Challenges to Caseload Management in Ryan White Part A funded NYC Care Coordination Programs

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Hello!

I am *Scarlett Macias*

Quality Management Specialist
Agenda

◉ Welcome
◉ Workshop objectives
◉ NYC DOHMH Ryan White Part A programs
◉ Care Coordination Program (CCP) Model
◉ The CCP Learning Collaborative Caseload Manageability Project
◉ Caseload Manageability Activity
◉ Learning Collaborative Outcomes
◉ Lessons Learned
Learning Objectives

1. Describe RWPA-funded Care Coordination programs in the NYEMA and provider led Learning Collaborative.
2. Describe root causes for unmanageable caseloads in high intensity HIV medical case management programs.
3. Identify barriers to caseload manageability.
4. Outline potential solutions to caseload unmanageability.
5. Rank potential solutions to caseload unmanageability by level of impact and effort.
What is Ryan White Funding?

- 28 years of Ryan White HIV/AIDS Program
- Provides a comprehensive system of care for PLWH who are underinsured
<table>
<thead>
<tr>
<th>Region</th>
<th>Population</th>
<th>HIV Diagnoses*</th>
<th>PLWH</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York City</td>
<td>8,537,673</td>
<td>2,279</td>
<td>123,877</td>
</tr>
<tr>
<td>Brooklyn (Kings County)</td>
<td>2,629,150</td>
<td>581</td>
<td>29,803</td>
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<tr>
<td>Bronx</td>
<td>1,455,720</td>
<td>520</td>
<td>29,803</td>
</tr>
<tr>
<td>Manhattan (New York)</td>
<td>1,643,734</td>
<td>468</td>
<td>32,476</td>
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<tr>
<td>Queens</td>
<td>2,333,054</td>
<td>415</td>
<td>18,307</td>
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<tr>
<td>Staten Island (Richmond)</td>
<td>476,015</td>
<td>61</td>
<td>2,398</td>
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<tr>
<td>Tri-County Region</td>
<td>1,400,222</td>
<td>122</td>
<td>4,023</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>9,937,895</strong></td>
<td><strong>2,401</strong></td>
<td><strong>127,910</strong></td>
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</tbody>
</table>

Sources: Population estimates: U.S. Census Bureau, American Fact Finder: Quick Facts –2016; New York, Kings, Queens, Bronx, and Richmond counties (NYC): NYC DOHMH, HIV Epidemiology and Field Services Program, data as of March 31, 2017; Putnam, Rockland, and Westchester counties: NYS Department of Health (NYS DOH), Bureau of HIV/AIDS Epidemiology, data as of September 3, 2017. *HIV diagnoses include those who were concurrently diagnosed with HIV and AIDS.
New York EMA -based HIV Care Continuum, 2016

HIV-diagnosed: 100%
Linked to Care: 86% of newly diagnosed
Retained in Care: 67% of all diagnosed
Prescribed ART: 86% of all diagnosed
Virally Suppressed: 70% of all diagnosed

Sources: Prescribed ART: NYC DOHMH, Medical Monitoring Project (MMP), 2016; All other: NYS DOH, Bureau of HIV/AIDS Epidemiology, data as of September 3, 2017.
Notes: "HIV-diagnosed" includes those diagnosed by 12/31/2015 and living and residing in NYC or the Tri-County region as of 12/31/2016; “Linked to care” includes those who were newly diagnosed with HIV in 2016 with one or more viral load or CD4 count within 91 days of diagnosis; “Retained in care” includes those among the HIV-diagnosed with at least two VL or CD4 counts in 2016 that were at least 91 days apart; “Prescribed ART” is defined as the proportion of NYC MMP participants who reported ART use during the 12 months prior to MMP interview date (interview date range June 3, 2015 - April 27, 2016); “Virally suppressed” includes those among the HIV-diagnosed whose most recent viral load in the year was <200 copies/mL.
NY EMA Ryan White Part - A programs

