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HIV CARE & TREATMENT

Creating and Implementing a Protocol for RWPA-Providers to Assess and Build HIV Patients’ Self-Management Skills

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Content Overview

- NYC Ryan White Part A Care Coordination Program
- Development of Self-Management Assessment
- Self-Management Assessment Tools
- Implementation and Findings

NYC Ryan White Part A

Care Coordination Program

NYC RWPA Care Coordination

- Federal Ryan White Part A (RWPA) funds support medical and social services for low-income persons living with HIV (PLWH).
- The New York City Department of Health launched the RWPA-funded Care Coordination Program (CCP) in 2009. This medical case management program supports PLWH who face barriers to maintaining engagement in care, adhering to treatment, and achieving viral load suppression.

NYC RWPA Care Coordination

- Based in HIV clinics and in community-based organizations that have formal partnerships with HIV primary care providers
- The previous model provided comprehensive medical case management to PLWH who are:
  - newly diagnosed
  - lost to care or sporadically in care
  - new to care
  - new to treatment
  - struggling with ART adherence

NYC RWPA Care Coordination

Barriers to previous model:

- Limited eligibility criteria
- Rigid program tracks
- No videoconferencing
- Lack of self-management assessment tools

NYC RWPA Care Coordination

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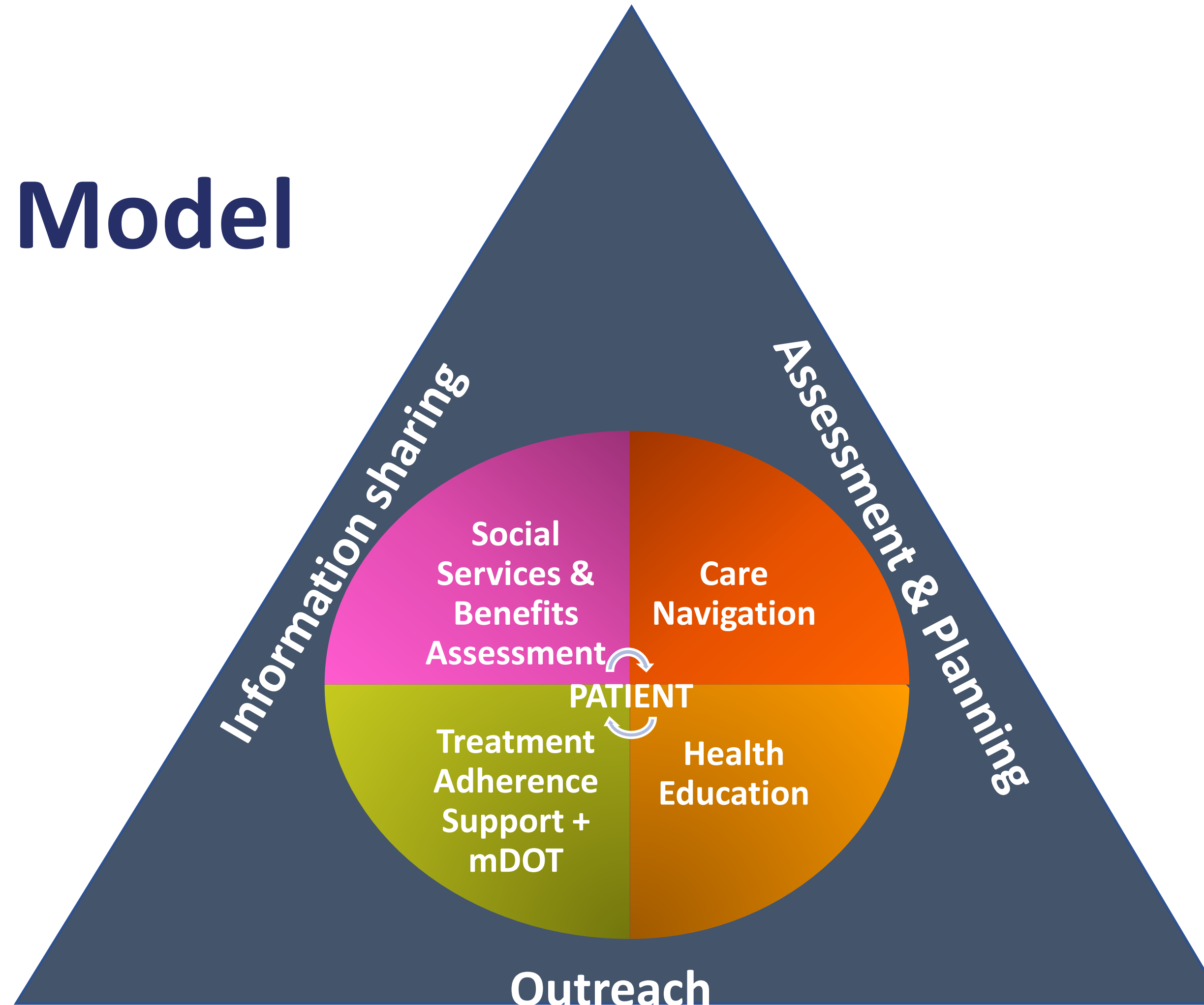
- In 2017 and 2018, the NYC Care Coordination program underwent a program model redesign to produce a more client-centered, team based, flexible model of coordination.

