PROJECT INSPIRE NYC: COMBATTING HCV IN NYC - A CMS INNOVATION AWARD

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October 10th, 2014

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Credit and Disclaimer

- The project described was supported by Grant Number 1C1CMS331330-01-00 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services.

- The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.

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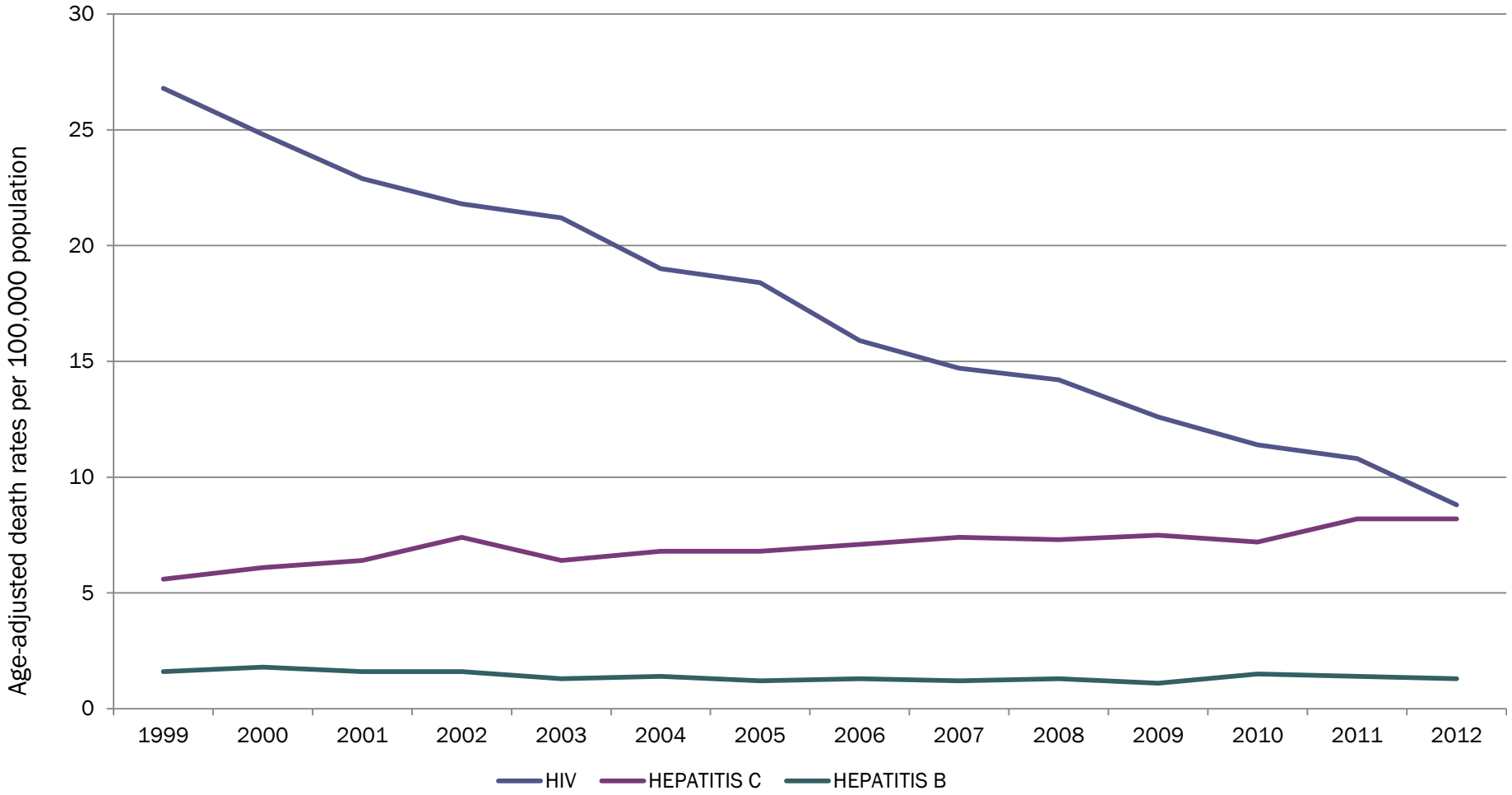
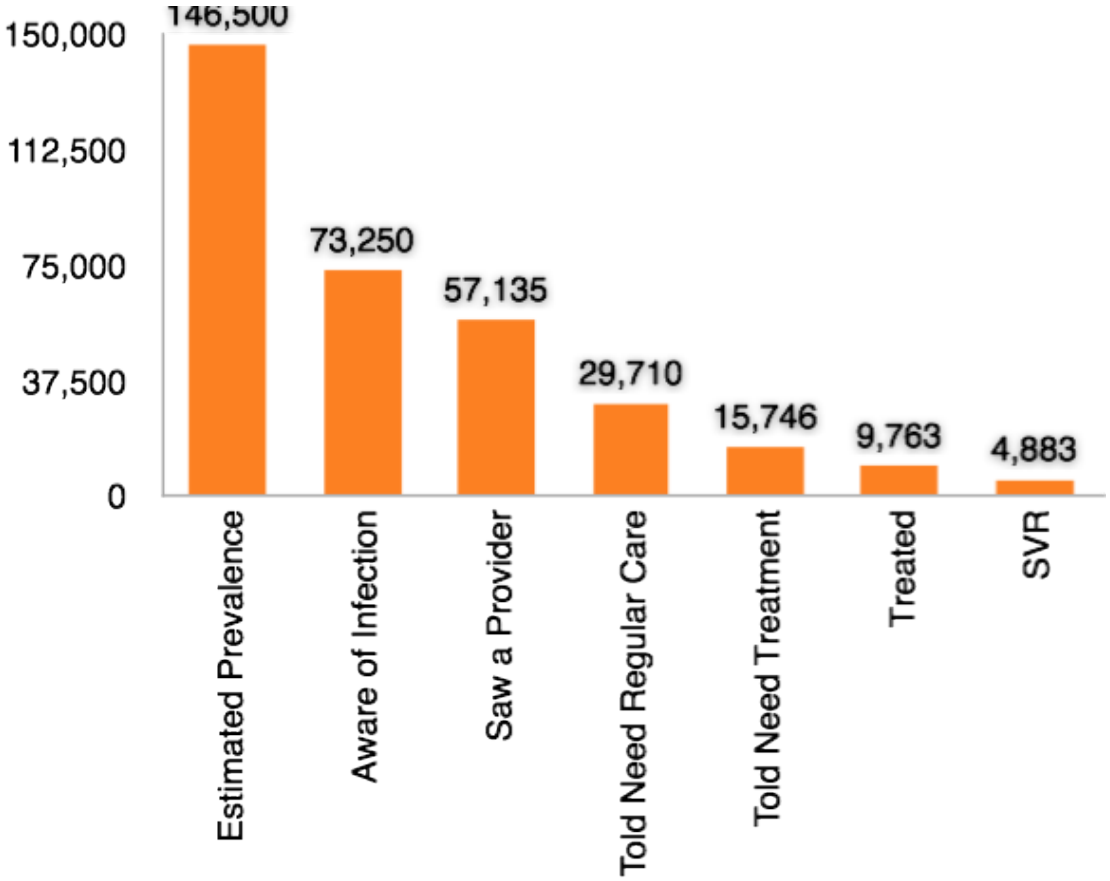
Trends of Age-Adjusted Death Rates From HIV, HCV and HBV Per 100,000 Population, 1999-2012, NYC



