VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Alliance/Ryan Health Pilot Project: Care Management & Peer Navigation

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Pilot Project GOALS

1. Implement medical-community partnership between Ryan Health and Alliance for Positive Change that can result in increased patient engagement in medical care and treatment.
2. Integrate peer navigators into medical care management teams, in order to increase linkage to medical care and decrease missed appointment rates.
3. Utilize start-up funds from MS PPS to co-locate Alliance HH CM and Peers into Ryan Health clinic, and document outcomes.

Pilot Approach

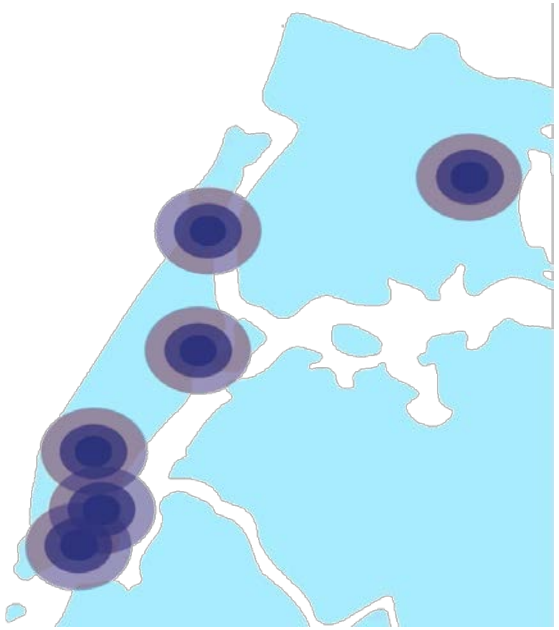
1. Leverage Alliance's capabilities to provide Peer Navigator services to find and engage hard to reach individuals (e.g., missed appointment follow-up, not virally suppressed, lost to care (> 6 mos.), or had 2 or more ED visits in the past year).
2. Utilize Ryan Health patient data system to generate lists of clinic patients who have missed appointments, 2 or more ED visits in the past year and/or fallen out of care, for targeted outreach and engagement.
3. Co-locate an Alliance Health Home Care Manager within Ryan Health to serve patients who have social determinants of health risk factors (e.g., substance use, mental health, ED visits or hospital admissions in the past 12 months).

Alliance for Positive Change

Alliance helps New Yorkers affected by HIV and other chronic illnesses make lasting positive changes towards health, housing, recovery, and self-sufficiency.

Each year, we help New Yorkers:

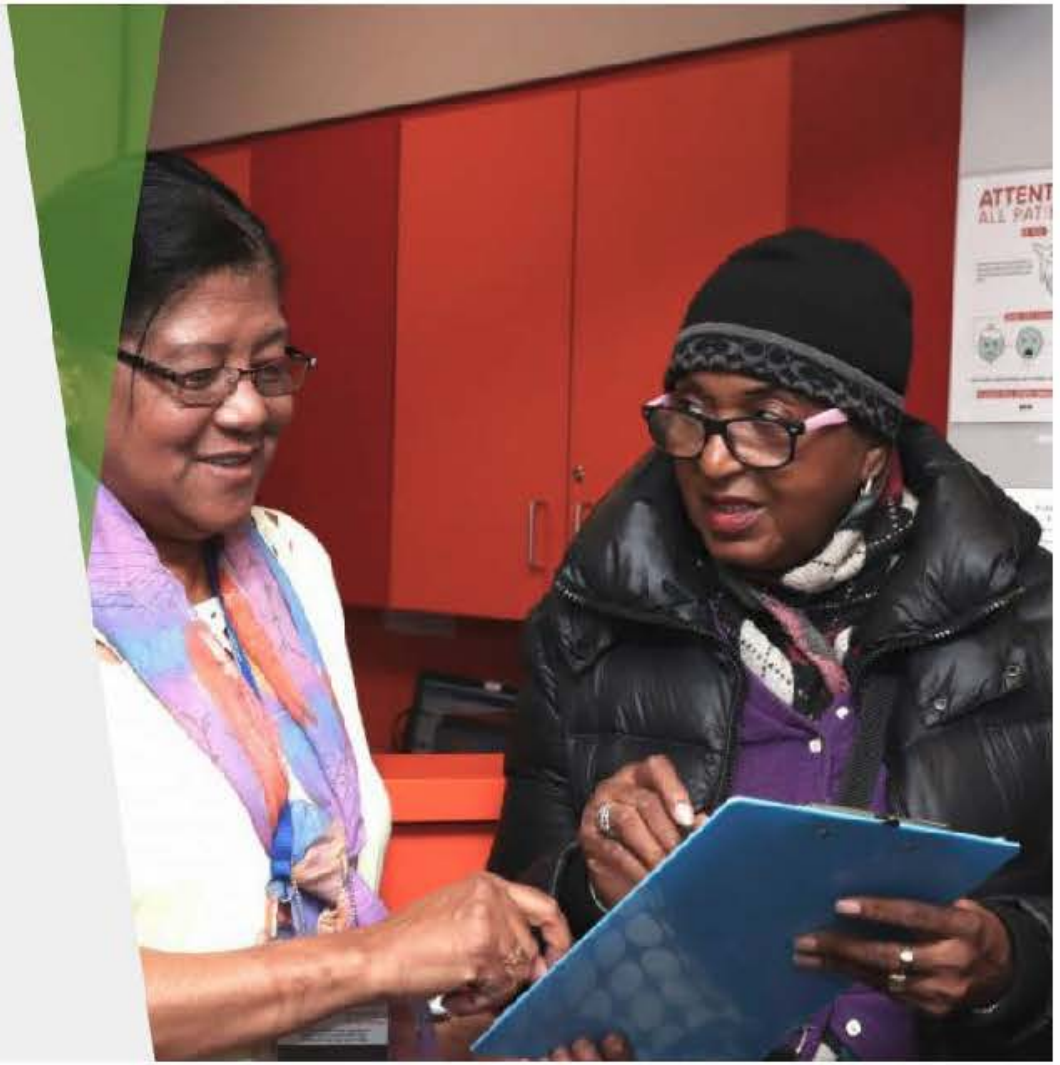
- Get tested for HIV
- Overcome addiction
- Access medical care
- Escape homelessness
- Rejoin the world of work
- Replace isolation with community
- And lead healthier and more self-sufficient lives.



The Alliance for Positive Change

Alliance's **individualized, full-service approach** gives each person the unique mix of support he or she needs to **feel better, live better, and do better**.

Ryan Health delivers exceptional primary care to our patients, as well as a range of services from women's health and pediatrics, to behavioral health, HIV care, and chronic disease management. Our Care Teams include doctors, physician assistants, nurse practitioners, medical assistants, nurses, health educators, and patient services representatives.