Revised Model

- More reach with eligibility requirements
  - newly diagnosed with HIV in past 12 months
  - lost to care or sporadically in care
  - previously diagnosed and new to care
  - new to treatment or undergoing change in treatment regimen
  - struggling with ART adherence
  - **virally unsuppressed at most recent viral load test within past 12 months**
  - **Currently living with hepatitis C and HIV**
  - **HIV+ and pregnant**
  - **At high risk for falling out of medical care or becoming unsuppressed**
- Videoconference use for service delivery
- Removal of rigid tracks
- Implementation of self-management assessment

Achieving Self-Management

The NYC Care Coordination Model



Development of Self-Management Assessment

Literature

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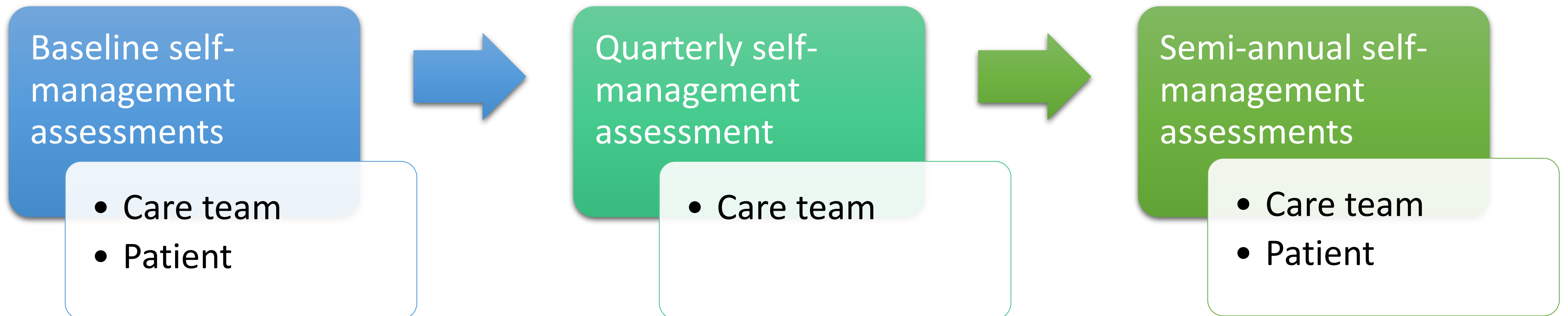
- H+H/Harlem Hospital Family Care Center presented their Transition Readiness Checklist at the annual quality improvement conference for RWPA providers in NYC.
  - Assess the self-management skills of HIV positive perinatally infected youth
  - Identify the health literacy and life skills necessary to navigate complex healthcare systems
- NYC Department of Health technical assistance (TA) staff reviewed validated psychometric assessments to determine the basic dimensions of self-management and how to assess skills with evaluation tools used in the United States and abroad.

