- Define the Problem
  - Shared Challenges + Provider Brainstorm
- Collect Data
  - Survey Frontline Staff
- Identify Possible Factors
  - Survey results +
  - 5 whys to help identify causal factors

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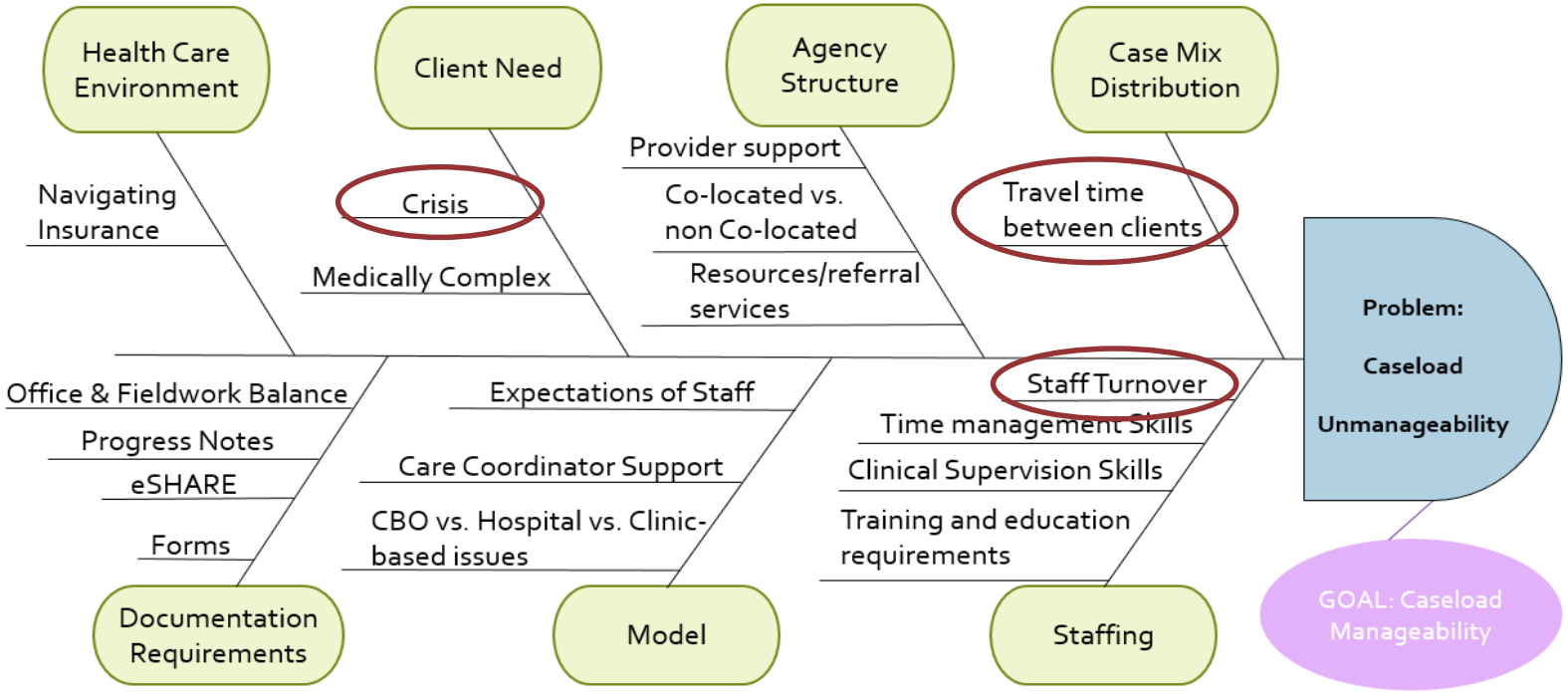
Root cause analysis: Fishbone Diagram



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Caseload Manageability Activity

On Root Cause Analysis

Brainstorming the Root Cause

1. Each sticker is assigned a problem area
   - Let's get into our groups!
2. Brainstorm root causes by filling out the 3 whys worksheet
3. Discuss with the group

