Lessons from the New York City Translation of a Care Coordination Program: Science-Based Translation of Effective Program Strategies (STEPS) to Care (Abstract 5494)

Presenter: Julie Rwan, MPH, Senior Program Officer, Vital Strategies
Formerly: STEPS to Care Intervention Specialist, Bureau of HIV/AIDS Prevention & Control, New York City Department of Health & Mental Hygiene

Authors: Mary Irvine, Aisha Wilkes, Lydia O'Donnell, Katherine Penrose, Patricia Bessler, Julie Rwan, Athi Myint-U, Cari Courtenay-Quirk

2019 National HIV Prevention Conference (NHPC)
Wednesday, March 20, 2019

Disclosures

Presenters have no relevant financial or nonfinancial interest to disclose.

Presentation Outline

- Background
- NYC Pilot Methods
- NYC Pilot Findings & Lessons Learned

Background

The NYC Ryan White Part A HIV Care Coordination Program & STEPS to Care

Ryan White Part A Care Coordination Program* (CCP)

- **Comprehensive Medical Case Management for persons recently HIV-diagnosed, new to ART, or with a history of non-adherence to visits and/or ART**
- **Key components: 1) case finding and outreach; 2) patient navigation; 3) case conferencing; 4) case management; 5) adherence support; 6) structured health promotion**
- **Required staff: Care Coordinator (CC), Patient Navigator (PN)**
- **Setting: Onsite or affiliated primary care**

* Added in 2015 to CDC Compendium of Evidence-based Interventions & Best Practices for HIV Prevention, based on findings of R01MH101028 ('CHORDS' Study)

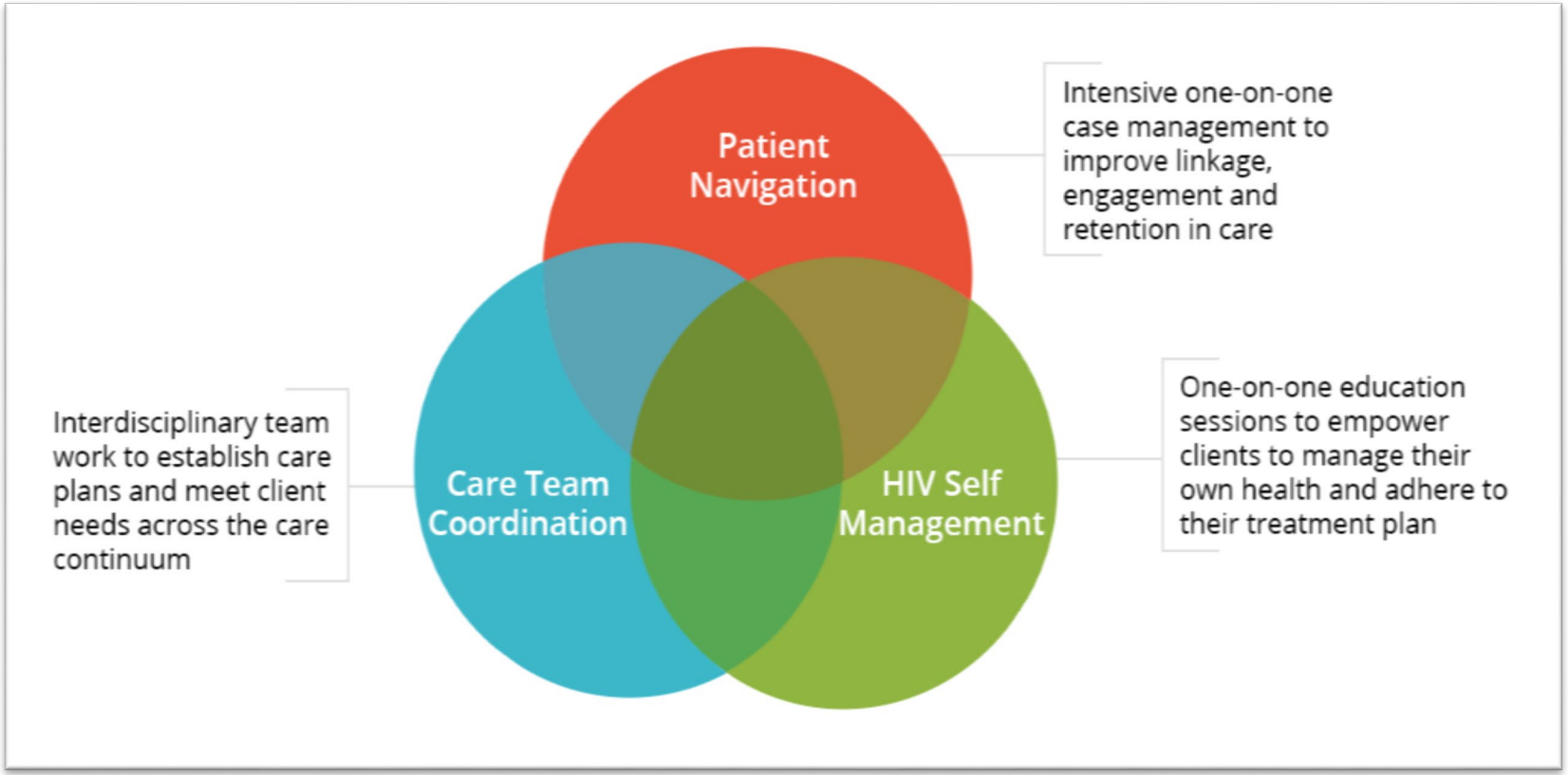
What is STEPS to Care?