Stakeholder Feedback and Cognitive Interviews

- The TA team held 2 meetings for RWPA-funded CCP providers to:
  - Identify specific aspects of self-management for their patients
  - Discuss potential questions on the tool and the assessment's frequency
  - Understand CCP staff needs in assessing and coaching self-management
- The TA team conducted 4 cognitive interviews with 3 HIV clinicians and 1 consumer providing valuable insights on refining the care team and patient facing questions.

Frequency of Self-management assessment

- Both assessments help to identify and highlight patient strengths and prioritize self-management goals and action steps in the service plan.



Self-Management Assessment Tools

Self-management Domains

- The care team assessment consists of 11 questions, while the patient consists of 10.
- Each assessment uses a 5-point Likert scale to answer questions within six domains:
  1. Medication Adherence and Management
  2. Communication with Care Team
  3. Appointment Management
  4. Maintaining Healthcare Coverage
  5. Side Effect Management
  6. Understanding Viral Load

❑ 1. Never	❑ 2. Rarely	❑ 3. Sometimes	❑ 4. Most of the time	❑ 5. Always	❑ N/A

Medication Adherence and Management

Patient

- ✓ I keep up with my HIV medications.
- ✓ I ask for medication refills before I run out.

Care Team

- ✓ Patient is adherent to HIV medications.
- ✓ Patient refills medication(s) before exhausting supply.

Communication with Care Team

Patient

- ✓ I feel comfortable telling health care providers about personal things, like substance use and sexual behavior.
- ✓ I share my medical history with my health care provider.
- ✓ I ask my health provider questions until I get the information I need.

Care Team

- ✓ Patient is willing to openly discuss personal things like substance use and sexual behavior with health care providers when asked.
- ✓ Patient accurately discusses recent medical history with providers.
- ✓ Patient asks questions about their health conditions.

Appointment Management

Patient

- ✓ I make appointments with my HIV doctor when I need to, for things like changes in symptoms, medication side effects, or new health concerns.
- ✓ I attend my medical appointments on my own.

Care Team

- ✓ For non-routine visits, patient makes their own appointments with medical providers as needed
- ✓ Patient attends medical appointments on their own.