= Documentation

= Agency structure

= Staffing

= Client need

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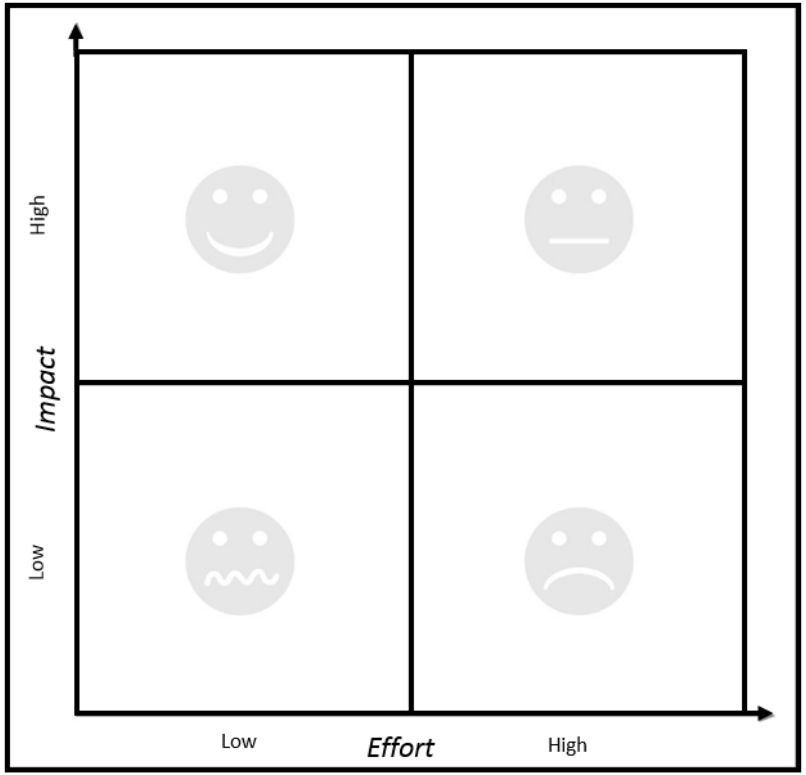
Brainstorm Potential Solutions

1. Brainstorm potential solutions with your group
2. List potential solutions on 2nd worksheet in the left-hand box
3. Discuss with the group

Prioritizing Solutions



1. In your groups, use the prioritization grid handouts to identify the impact and effort levels for all your potential solutions
2. Discuss with the group