Source: Contributing causes of death were obtained from the NCHS Multiple Cause files for NYC except for 2012 which use the

NYC HCV Estimated Treatment Cascade



Prevalence estimates among persons ≥20 years: Balter et al, Epidemiol Inf 2013
NHANES 2001-2008: Denniston, et al, Hepatology 2012

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CMS Grant Overview – Project INSPIRE

- **INSPIRE** - Innovate & Network to Stop HCV & Prevent complications via Integrating care, Responding to needs and Engaging patients & providers

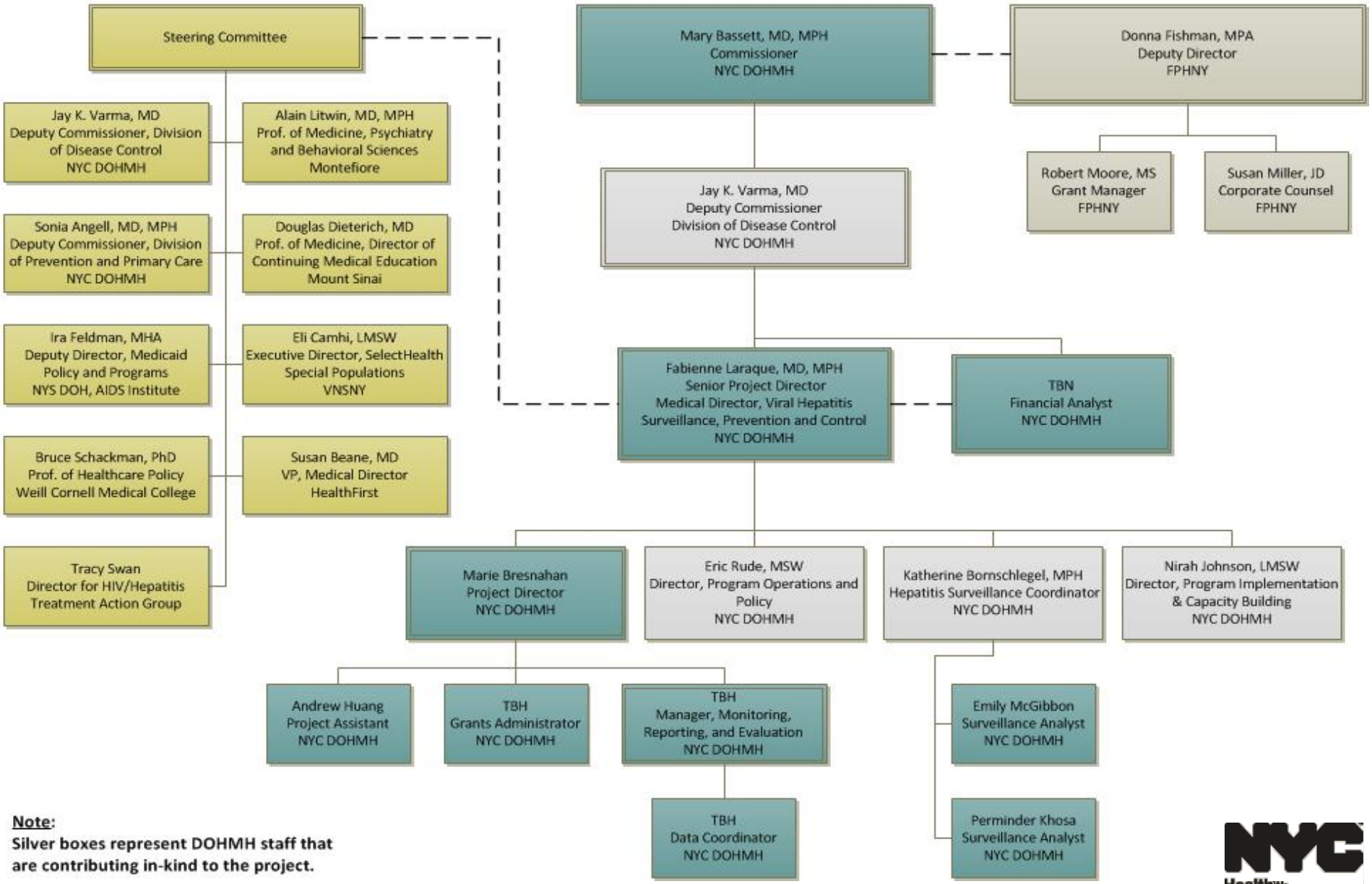
- **Program Period:** September 1st, 2014 – August 31st, 2017 (3 years)

- **Geographic Reach:** Upper Manhattan and South Bronx

- **Funding Amount:** $9,948,459

- **DOHMH Staffing Pattern:**
  - Program management
  - Surveillance
  - Evaluation
  - Staff will include current employees and new hires

CMS HCIA II – "Project INSPIRE NYC"
CFDA 93.610 / Grant No. 1C1CMS331330-01-00
Organizational Chart



Note:
Silver boxes represent DOHMH staff that are contributing in-kind to the project.

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Project INSPIRE – Goals

- **Primary Aim:** To demonstrate a model of service delivery and payment that can reduce morbidity and death from chronic illnesses and reduce costs associated with its complications, using chronic HCV infection as a case study.

Project INSPIRE - Detailed Goals

1. **Better care,** by increasing the number of patients starting hepatitis C therapy, strengthening management of behavioral health problems, reducing hospitalizations and emergency department visits, and maintaining a high level of satisfaction among enrollees;
2. **Better health,** with increased hepatitis C cure rates, fewer hepatitis C-related complications, and increased screening for depression and alcohol abuse; and
3. **Lower costs,** by reducing expenses from preventable hospitalizations, emergency department visits, and complications of hepatitis C infection.

