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The High Priority Project:

An ETE Pilot

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Question: What can an MCO do to promote viral suppression?

- Background:
  - Medicaid HIV care in NY has been a remarkable success. VNSNY SelectHealth has a VLS of 81%. We can do better.
- Some assumptions
  - Care is centered on a patient and provider
  - Providers must be compensated for care-coordination activities between or in the absence of visits.
  - Data sharing, real time communication vital.

Program Design and Rationale

- **Stratify members** identified by NYS match using visit, pharmacy and lab data:

1. Lost to follow up.

2. Marginally engaged.

3. Engaged (often suppressed).

- Interventions:
  - Group 1 **(LOST**)
    - Review case with provider.
    - Field outreach by peers.
    - Home medical visit by NP
  - Group 2 (**MARGINAL**)
    - Review case with provider.
    - Referral to local adherence services.
    - Adherence education by peers.
  - Group 3 (**ENGAGED**)
    - Confirm status with provider.
    - Monitor adherence lapse.

Outreach Strategies

Bringing Peer Navigators & Medical Providers
to the Hard to Reach Individual

ASCNYC positive change

PROJECT RENEWAL
Renewing lives. Reclaiming hope.

Outreach Case 1

- 29 year old gay AA male with 1 PCP visit in the last 18 months
- **"I can't go downtown. People will know I am sick"**
  - CD4 in double digits, unsuppressed VL
  - Non adherent to refilled HIV regimen
  - Several hospitalizations in last year
  - First seen by Peer and medical outreach team during hospitalization after numerous attempts at home visit……

Outreach Case 2

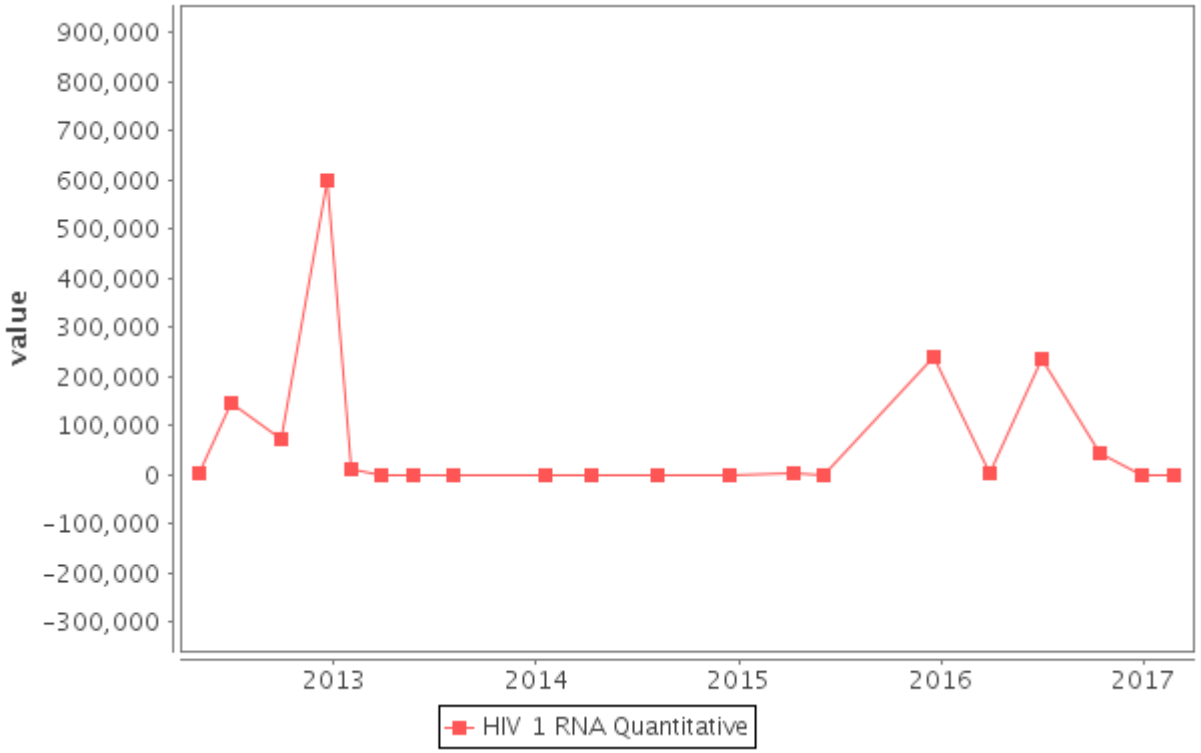
- 40 year old AA female living in the Bronx with her 9 year old daughter
- HIV > 12 years
- CD4 of 12 18 months ago
- VL 300,000 +
- 6 months later, > 12 home and escorted visits back to her PCP by Peers, 2 home visits by outreach NP…….