- **Funder:** CDC, under a 3-year Cooperative Agreement; Aisha L. Wilkes, MPH, PO
- **Grantee:** Education Development Center, Inc. (EDC); Lydia O'Donnell, EdD, PI
- **Partner:** NYC Dept. of Health & Mental Hygiene (DOHMH); Mary Irvine, DrPH, PI
- **Purpose:** Translation of evidence-informed CCP strategies into web-based tools and training to improve linkage, retention, and reengagement of PLWH in care
- **Final Product:** Provider- and Client-directed Web-based tools, available at https://effectiveinterventions.cdc.gov/care-medication-adherence/group-4/steps-to-care

Why Translate to Web-based Tools?

1. **Challenge of transferring effective strategies to new settings**
2. **Need for alternatives to costly face-to-face training and one-on-one TA**
3. **Value of online platform for making strategies available to all those interested in practice change**
   - Can accelerate large-scale technology transfer

STEPS to Care Strategies



Patient Navigation

- **Patient Navigators are key players on care team**
  - Have the most interaction with the clients
  - Bridge the gap between the clinic and the community
- **Services (often in client's home) include:**
  - Health promotion (following structured curriculum)
  - Accompaniment
  - Treatment adherence support, including modified DOT

Photo of navigator entering apartment building

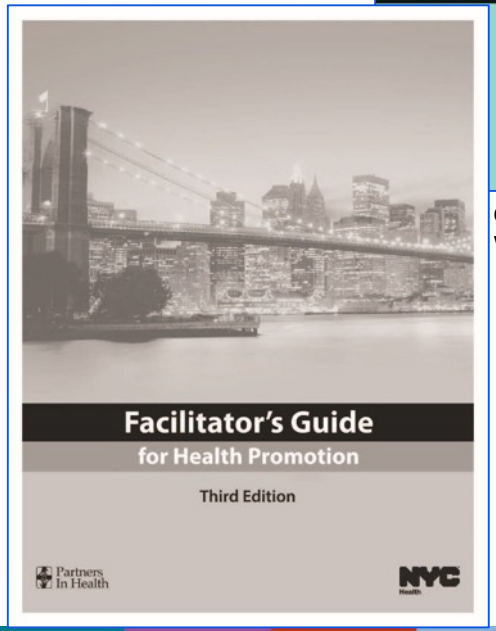
Care Team Coordination

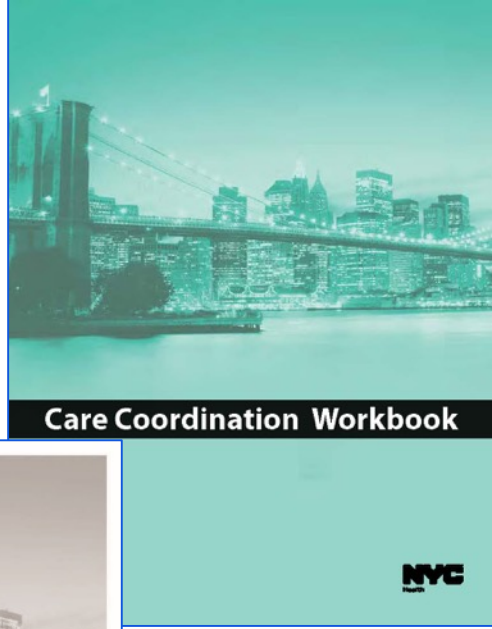
- **Interdisciplinary care team meeting**
  - Program Staff (CC and/or PN)
  - Clinician (MD/DO/NP/PA)
  - Patient (optional)
- **Review labs, adherence, home conditions**
- **Develop and update client care plan**

Photo of care team meeting

HIV Self-Management

- **HIV education, coaching and counseling**
- **Adapted Partners in Health PACT curriculum**
- **Conducted by Patient Navigators**
  - One-on-one sessions





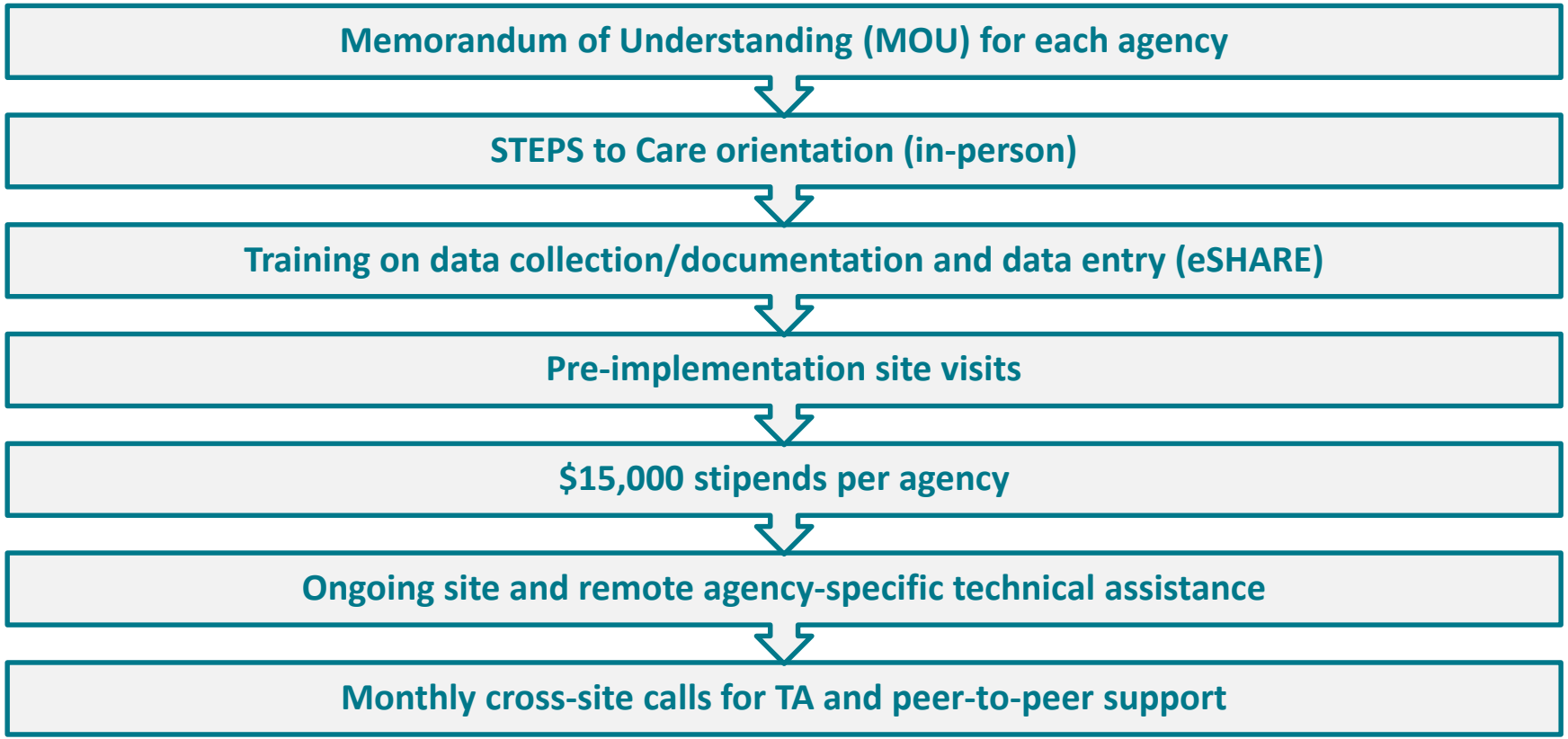
Covers of Care Coordination Workbook and Facilitator's Guide