Who do we serve?
NY EMA RWPA Program by the numbers, 2017

15,378 Active HIV+ Clients in Ryan White Part A Services

- 91% Persons of color
- 70% Medicaid
- 35% Latinx
- 51% Age >50
- 53% Black
- 7% Uninsured
- 68% Male
- 5% Homeless or Unstably housed

Data retrieved from the New York City Ryan White Part A (Base and MAI) Annual Enrollment Report: March 2016-February 2017—Active HIV Positive Clients
Active Clients in Care Coordination, 2017

3948

Active Care Coordination Clients

26%

Of RWPA Active Clients

Data retrieved from the New York City Ryan White Part A (Base and MAI) Annual Enrollment Report: March 2016-February 2017—Active HIV Positive Clients
Care Coordination Program Model
The NYC Care Coordination Model

Information sharing

Social Services and Benefits Assessment

Care Navigation

DOT including Treatment Adherence

Health Promotion

Outreach
Service Delivery Tracks

Clients may change tracks within the model based on their needs.
The Care Team

Clinic Based
Vs
Community Based Organizations (CBO)
Vs
Hospitals

- 5 Clinic Based
- 6 CBOs
- 15 Hospitals
- 26 total programs
Care Coordination Program

Eligibility

Meet at least one of the following criteria:

◉ Newly diagnosed with HIV
◉ Out of care
◉ Previously diagnosed but new to care OR inconsistently in care
◉ Currently living with untreated Hepatitis C and HIV
◉ New to HIV treatment
◉ HIV+ and pregnant
The CCP Learning Collaborative

Caseload Manageability Project
What is the Care Coordination learning collaborative?

- Quality Improvement group
- 14 programs in the group
- Past projects:
  - Increasing DOT enrollment
- Current project:
  - Developing Quality Indicators for new iteration of the model
How do we find the root causes of a problem?

Collect Data

Define Problem

Identify factors

Root Cause
What are the top 3 reasons your caseload is unmanageable?

- Clients in crisis: 47.5%
- Progress notes: 63.9%
- Recording services in eSHARE: 21.3%
- Short staffed: 36.1%
- Too many clients in caseload: 26.2%
- Too many DOT clients: 13.1%
- Too many weekly clients: 42.6%
- Too many monthly clients: 1.6%
If there are other reasons that are not listed…

![Bar chart showing various reasons for assistance](chart.png)

- Assistance with: 6.7%
- Case mix: 11.1%
- Paperwork: 33.3%
- Support: 8.9%
- Time Management: 17.8%
- Transiency: 8.9%
- Travel: 13.3%
Getting at the Root Causes

❐ Define the Problem
  ○ Shared Challenges + Provider Brainstorm

❐ Collect Data
  ○ Survey Frontline Staff

❐ Identify Possible Factors
  ○ Survey results +
  ○ 5 whys to help identify causal factors
Root cause analysis: Fishbone Diagram

Health Care Environment
- Navigating Insurance
- Office & Fieldwork Balance
- Progress Notes
- eSHARE
- Forms
- Documentation Requirements

Client Need
- Crisis
- Medically Complex

Agency Structure
- Provider support
- Co-located vs. non Co-located
- Resources/referral services

Case Mix Distribution
- Travel time between clients

Model
- Expectations of Staff
- Care Coordinator Support
- CBO vs. Hospital vs. Clinic-based issues

Staffing
- Time management Skills
- Clinical Supervision Skills
- Training and education requirements

Problem:
- Caseload
- Unmanageability

GOAL: Caseload Manageability
Caseload Manageability Activity

On Root Cause Analysis
Brainstorming the Root Cause

1. Each sticker is assigned a problem area
   ○ Let’s get into our groups!
2. Brainstorm root causes by filling out the 3 whys worksheet
3. Discuss with the group

= Documentation
= Agency structure
= Staffing
= Client need
1. Brainstorm potential solutions with your group
2. List potential solutions on 2\textsuperscript{nd} worksheet in the left-hand box
3. Discuss with the group
Prioritizing Solutions

1. In your groups, use the prioritization grid handouts to identify the impact and effort levels for all your potential solutions