Challenges and Opportunities

- Context of our Challenges:
  - How we measure progress
  - How we think about success
  - Peer and agency/subcontractor supervision
  - The public vs. the individual burden of HIV
  - Labor intensive
  - Efficacy
  - Reproducibility

ETE Data issues: More is More

- Single viral load each year cant distinguish a short adherence lapse or “blip” from a prolinged pattern of poor engagement/adherence.
- NYS should provide plans with all viral load data on their members.
- CD4 trend over time also helpful in identifying those most in need of engagement.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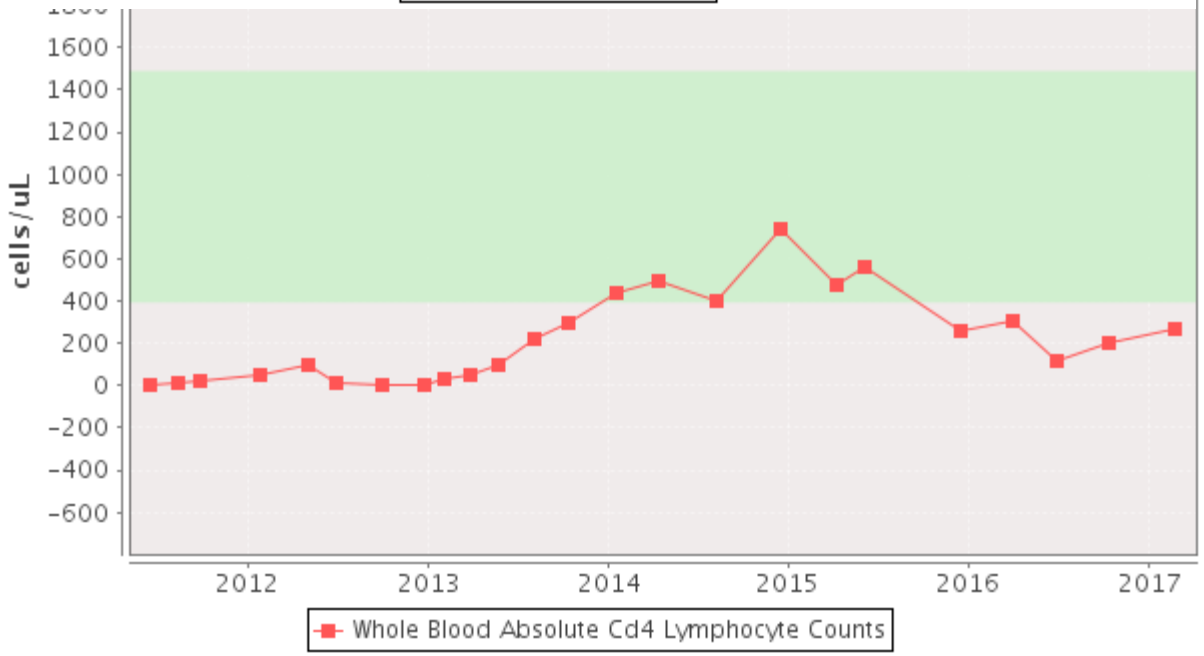
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2012
2013
2014
2015
2016
2017
Whole Blood Absolute Cd4 Lymphocyte Counts

Random cohort entry/exit at low level viremia

Viral load Bucket	Range	Proportion remaining in cohort
V 2	200-999	35%
V 3	1000-9999	48%
V 4-5	>10,000	51%

High Priority Projerct Provider Case Conferences

Subcontract with Major Providers

per capita payment of $40 per month for each member on ETE roster

$20 for monthly report of lab and PCP visit

$10 for each of two case conferences

Implementation Issues

requires amending provider contracts or initiating new ones;

sometimes delayed by other contract issues.

need to identify appropriate staff, schedule etc.

Case Conferences: Early experience

Program launched 10/16 covering 3 major DACs.

Findings:

Most lost to follow ups confirmed; some new contact data.

Non-progressors over-represented and mis-classified as “lost”.

Several members mis-assigned to DAC in plan database.

Real-time lab/visit data allows restratification since State data) and most plan data is aging.

Unmet psychosocial needs identified.

Future directions

- PCP involvement on complex cases needed. How?
- Health Home involvement ???
- Adherence interventions:
  - MCO report ARV refill rate to PCP.
  - More aggressive use of on site pharmacies.
  - Expanded availability and use of other adherence interventions
    - Pillbox pickup
    - Home delivery
    - Center DOT
    - Home DOT