NYC Pilot Methods

Top 5 Criteria for Selection of Pilot Agencies

Primary care provider onsite at agency or strongly affiliated
≥1 of the following already on staff: case manager, social worker, case worker, community health worker, patient navigator, paid peer, patient coach, or health educator
≥2/3 Black & Latino/a or ≥2/3 foreign-born HIV patient pop.
≥100 HIV patients served annually for past 3 years (age 13+)
Documented difficulty achieving care continuum outcomes

Preparation and Support of Pilot Agencies



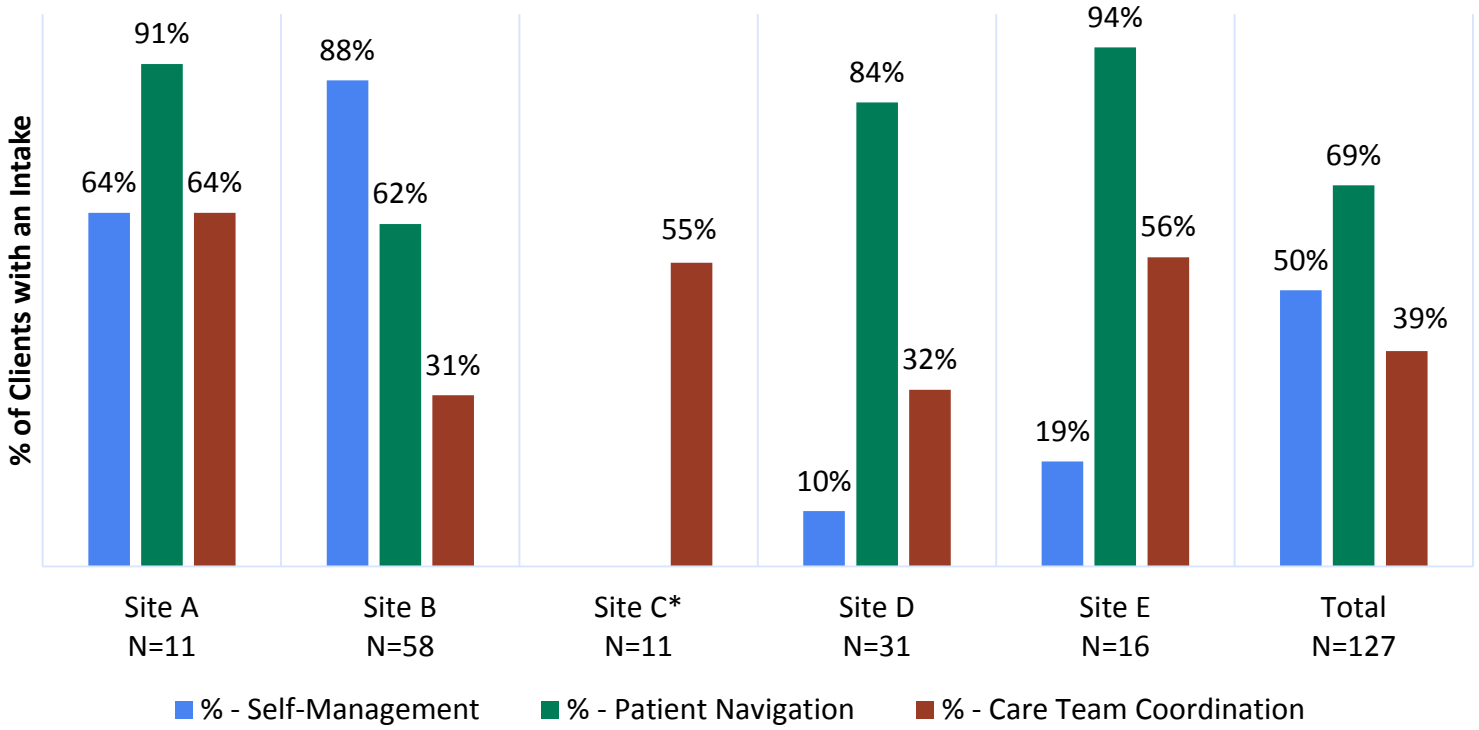
NYC Pilot Findings & Lessons Learned

Piloted in 5 NYC Agencies, July 2015-February 2016