2. Discuss with the group
5

The CCP Learning Collaborative Project Outcomes

Caseload Manageability Project
Identifying and Prioritizing Potential Solutions

Frontline Staff Survey

Provider Brainstorm

Solution prioritization
What are some strategies you’ve developed to manage your own workload?
Prioritizing Potential Solutions

- DOHMH facilitated workgroup for frontline staff
- Forms Review and Feedback
- Time Management Toolkit

Model Revisions
- Less/Simplified Required Forms
- Data Entry Staff Required in contracts

- Periodic Newsletter to share ideas, problems, and solutions
### Services Tracking

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<tr>
<th>Client</th>
<th>Track</th>
<th>Dual</th>
<th>Enrolled</th>
<th>Frequency</th>
<th>Second to Last Face to Face</th>
<th>Last Face to Face Encounter</th>
<th>Last Face to Face Service</th>
<th>Next Face to Face</th>
<th>First Outreach</th>
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<tr>
<td>John</td>
<td>C2</td>
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<td></td>
<td>weekly</td>
<td>5/18/2018 Informal Case Conference</td>
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<td>5/25/2018</td>
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<td>Ann</td>
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<td>4/1/2017 Assistance with Benefits, Informal Case Conference</td>
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### Forms Tracking

<table>
<thead>
<tr>
<th>Client</th>
<th>Last Case Conference</th>
<th>Next Case Conference</th>
<th>Last Care Plan</th>
<th>Next Care Plan</th>
<th>Last Reassessment</th>
<th>Next Reassessment</th>
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<td>TO</td>
<td>Miles</td>
<td>Time</td>
<td>Directions</td>
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<td>-----------------------------------------------------------------------------</td>
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| argus community   | NYC DOHMH           | 7.7   | 00:44  | Walk to 3 Av - 149 St - 0.4 mi  
Subway towards Flatbush Av - Brooklyn College - 5.0 mi  
Walk to Lexington Av/59 St - 0.2 mi  
Subway towards Forest Hills - 71 Av - 2.0 mi  
Walk to 42-09 28th St, Long Island City, NY 11101, USA - 0.1 mi |
| HHC Bellevue      | NYC DOHMH           |       | 00:38  | Walk to 23 Street Station - 0.8 mi  
Subway towards Forest Hills - 71 Av - 4.5 mi  
Walk to 42-09 28th St, Long Island City, NY 11101, USA - 0.1 mi |
| housing works     | NYC DOHMH           | 5.6   | 00:27  | Walk to Prince St Station - 0.1 mi  
Subway towards Astoria - Ditmars Blvd - 5.4 mi  
Walk to 42-09 28th St, Long Island City, NY 11101, USA - 0.1 mi |
| NYC DOHMH         | Unique People Services | 14.8  | 00:48  | Walk to Queensboro Plaza - 0.1 mi  
Subway towards 34 St - 11 Av - 2.5 mi  
Walk to Grand Central Terminal - 0.2 mi  
Train towards Crestwood - 11.7 mi  
Walk to 4234 Vireo Ave, Bronx, NY 10470, USA - 0.2 mi |
PDSA: Improving the Time Management Toolkit

Helpful aspects of the tool:
- Transportation planning
- Color coding
- Forms tracking can be helpful for both frontline staff roles
- May be a helpful supervision tool

Aspects to consider and/or improve:
- Initial data entry is time consuming
- May be difficult for less excel savvy staff
- Tool may not stay updated in the field
- May be better for new staff

Changes made:
- Pop-up instructional guide on using sheets
- Password-locked formulas across sheets
- Face-to-face visit calculator on separate sheet so staff can choose parts of the tool that suit their style best
5 Lessons learned

What are your takeaways?
DOHMH Lessons Learned

- Greater understanding and acknowledgement of the challenges around managing caseloads in HIV programs
- Findings inform service delivery and program model requirements
- Deliberate decisions in redesigning the care coordination program to address identified root causes
Thanks!

Any questions?

You can find me at
- Scarlett Macias, smacias@health.nyc.gov
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