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Integrated Service Model: Addressing HIV Disparities within Latino community

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Learning Objectives

- Learn ways to implement two coordinated models of care in a health care setting that targets underserved communities living with HIV.
- Demonstrate how culturally appropriate psychosocial, risk reduction, ART compliance and medical interventions, adaptable processes, and a multi-disciplinary approach are effective strategies to improve health outcomes of persons living with HIV living with multiple life stressors.
- Discuss the challenges identified in dealing with underserved and marginalized populations.

Introduction

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AltaMed has delivered quality care to the underserved communities of Southern California for more than 40 years. Designated by the Joint Commission as a Primary Care Medical Home (PCMH), AltaMed prides itself in the quality of its care delivered by its premier health care professionals. AltaMed serves the entire family with:

1) Primary medical care
2) Dental clinics
3) Specialty HIV/AIDS care for over 20 years
4) Senior long-term care services
5) Delivers disease management programs
6) Health education
7) Youth services,
8) Substance abuse treatment

3

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5 HIV Treatment Sites

Los Angeles & Orange County
1,700 HIV positive clients

2009 Opt-out HIV screening

2011 Systemize routine HIV testing in all clinics
Screen all persons 13-64

1986

Founded with Substance Abuse Treatment

Expanded Care now includes
- Medical & Oral Health
- Psychosocial Services
- Prevention Services

HIV Testing

Over 5,000 HIV targeted tests annually
Over 30,000 Opt out HIV tests annually
- Over 70 HIV+ persons identified annually

Presented by AltaMed

National HIV/AIDS Strategy

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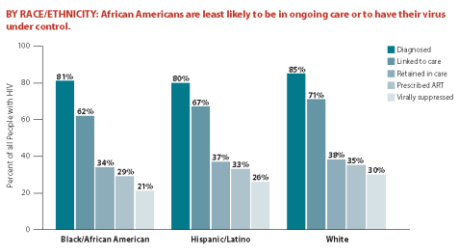
A NATIONAL HIV/AIDS STRATEGY FOR THE UNITED STATES
JULY 2010

Three Primary Goals

1. Reduce New HIV Infections
2. Increase Access to Care and Improve Health Outcomes for People Living with HIV
3. Reduce HIV-Related Disparities and Health Inequities

The Gardner Cascade



Hall, HI, Frazier EL, Rhodes P, et al. Differences in Human Immunodeficiency Virus Care and Treatment Among Subpopulations in the United States. *JAMA Intern Med*. 2013:1-7. DOI:10.1001/jamainternmed.2013.6841.

6

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Why Integrated Care Models Matter

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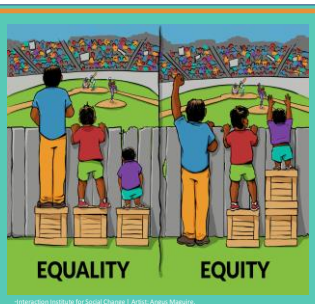
Centers for Disease Control and Prevention
(July 2012)

Released the Stages of Care, a comprehensive analysis showing that only 25% of the 1.1 million Americans living with HIV have their virus under control



·Interaction Institute for Social Change | Artist: Angus Maguire.

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AltaMed Specialty Services

Medical	Psychosocial Support Services	Prevention Services
Medical Outpatient	Mental Health	HIV Counseling & Testing
Oral Health	Case Management •Benefits Specialty •Youth TCM •Medical Care Coordination •LIFE program	Linkage to Care
Treatment Education		PreP
Pharmacy	Dietitian	Healthy Relationships
Hep C Treatment	Psychiatry Referrals	Popular Opinion Leader
STD Testing & Treatment		

Coordinated Case Management Models within the HIV Setting

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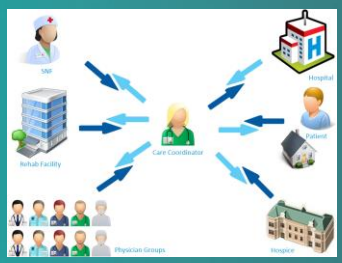
MCC
Medical Care Coordination

L.I.F.E. Program
Living Independently Feeling Empowered



What is MCC?