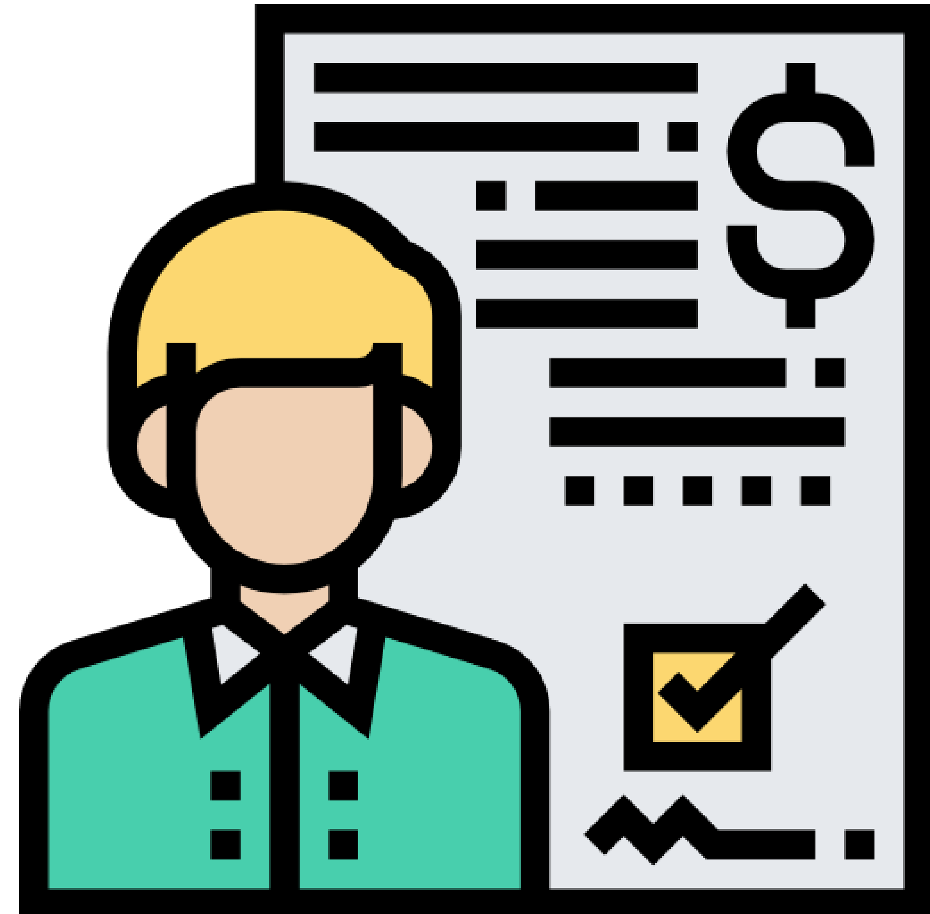
Maintaining Healthcare Coverage

Patient

- ✓ I keep my medical insurance active.

Care Team

- ✓ Patient keeps medical insurance active



Side Effect Management

Patient

- ✓ I understand how I can manage any side effects from my HIV medications.

Care Team

- ✓ Patient understands how to manage side effects of HIV

Understanding Viral Load

Patient

- ✓ I understand what changes in my viral load mean.

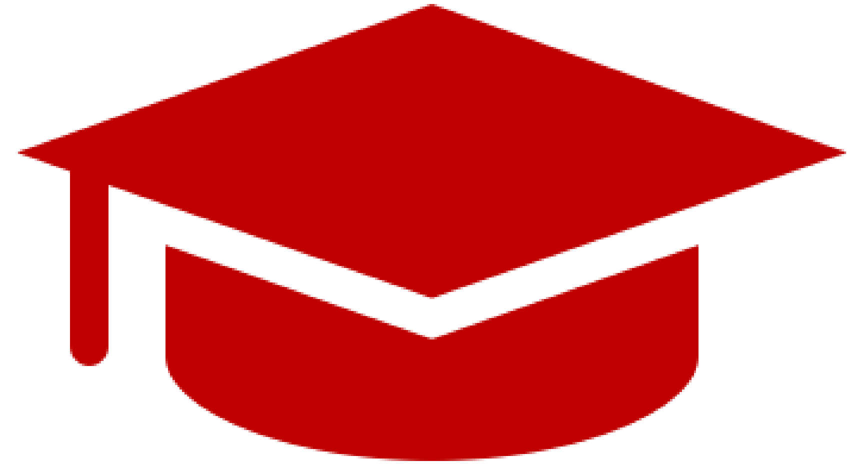
Care Team

- ✓ Patient knows last viral load.

Self-Management

Care Team

- ✓ Patient can manage their HIV on their own without the Care Coordination program.



Language Accessibility

- Self-management forms are available in various languages:
  - English
  - Spanish
  - Haitian-Creole
  - French

Implementation and Findings

Using the Self-Management Assessment

- Paper forms are available to providers to complete self-management assessment
  - Recent development of editable PDFs for remote access
- Patients can complete the form on their own or with assistance from the care team
- Care coordinators typically complete the care team assessment in collaboration with the care team
- After completion, data is reported into the NYC Health Department's secure web-based Electronic System for HIV/AIDS Reporting and Evaluation (eSHARE)

Staff Trainings

- Health Department trainers, including TA staff, review the new self-management assessment tools and protocol during updated CCP core trainings with providers, including a module on HIV self-management that focuses on:
  - Defining patient self-management and identifying components of self-management
  - Describing the rationale for using a self-management assessment
  - Facilitating conversations with patients about the self-management domains
  - Demonstrating how to use the self-management assessment tool

Programmatic Site Visit Findings

- Since 2018, QMTA has conducted 32 site visits
  - Care teams consistently rated patients' self-management skills lower than patients themselves did.
  - Some items on the assessment were difficult for patients to comprehend even after testing and revisions.
  - Some patients have difficulty with self-administration of the assessment due to literacy.
  - Results from self-management assessments improved patients' understanding of their strengths and challenges.
  - Results from self-management assessments contributed to the development of service plans and focused care management activities on building patients' capacity to manage their HIV care.

Conclusion

- Through the collaboratively developed CCP self-management protocol, care teams and patients have been able to systematically identify patient strengths and challenges, contribute to the development of patients' service plans, and develop patients' self-awareness about their capacity to manage their HIV care.
- Future developments

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30 YEARS

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