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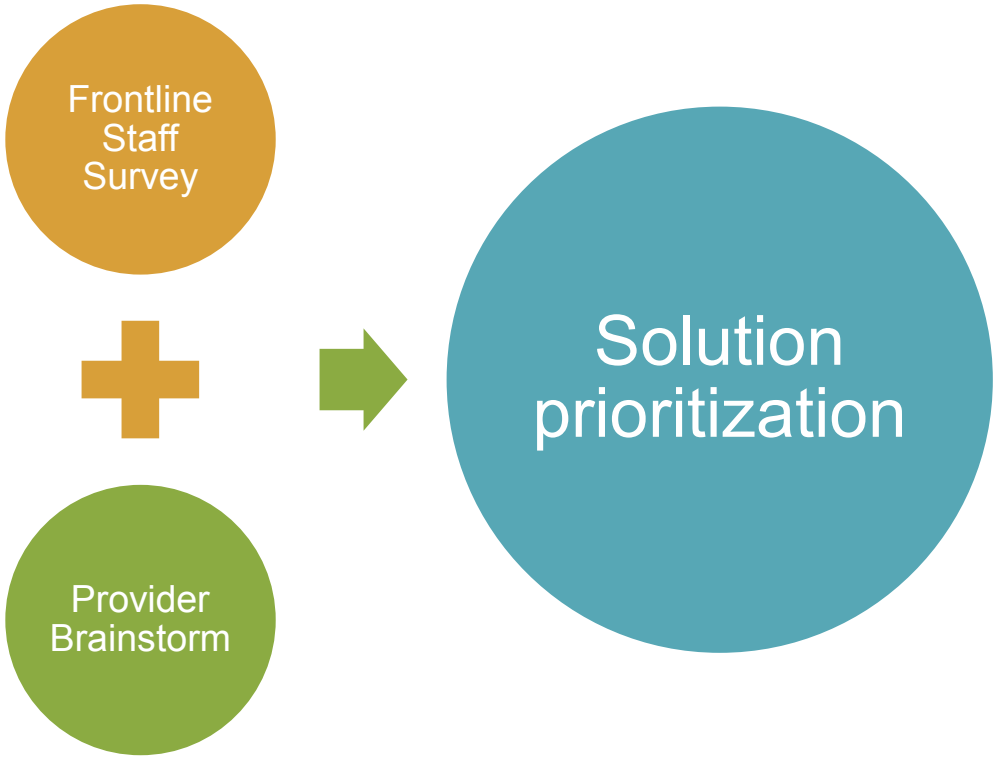
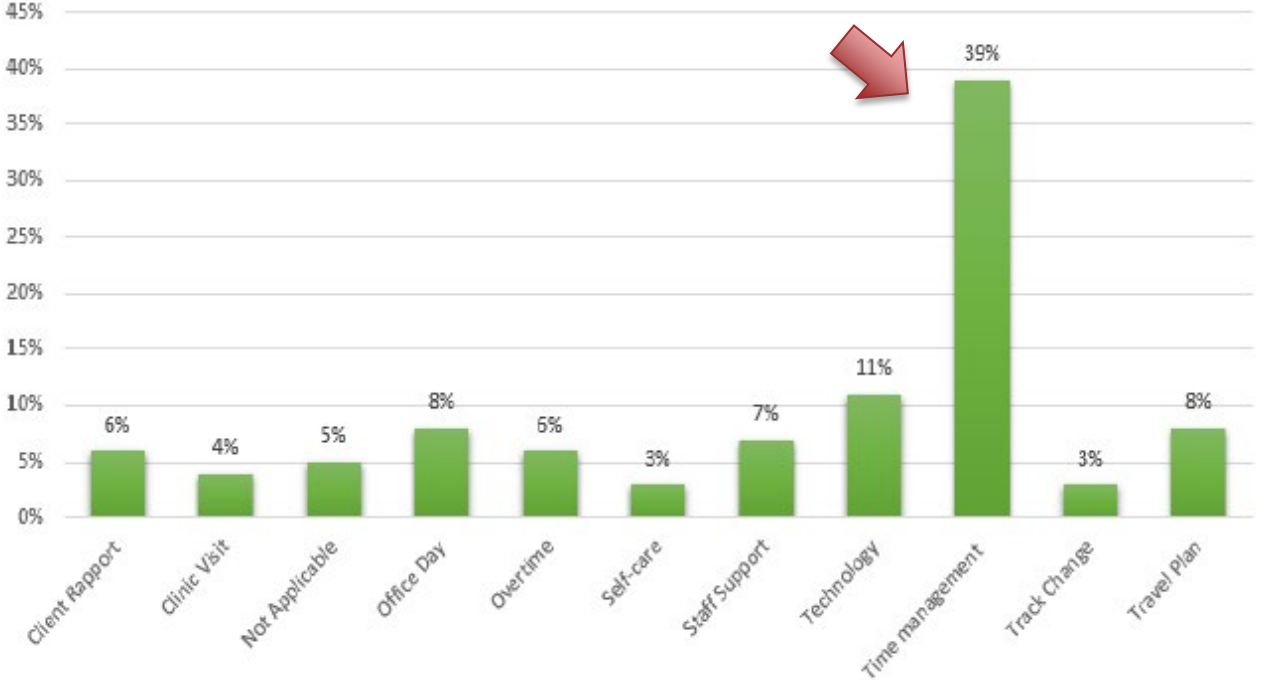
The CCP Learning Collaborative Project Outcomes