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Medical Care Coordination (MCC) **is a multi-disciplinary team approach that integrates medical and non-medical case management by coordinating behavioral interventions and support services with medical care to promote improved health outcomes."(DHSP, 2013)**

Core MCC team comprised of: **Medical Care Manager** (MCM)- RN **Patient Care Manager** (PCM)- Masters-Level MentalHealth Clinician **Case Worker** (CW)- Bachelors-Level case worker or LVN	MCC team embedded within HIV medical clinic setting - Greater access to PCP - Compliments existing suite of HIV services	MCC is a **Behavioral Intervention**. Biomedical Goal Overall goal of MCC is biomedical in nature Behavior Change Cannot achieve biomedical goal without behavior change

MCC Program Goals

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Streamline care coordination to improve HIV+ patients':

- Access to medical care
- Adherence to care and treatment
- Health outcomes (viral suppression)
- Empower patients to self-manage care and reduce dependence on care system
- Reduce HIV transmission

Integrative Approach

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- Traditional case management elements, disease management and integrated care
- Coordination of services: Comprehensive Assessment with integration of medical and ancillary, supportive services
- Holistic: Biological, Psychological and social needs
- Treatment adherence and health outcomes focus coordinating medical and ancillary services along with behavioral interventions (Soto, Bell, & Pillen, 2004)

MCC Team

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Team Lead

Medical Care Manager
- Registered Nurse (CA)
- Ensures patient's biomedical needs are met
- Care is coordinated across levels of care including co-morbidties
- Brief interventions on patient education, Tx adherence and side-effects, preventative care and risk reduction

Patient Care Manager
- Masters-Level Mental Health Clinician(MSW, LCSW, MA/MS Clinical/Counseling Psychology, MFT-LLMFT)
- Comprehensive and thorough assessment of patient's psychosocial needs related to mental health needs and substance use
- Brief behavioral interventions focused on substance use/abuse, mental health needs, risk reduction, partner notification
- Coordinate mental health services across levels of care
- Assess and/or rule out crisis
- Not traditional psych

Case Worker
- Bachelor's degree preferred BSN, BSW, BA/BS in Psychology, Human Services and/or LVN
- Assists patient with socioeconomic needs
- Linkages to other social/human services
- Patient screening, monitoring, reassessment and tracking program outcomes
- Works closely with various points of entry to identify MCC eligible patients

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Patient Demographics

Overall Age Range in HIV Care

4%	Ages 13-24
45%	Ages 25-44
47%	Ages 45-64
4%	Ages 65+

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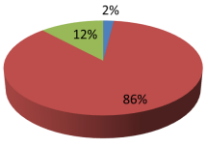
Patient Demographics

Overall Gender Breakdown in HIV Care



86%	Male
12%	Female
2%	Transgender

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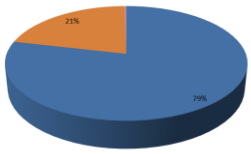
Patient Demographics

Overall Ethnicity Breakdown in HIV Care



79%	Latino or Hispanic
21%	Not Latino or Hispanic

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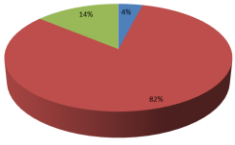
MCC Specific Patient Demographics

MCC Specific Gender Breakdown



82%	Male
14%	Female
4%	Transgender

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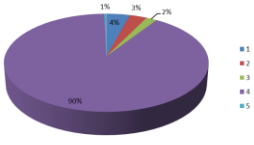
MCC Specific Patient Demographics

MCC Specific Race/Ethnicity Breakdown



1%	Native Hawaiian Other PI
2%	Asian
3%	Black/African American
4%	White
90%	Latino

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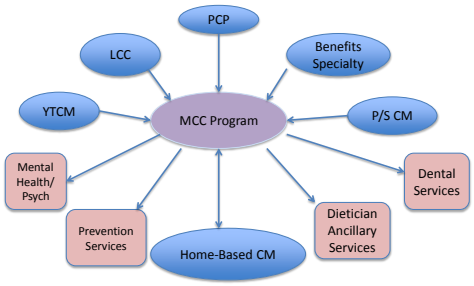
Seamless Suite of Services



Objectives of MCC Program

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1. Support patients in adhering to medical care and antiretroviral therapy (ART)
2. Promote sexual risk reduction
3. Facilitate access and linkage to appropriate services in the continuum of care
4. Increase patient self-efficacy by reducing acuity level
5. Eliminate duplication of services by integrating medical and non-medical case management for HIV-positive patients
6. Increase coordination among providers

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Eligible Patients enrolled in Active MCC

- Recently diagnosed with HIV (in the past 6 months)
- Fallen out of HIV care (no HIV medical appointments in the past 7 months or more)
- Not on antiretroviral therapy (ART) but meet current clinical guidelines for treatment
- Currently on ART and have detectible viral load (greater than 200 copies/mL)
- Have multiple medical and/or psychosocial co-morbidities that negatively affect health status
- Incarcerated within the last 6 months
- Recently diagnosed with other STI in the past 6 months
- PCP referral

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Components of the MCC Program

Screening
- Every 6 months
- Identify patient's eligible to be enrolled as active MCC