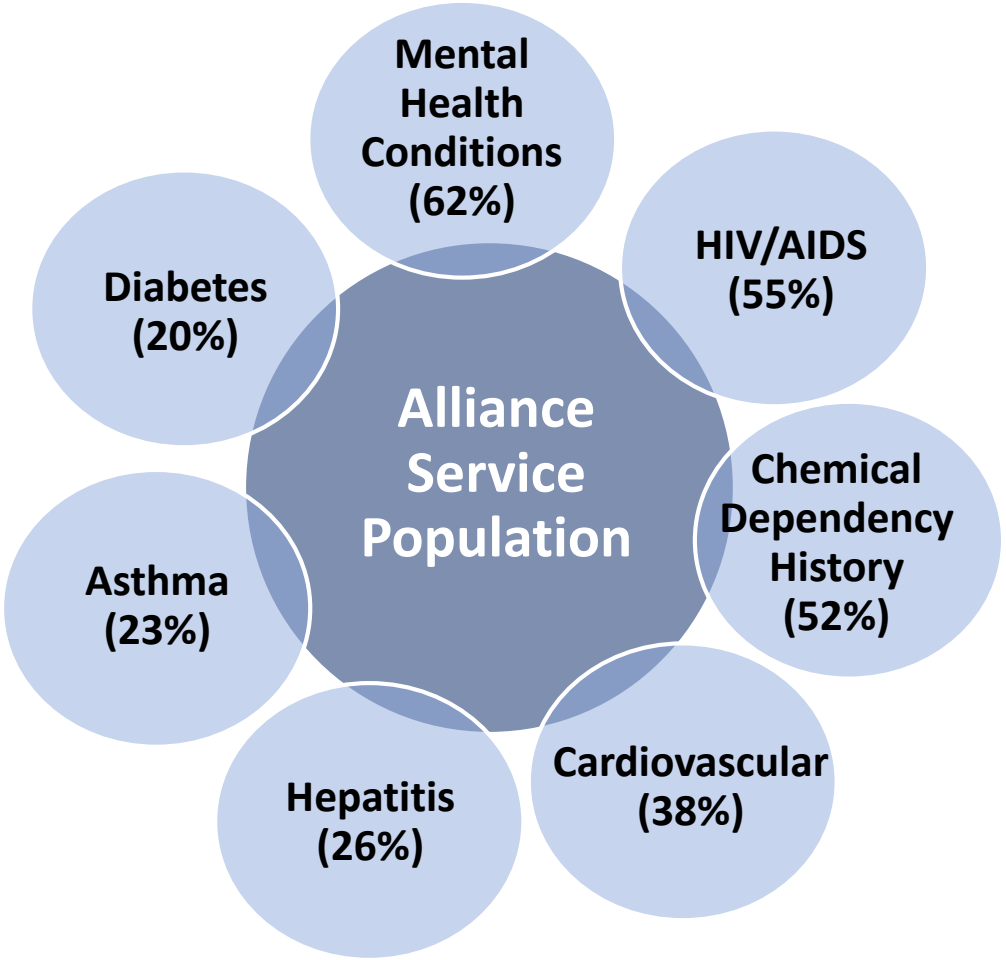


Alliance Service Population

Most clients have multiple chronic illnesses.

We address Social Determinants of Health to enhance access to needed care and support:

- **Housing:** unsafe, unstable, threats of eviction, rent arrears, needed repairs
- **Mental Health / Substance Use:** depression, anxiety, addiction
- **Food Insecurity**
- **Entitlements:** undocumented, Medicaid reactivation, spend-downs



Co-Location of HH Care Managers in Medical Clinics

Co-locate Community Care Manager into medical clinic to address social determinants of health and retain patients in care by providing medical and behavioral health navigation, treatment adherence support, transportation assistance, and linkage to other community based support care.

Co-located Care Management Services

- Coordinate medical care appointments
- Collaborate with care team
  - Attend daily huddles
  - Discuss cases with nurse care manager
  - Participate in interdisciplinary case conferences
- Service plan development
- Social determinants of health screening
- Connect clients to wrap-around services
- Provide HCBS education for HARP clients & connect to services

Photo: David Nager/Alliance

Benefits of Peer Navigation

Each Alliance Health Home Care Manager has a **dedicated Peer Navigator** to provide the **"feet on the ground"** for the patients. Together, the HH Care Manager and Peer Navigators help patients work through any barriers that might prevent her/him from seeing their doctor or other medical care professional.

Photo: David Nager/ASCNYC

Role of Alliance Peer Navigators

- Shared Lived Experience:
  - Culturally
  - Linguistically
  - Socially
  - Economically
- Reduce Barriers to Care
- Foster Trust
- Promote Long-term Engagement
- Guide Patients Toward Health and Stability

Photo: David Nager/Alliance

Role of Alliance Peer Navigators

Engagement:

- Peer coaching and motivational interviewing
- Reminder calls and accompaniment to clinic and specialty appointments
- Conduct home visits and community field work
- Complete environmental assessment
- Address social determinants of health
- Enroll in HH care management and provide “warm hand-off”

Photo: David Nager/Alliance

Identification of High Need Patients

Medical clinic generates list of patients who had at least 2 ED visits in the past year, have missed appointments and/or fallen out of care, for targeted outreach and engagement:

- Utilize Peer Navigators to re-engage Ryan Health patients
- Link patients to Health Home Care Management
- Link patients to Treatment Adherence Services
- Ensure patients reach “Alignment” with medical provider (2 or more consecutive visits in 6 month period)
- Participation in case conferencing as members of patient care team
- Contributions to service plan development

Photo: David Nager/Alliance

Co-Location Works!