Caseload Manageability Project

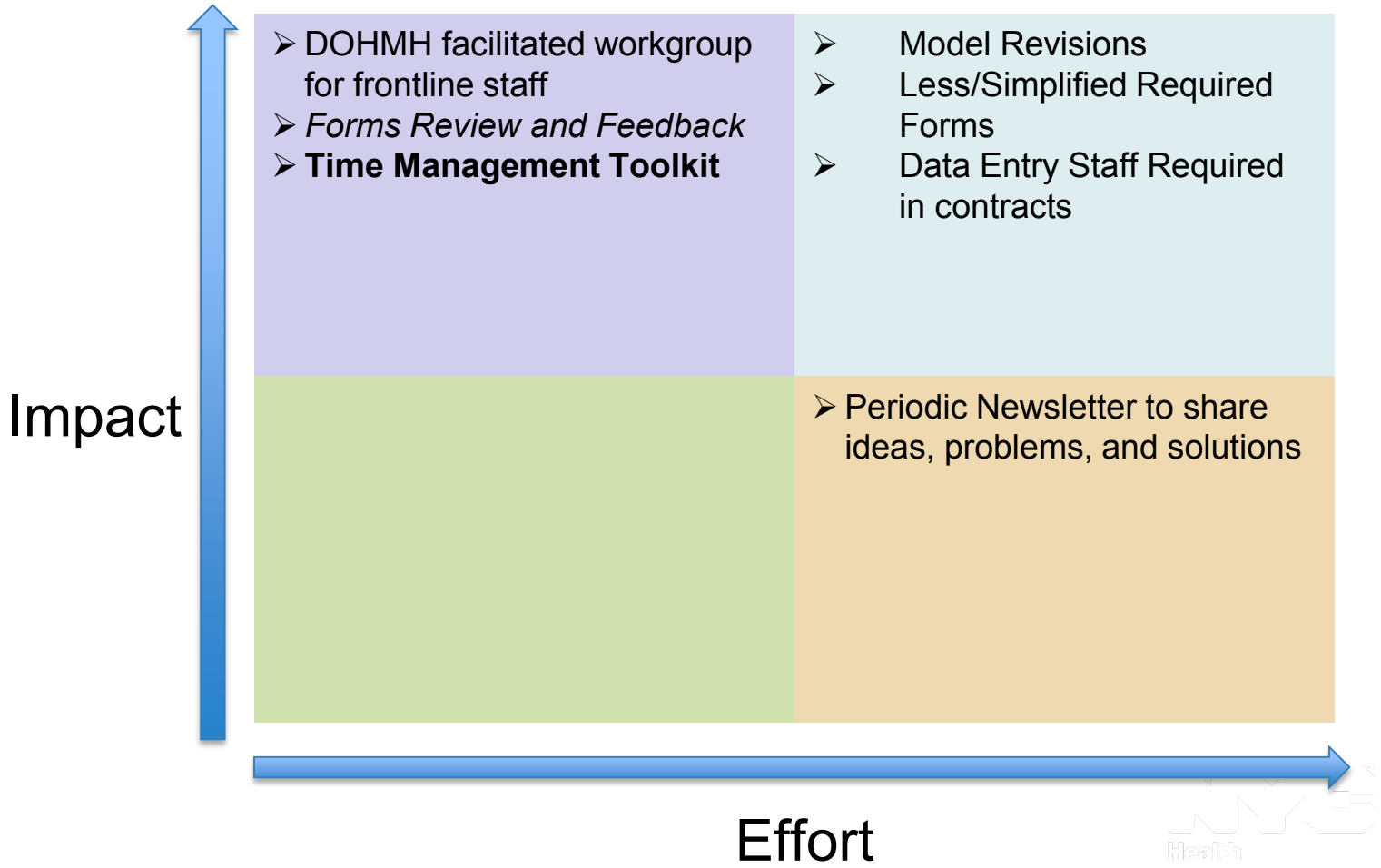
Identifying and Prioritizing Potential Solutions



What are some strategies you've developed to manage your own workload?