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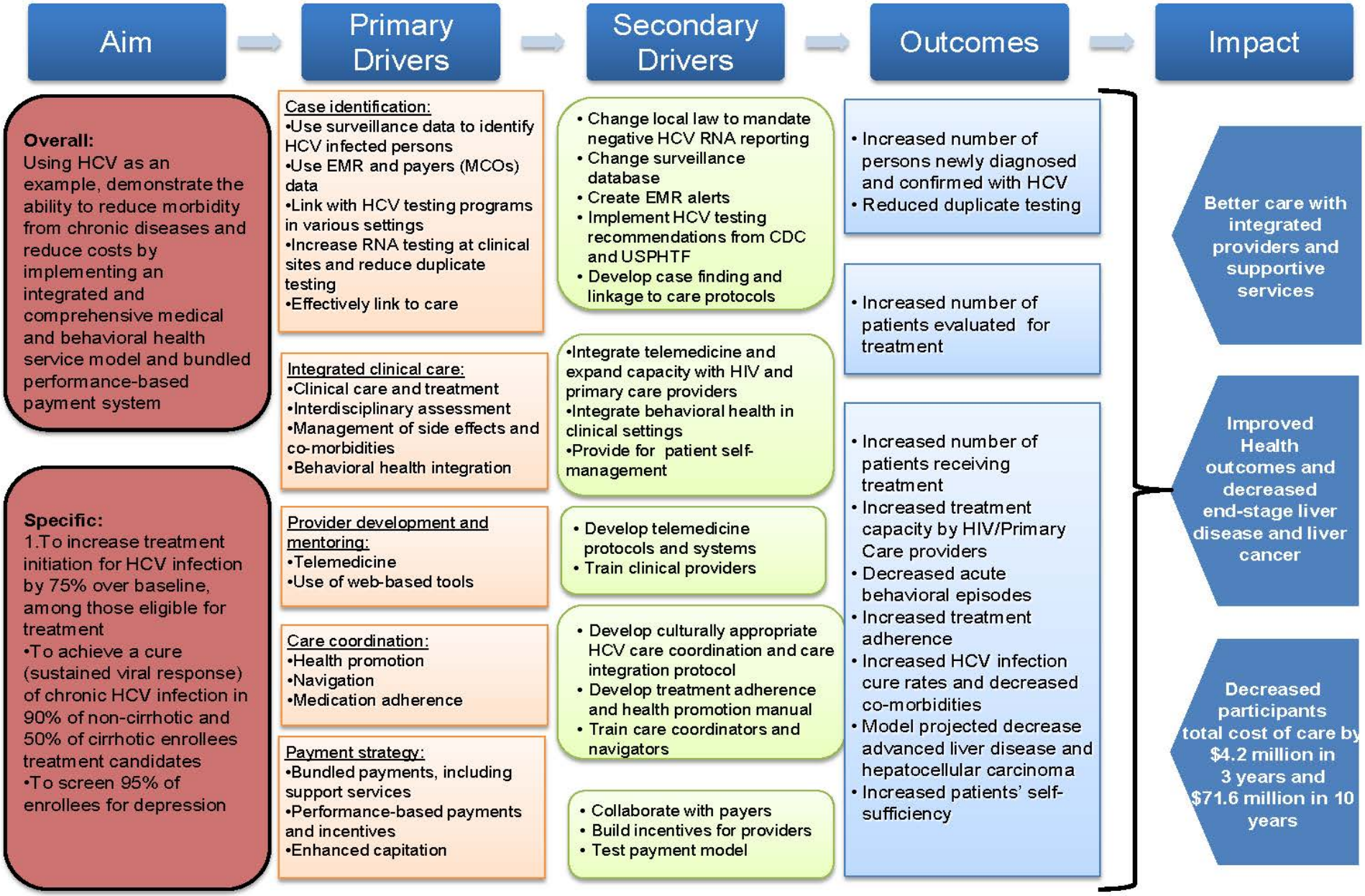
NYC DOHMH CMS Innovation Award II
HCV Infection Comprehensive Care Logic Model



Project INSPIRE – Major Activities

- Identify HCV-infected persons using EMR, surveillance data, and routine screening
- Enroll 3,200 chronic HCV patients and treat at least 2,000
- Integrate primary care with behavioral health
- Use primary care and HIV providers for clinical care and hepatologists as mentors, via telemedicine
- Provide care coordination, navigation, health promotion, and medication adherence support = patient-centered medical home
- Design and test an innovative capitated payment system
    - Cover cost of care, care coordination and telemedicine