- 3 community health centers, 2 hospitals
- 2 Bronx-based, 2 Manhattan-based, and 1 Brooklyn-based agency, representing a mix of:
  - Medicaid Health Homes, Designated AIDS Centers, & Federally Qualified Health Centers
- 2 agencies had CCP contracts, 1 had given up CCP contract, 2 had other case management only
- All annually served >300 HIV patients, >75% of whom were Black or Latino/a
- All had some existing practice for care team coordination/case conferences
- Together, these agencies completed enrollments and intakes with 127 clients

Photo of New York City skyline

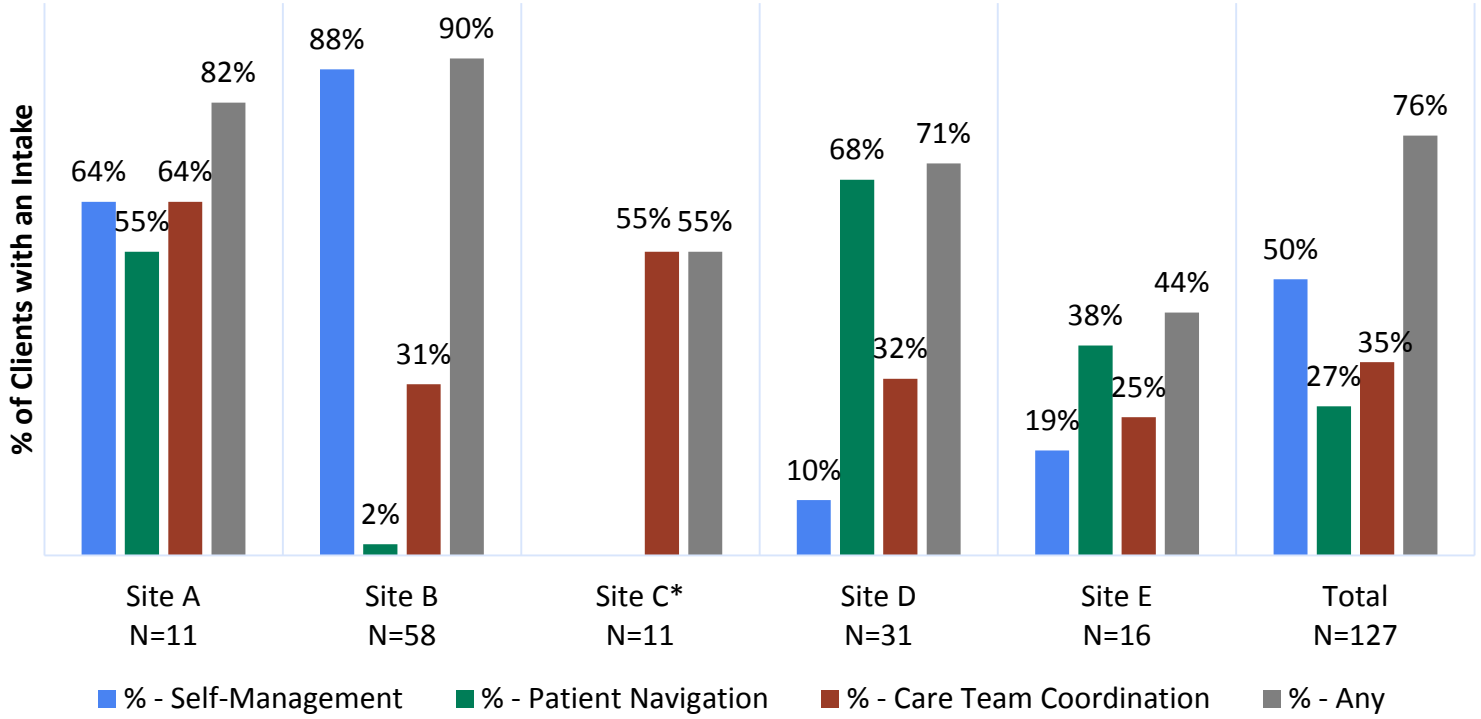
Client Receipt of Services beyond Intake, by Strategy



