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

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Credit and Disclaimer

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