RWPA Care Coordination Program & Hepatitis C

New York City Department of Health and Mental Hygiene, Bureau of HIV/AIDS, Care and Treatment Program ,
Quality Management and Technical Assistance Unit

NYC Health

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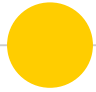
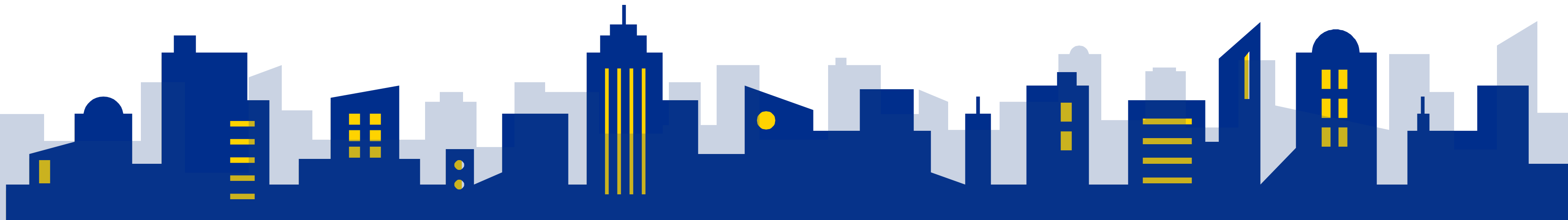


Hello!

We are Scarlett and Tye.

Quality Management Specialists



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Funded by Ryan White Part A

- Ryan White legislation was first enacted in 1990 as the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act
  - Legislation divided into several portions or parts
  - Care Coordination Program services are supported with Part A funding awarded to NY Eligible Metropolitan Areas (EMAs)
  - RWPA funding is allocated to other services that support engagement in care and is meant to close gaps in the service delivery system

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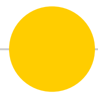

Goals of Care Coordination Program

- Address HIV healthcare disparities by facilitating access to care and other services
- Use a client-centered, holistic and comprehensive approach to meeting the needs of PLWH through team based care management
- Use patient navigation to identify, advocate for, and coordinate resources for PLWH to ensure improved outcomes
- Encourage and support PLWH to gain and maintain independence in accessing and using healthcare services

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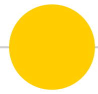

Care Coordination Program Eligibility Criteria

In addition to RWPA eligibility criteria

- Newly diagnosed with HIV
- Out of care
- Previously diagnosed but new to care OR previously diagnosed but inconsistently in care or at high risk of falling out of medical care or becoming unsuppressed or undergoing change in treatment regimen
- Virally unsuppressed
- Currently living with untreated Hep C & HIV
- New to HIV treatment
- HIV+ & pregnant

❖ Care Coordination programs are associated with clinics, so in order to enroll in a program, PLWH have to be – or become- patients of the clinic with which the program is associated.

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Patient Flow

Case finding
Reports from clinic panel
Inpatient or emergency departments
HIV testing

→

Introducing the program
Discussing program enrollment w/both patient & provider
Providing patient w/info they need to decide

→

Comprehensive assessment
Assessing patient's needs, strengths, etc.
Evaluating the patient's ability to manage their care
Case conferencing w/care team

↓

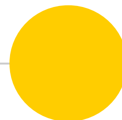
Initial service plan
Drawing from assessment, working w/patient to develop goals for their participation in the program, services to be provided, actions to be taken

→

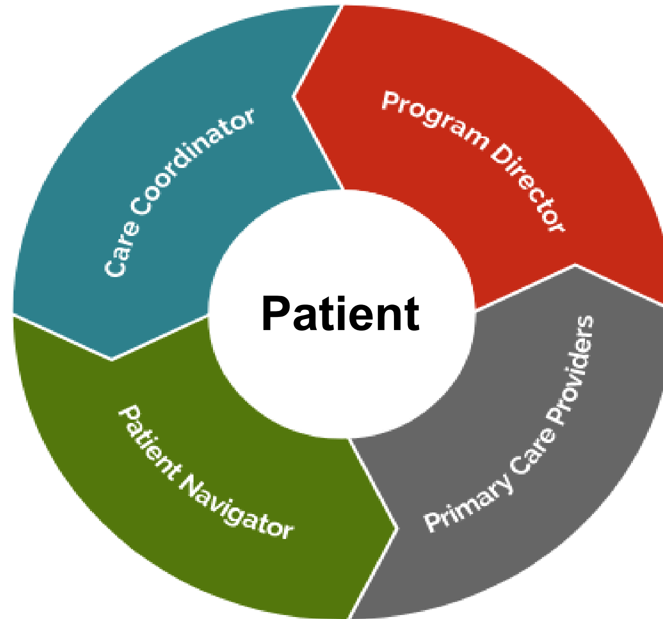
Every quarter
Health Education
Case conference
Self-management assessment (care team)
Home/field Visit
Service coordination