Co-location of CBO care management within the medical setting provides:

- Real time data exchange
- On-site case conferencing between care managers and medical providers
- Fast track access to medical appointments
- Resources to address social determinants of health
- Intensive field-based outreach to clients lost to care
- Connect clients to wrap-around services
- Provide HCBS education for HARP clients & connect to services

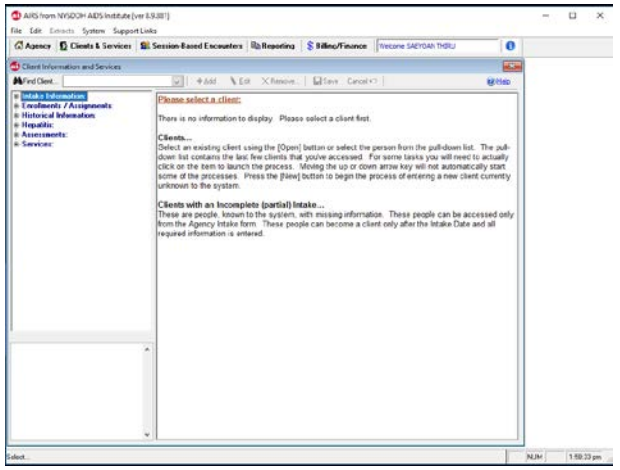


Photo: David Nager/Alliance

Impacts: Pilot Project February – June 2019

HH Enrollment:

- 90% conversion from clinic patient outreach to HH enrollment
- HH CM caseload from 0 to 31 in 5 months;
- HHCM Caseload 55 Ryan Health patients as of 10/31/19 and continues today

Follow-Up on Missed Appointments

- 43% "find/re-engage" rate (45 of 104 patients)
- Average of 4 outreach encounters per person to achieve re-engagement
- Appointment reminders via texting app; peer accompaniment; transportation assistance and coordination

Staffing Pattern

- One HH CM, Two Peer Navigators, plus Supervisor (inkind) @ Ryan and Alliance

Photo: David Nager/Alliance

Impacts: Pilot Project Present Day

HH Enrollment:

- HHCM Caseload 50-60 Ryan Health patients continues
- Population Trends: >65yo, disabled or geriatric with multiple Chronic Conditions, predominantly Spanish-speaking living in Upper Manhattan or in the Bronx
- Staffing: One HH CM, One Peer Navigator Intern

Successes and Current Trends

- 98% of currently enrolled patients have had at least 2 PCP appointments in the past 12 months (53 of 54 patients, June 2020)
- 100% of currently enrolled patients are consistently engaged with the care management team ongoing every month
- HHCM continues to coordinate and schedule ongoing non-emergency Medicaid medical transportation for patients with immediate approval to improve appointment adherence

Photo: David Nager/Alliance

Impacts: Pilot Project Present Day

Successes and Current Trends

- HHCM reduces Emergency Room/Hospital Visits in patients by promoting urgent care and same day visits at the Ryan Center when needed
- HHCM advocates for Durable Medical Equipment (DME) for patients via Parachute Health; Patients receive DME orders as early as same-day or next day
- Out of 31 patients in the first 6 months, 9 patients had a cumulative total of 14 ED Visits
- One year later, the caseload almost doubled to 55+ patients, and ***only 2 of the original 9 patients had ED Visits***.
- Additionally, with almost double the # of patients, ED visits remained constant at 14 over the past year