*Site C experienced major staff turnover resulting in data reporting gaps.

We assigned services to strategies here based on the Key Components Checklist, but excluded Intake Assessment and Case Finding (a cross-cutting activity).

Client Exposure to STEPS to Care tools in ≥1 Service beyond Intake, by Strategy



*Site C experienced major staff turnover resulting in data reporting gaps.

We assigned tools to strategies here based on the Key Components Checklist, but excluded Intake Assessment and Patient Selection Criteria (cross-cutting).

NYC Pilot Test Key Findings

Need Identified ⟹	Refinement to Toolkit
Support for selective adoption	Added Key Components Checklist
Tips on which tools to access first	Redesigned Dashboard
More tools for agency administrators	Added Preview Guide for Program Directors and FAQs
Guidance on how to deliver HIV Self-Management sessions	Added Facilitators' Guide

Implementation

+ **STEPS to Care used as a resource for professional development**
+ **STEPS to Care facilitated team communication**
- **Limited reports of specific Patient Navigation or Care Team Coordination tool use**
- **Data entry under-represented services**

Lessons Learned

- Need to clearly define key components to help agencies tailor/ selectively adopt
- Agency policy or funding constraints may limit capacity to do home/ field visits
- Some training and TA is still needed alongside web-based tools
- Agency STEPS to Care champion and provider participation are keys to success
- Brief pilot with agencies selected to meet project-driven criteria does not simulate real-world adoption

Acknowledgments

Other Contributors:

CDC

Chezia Carraway

Monique Carry

Chela Hall

Jeffrey Herbst

Darrel Higa

Jerris Raiford

David Whittier

EDC

Deb McLean

Maya Lagu

NYC DOHMH

Graham Harriman

Stephanie Chamberlin

Beau Mitts

CUNY ISPH

Denis Nash

Community Advisory Board members and staff of pilot agencies.

Thank you!

Find our tools on STEPS to Care website:

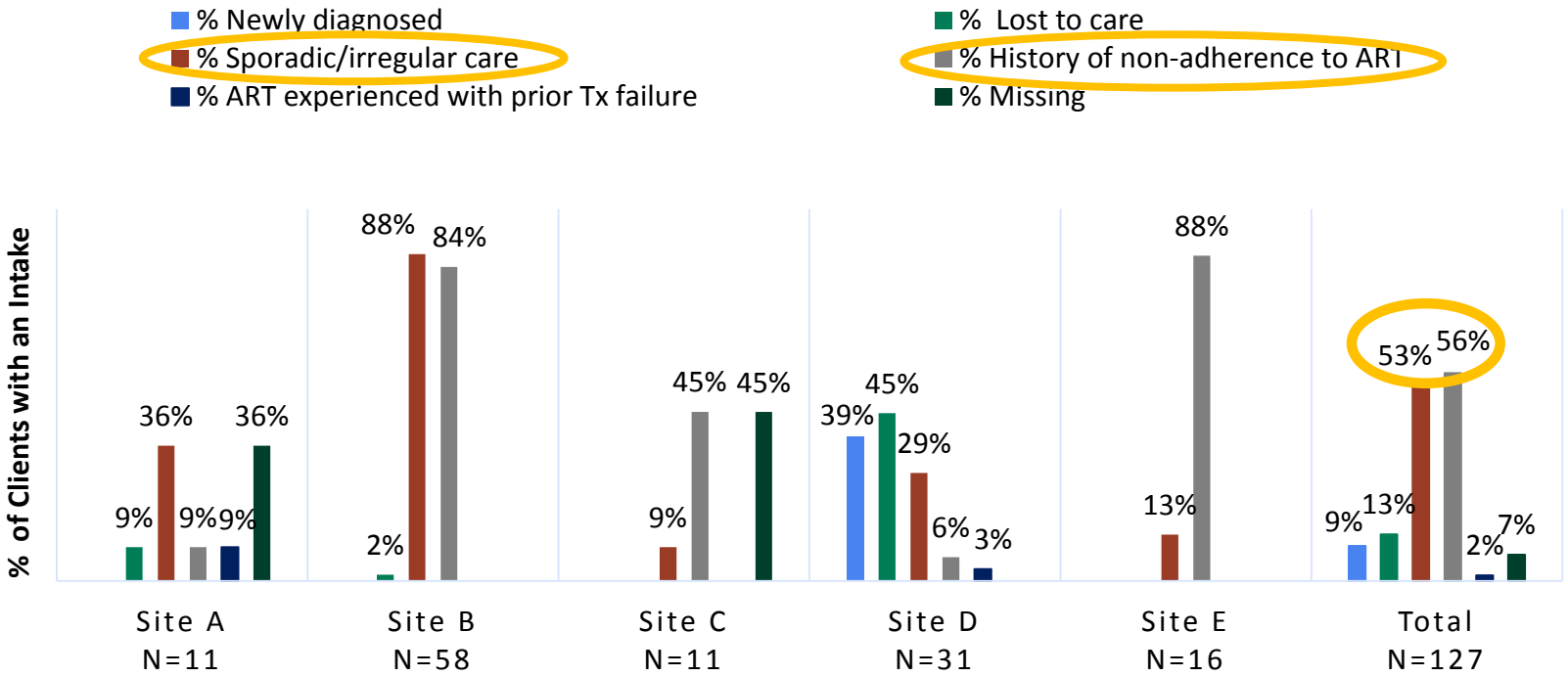
https://effectiveinterventions.cdc.gov/en/2018-design/care-medication-adherence/group-4/steps-to-care

For more information, contact CDC
1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 www.cdc.gov

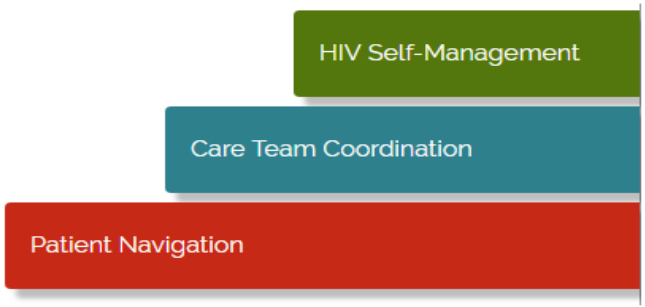
Questions & Comments?

Additional Slides (as needed) for Q&A

Reasons for Enrollment (N=127)



STEPS to Care Strategies



3 **Proven Strategies**

based on the New York City Department of Health and Mental Hygiene's HIV Care Coordination model

These strategies work in concert:

Patient Navigation

Patient navigators work one-on-one with clients to encourage continued commitment and adherence to medical treatment. Through home visits, HIV education, and guidance with goal setting, navigators ensure medication adherence, access to social services, improved communication, and prompt re-engagement in care.

Care Team Coordination

The role of the care team is to support information-sharing and collaborative decision-making to improve health outcomes for clients. Teams meet in formal and informal meetings to discuss client progress and needs, develop, monitor and update care plans, and identify and assign team member activities.

HIV Self-Management

Through easy-to-use client resources available on the HIV Self-Management website and in the workbook, navigators help clients build knowledge and skills for self-care, navigating the health care system, and independent health maintenance.