Prioritizing Potential Solutions



COMBINING IDEAS AND TOOLS FOR TIME MANAGEMENT TOOLKIT

Services Tracking

Client	Track	Dual Enrolled	Frequency	Second to Last Face to Face	Last Face to Face	Last Encounter	Last Face to Face Service	Next Face to Face		First Outreach	Last Outreach	Type	Next Outreach
John	C2	No	weekly		5/18/2018	Informal Case Conference	Health Promotion	5/25/2018					
Vincent	C1	No	outreach		3/31/2017	Assistance with Housing	DOT, Health Promotion	3/31/2017		3/23/2018	5/21/2018	HomeVisit	6/20/2018
Ann	C2	Yes	weekly		4/1/2017	Assistance with Benefits, Informal Case Conference	Accompaniment, Health Promotion	4/8/2017					

Forms Tracking

Client	Last Case Conference	Next Case Conference	Last Care Plan	Next Care Plan	Last Reassessment	Next Reassessment
John	03/11/2018	6/2/2018	09/09/2017	3/3/2018	09/15/2017	3/9/2018
Vincent	02/28/2018	5/22/2018	12/11/2017	6/4/2018	12/15/2017	6/8/2018
Ann	01/13/2018	4/6/2018	11/26/2017	5/20/2018	11/30/2017	5/24/2018
Sophia	04/26/2018	7/18/2018	05/15/2018	11/6/2018	05/20/2018	11/11/2018

Key	
	Due in 1 month or less
	Due in 1 week or less
	Overdue

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Travel Planning

FROM	TO	Miles	Time	Directions
argus community	NYC DOHMH	7.7	00:44	Walk to 3 Av - 149 St - 0.4 mi Subway towards Flatbush Av - Brooklyn College - 5.0 mi Walk to Lexington Av/59 St - 0.2 mi Subway towards Forest Hills - 71 Av - 2.0 mi Walk to 42-09 28th St, Long Island City, NY 11101, USA - 0.1 mi
HHC Bellevue	NYC DOHMH		00:38	Walk to 23 Street Station - 0.8 mi Subway towards Forest Hills - 71 Av - 4.5 mi Walk to 42-09 28th St, Long Island City, NY 11101, USA - 0.1
housing works	NYC DOHMH	5.6	00:27	Walk to Prince St Station - 0.1 mi Subway towards Astoria - Ditmars Blvd - 5.4 mi Walk to 42-09 28th St, Long Island City, NY 11101, USA - 0.1 mi
NYC DOHMH	Unique People Services	14.8	00:48	Walk to Queensboro Plaza - 0.1 mi Subway towards 34 St - 11 Av - 2.5 mi Walk to Grand Central Terminal - 0.2 mi Train towards Crestwood - 11.7 mi Walk to 4234 Vireo Ave, Bronx, NY 10470, USA - 0.2 mi

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PDSA: Improving the Time Management Toolkit

- **Helpful aspects of the tool:**
  - Transportation planning
  - Color coding
  - Forms tracking can be helpful for both frontline staff roles
  - May be a helpful supervision tool
- **Aspects to consider and/or improve:**
  - Initial data entry is time consuming
  - May be difficult for less excel savvy staff
  - Tool may not stay updated in the field
  - May be better for new staff
- **Changes made:**
  - Pop-up instructional guide on using sheets
  - Password-locked formulas across sheets
  - Face-to-face visit calculator on separate sheet so staff can choose parts of the tool that suit their style best

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5 Lessons learned

What are your takeaways?

DOHMH Lessons Learned

- Greater understanding and acknowledgement of the challenges around managing caseloads in HIV programs
- Findings inform service delivery and program model requirements
- Deliberate decisions in redesigning the care coordination program to address identified root causes

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Thanks!

Any questions ?

You can find me at

- Scarlett Macias, smacias@health.nyc.gov

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