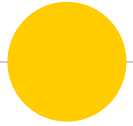
→

Every six months
Case conference
Self-management assessment (care team & patient)
Reassessment
Service plan update or case closure



The NYC Care Coordination Team





Program Services

relevant to Hepatitis C

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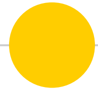

Health Education

- At least one session (individual or group) every 3 months:
- Goal setting
- Managing care
- Co-occurring conditions
- **Me and Hepatitis C**

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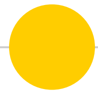

Modified Daily Observed Therapy (mDOT)

- mDOT is offered to patients prescribed antiretroviral therapy (ART) or medications to treat mental health problems, opportunistic infections, or **hepatitis C.**
- **face-to-face** mDOT (in the home, field, or clinic)
- **video** mDOT through video conferencing or mobile applications (as permitted by the organization's policies and procedures)

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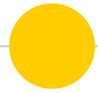

Modified Directly Observed Therapy (mDOT)

Must be offered to all patients who have difficulty maintaining adherence to prescribed medications on their own

Available for both ART & some non-ART medications:

- Opportunistic Infections (OIs)
- Psychotropic
- Hepatitis C (Hep C)

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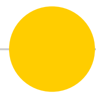
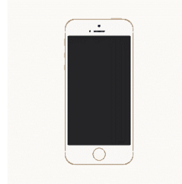


Modified Directly Observed Therapy (mDOT)

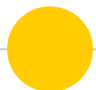
- Patient Navigators are primarily responsible for providing mDOT services.
- Licensed clinical staff may also provide mDOT.



F2F or video

ART, OI's, Hep C, psych

Clinic or field



When is mDOT offered?

- Patients should be offered mDOT
  - at enrollment to the program
  - when starting ART
  - changing ART medication regimens
  - starting medication regimens to treat mental illness, opportunistic infections, or hepatitis C.
- mDOT must occur at least 3 times a week, adjusting for patient need and preferences.

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Borough	Care Coordination program
Manhattan	APICHA
	Mount Sinai- Beth Israel Medical Center
	Betances Health Unit, Inc.
	Mount Sinai Medical Center
	Callen-Lorde Community Health Center
	New York Council on Adoptable Children
	The Institute for Family Health
	Mount Sinai-St. Luke's - Roosevelt Hospital
Bronx	Argus Community
	Bronx Care Hospital
	Bronx Parent Housing Network
	La Casa de Salud
	Morris Heights Health Center
	HHC Jacobi Medical Center (North Bronx Healthcare Network)
	Services for the Underserved
Brooklyn	Brooklyn Plaza Medical Center
	Joseph P. Addabo Family Health Center
	Housing Works
	HHC Kings County Hospital Center
	SUNY Downstate Medical Center and Brookdale Hospital- STAR Health Center
	Sunset Terrace - Lutheran Family Health Center
	Wyckoff Heights Medical Center
Queens	AIDS Center of Queens County (ACQC)
	HHC Elmhurst Hospital Center
Staten Island	Community Health Action of Staten Island (CHASI)

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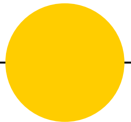
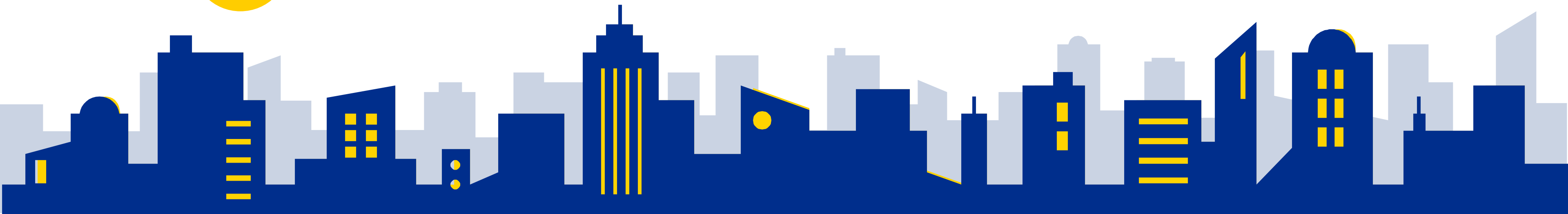
Q&A





Thanks!

Any questions ?

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