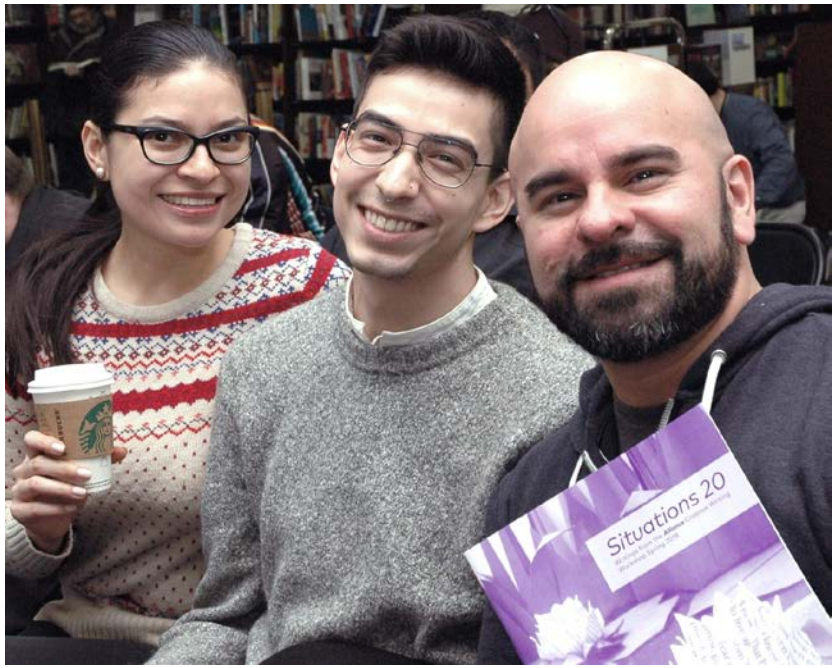
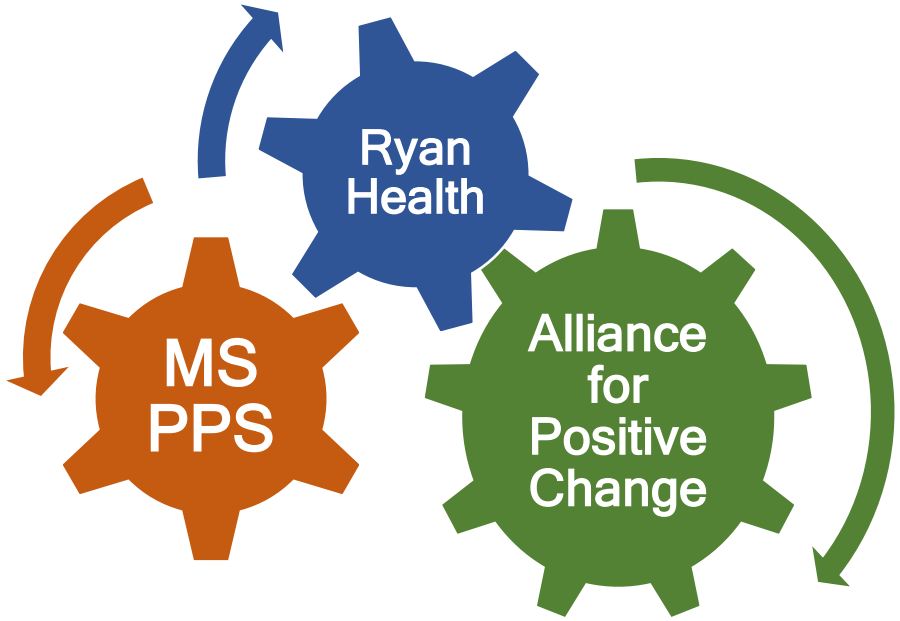


Photo: David Nager/Alliance

Collaboration In Action



- Partnership weekly planning calls to develop the evaluation and refine program protocols, attended by stake holders from each program
- Cooperation around data points and reporting metrics
- Teamwork in ensuring all data teams are trained to properly document and utilize each data system

THANK YOU!!!

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The Alliance for Positive Change