Partner Organizations & Roles

Mt. Sinai and Montefiore Medical Centers: clinical sites

- Implement the integrated care model
- Provide telemedicine consultation
- Enroll 3,200 HCV patients, increase treatment initiation for patients by 75% over baseline, and achieve the following outcomes:
    - Screen 95% of enrollees for depression.
    - Complete treatment for 75% of enrollees.
    - Achieve cure rate (SVR) of 90% for non-cirrhotic and 50% of cirrhotic patients.
- Provide care coordination
- Oversee the Care Coordinators, who will lead a team of peer navigators, responsible for patient care and supportive services at each site

Clinical Site Deliverables – Year 1

Clinical Services

- Enroll ~1,200 patients in year 1
- Implement the intervention
- Average 75% caseloads for Care Coordinators by Month 6
- Provide data for monitoring and evaluation to DOHMH every month
- Administer a client satisfaction survey and send results to DOHMH/Cornell for analysis

Provider Training

- Recruit 8 primary care providers to be HCV champions by Month 4
- Develop a telemedicine protocol by Month 4
- Initiate HCV care training for 8 primary care providers by Month 12

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Partner Organizations and Roles

Weill Cornell Medical College: project evaluation

- Develop monitoring and evaluation processes
- Work with DOHMH to collect data from patients and providers
- Evaluate clinical outcomes
- Evaluate costs
- Participate in development of payment model

MCOs: payment model

- Advise on the development of the capitated per-member-per-month payment model
- Test payment model

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Evaluation Deliverables

- Clinical Outcomes Evaluation using data from clinical sites
  - Care and treatment indicators
  - Care coordination services
  - Patient and provider survey analysis
  - Monthly analysis and quality improvement discussions
  - Quarterly reporting
- Telemedicine Evaluation
  - Monthly tracking of mentoring services utilization
  - Quarterly reporting
- Cost of services
  - Quarterly analysis and reporting
- Quarterly reporting with DOHMH to CMS

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Payment Model Deliverables

- Explore payment models options
- Develop and finalize a payment model by Year 2
- Obtain input from providers
- Meet with payers every 6 months to review data and advise on payment model development
- Test payment model in Year 2 and 3

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Data Available for Outcome Analysis

- Surveillance data:
  - Identify patients for enrollment at clinical sites
  - Outcome evaluation
- Medicaid/Medicare data: DOHMH approved to receive identified Medicaid data from NYS and in the process of requesting Medicare data from CMS
  - Service utilization
  - Outcome evaluation
  - Cost analysis
- DOHMH Clinical data from sites:
  - Outcome evaluation

Progress to Date – Quarter One

- Project staffing at DOHMH almost complete and advancing at partner site
- Steering Committee formed and met once
- Contracts completed or in final stages
- Obtained all IRB approvals except one
- Data sharing agreements in final stages
- Surveillance database changed and negative RNA reporting under way
- Completed care coordination protocol and working on health promotion manual and training materials
- Began patient identification
- Variables list, databases and data collection set up

Quarter Two Milestones

- Steering Committee and Task Force meetings
- Finish hiring
- Staff training
- Finish evaluation and quality improvement plans
- Start patient enrollment
- Set up telemedicine protocols and systems
- Initiate telemedicine training for primary care physicians
- Initiate discussion of payment model design
- Finish hiring and contracting
- Start collecting patient data

Steering Committee – Role & Function

- Provide guidance on Project INSPIRE activities
  - Clinical expertise
  - Health care/insurance coverage policy
  - Community outreach
- Keep INSPIRE on track:
  - Ensure that milestones are met
  - Propose resolutions to conflicts
  - Guide corrective action
- Ensure that deliverables are achieving the goals
- Encourage collaboration and effective use of resources
- Ensure that final product is valuable and replicable for CMS

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Project INSPIRE Staff

- Senior Project Director/Medical Director: Fabienne Laraque
- Project Director: Marie Bresnahan
- Grant Administrator: Nicolette Gantt
- Monitoring and Evaluation Manager: Mary Ford
- Data and Training Coordinator: Payal Desai
- Program Assistant: Andrew Huang
- Surveillance data analysis: Emily McGibbon and Perminder Khosa

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Staffing (cont')

- In kind contributions:
  - Eric Rude, management and policy
  - Nirah Johnson: intervention development and training
  - Katie Bornschlegel: surveillance data expertise
  - Andrea King: Medicaid data expertise

QUESTIONS