Assessment/reassessment
- Across 12 domains, calculating acuity level
- At varying time intervals dependent on acuity level

Integrated Care Plan (ICP)
- Patient-centered goals and objectives
- At varying time intervals dependent on acuity level

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Components of the MCC Program

Brief Interventions
- In alignment with ICP goals and objectives
- At varying time intervals dependent on acuity level

Follow-up Communication
- In support of ICP goals and objectives
- At varying time intervals dependent on acuity level

Case Consultation
- Among MCC team
- Among multidisciplinary clinic staff

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Components of the MCC Program

Provide referrals both inter and intra agency and verify successful linkages

Successfully transition to lower acuity level

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GETTING STARTED

- Work flow
- Protocol implementation
  - Identify
  - Refer
  - Screen
  - Assess
  - ICP
  - Case conference
  - F/u & interventions

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IDENTIFY

UTILIZATION OF EXISTING SYSTEMS

- New patient tracker
- Linkage to care
- Benefits specialists
- MD

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WHO REFERS TO MCC?

- MD
- Benefits Workers
- Linkage to Care Coordinator

(DHSP, 2013)

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REFERRAL

How?

- EHR Task
  Referral sent through EHR to MCC team
- MTM
  Existing bi-weekly multidisciplinary team meetings
  Co-located

(DHSP, 2013)

MCC Program Elements

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SCREEN
- MCC Case Worker
  - Screens patient
  - Contacts patient to schedule 'screener appointment'
  - Introduces MCC program to patient
  - Formal screener in Case Watch
  - Eligible clients who accept services scheduled for assessment within 30 days

ENROLL
- PCM AND MCM
  - Review reason for referral with patient
  - Enroll patient
    - MCC members are part of existing medical team- not separate entity.
    - "Sets clock"
  - Patients who opt-out are registered as self-managed and **re-screened in 6 months**.

ASSESSMENT
- Conducted by MCM or PCM
  - Assessment Broken into 12 Areas/Domains
  - Allowing for open conversation

29

Assessment Domains

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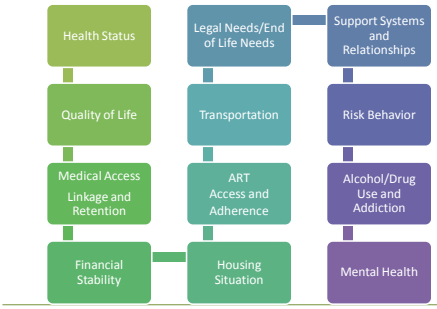

30

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Acuity-Driven Service Intensity

MCC SERVICE ACTIVITY (MINIMUM)						
ACUITY LEVEL	Registration/ Screening	Re-Assessment	ICP	Brief Interventions	Ongoing Follow-Up	Case Conference
Severe	Every 6 months	Every 30 days	Every 30 days	Weekly	Weekly	Monthly
High	Every 6 months	Every 90 days	Every 90 days	Monthly	Monthly	Quarterly
Moderate	Every 6 months	Every 6 months	Every 6 months	Every 90 days	Monthly	Every 6 months
Self-managed	Every 6 months	n/a	n/a	Referrals as needed	As needed	n/a

(DHSP, 2013)

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Transition To Reduced Acuity Level

Re-assessment 3-6 months based on acuity

- Severe
- High
- Moderate
- Self-Managed

(DHSP, 2013)

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Integrated Care Plan

Plan created with patient to create overall health goal and objectives to help achieve that goal.

Identifies behaviors a patient is willing to change- steps to change that behavior.

(DHSP, 2013)

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Challenges To MCC Addressed Within ICP

Drug use
Co-morbid conditions
Homelessness
Mental illness
Work related challenges
Undocumented population

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ICP

- Within 2 weeks of assessment completion
- Outlines objectives and necessary steps for behavior change
- SMART objectives
  - Specific
  - Measurable
  - Achievable/Attainable
  - Relevant
  - Timely

(DHSP, 2013)

INTEGRATED CARE PLAN

		(what/how much)		(how)	(who)	(by when)	
DATE	GOAL	OBJECTIVE	BARRIERS ADDRESSED	ACTION STEPS	WHO IS RESPONSIBLE?	TIME FRAME	DISPOSITION

Specific – What do you want to do, by when, with who, and how much (to what degree)?
Measurable – Can you measure progress towards the goal? How will you know if the goal is reached or accomplished?
Achievable/Attainable – Can you realistically achieve the outcome given their time frame, resources, and ability?
Relevant – Does it align with the goals of MCC, i.e., prevent acquisition/forward transmission of HIV/STDs, HIV medical care/treatment access and/or adherence?
Time – Is the time frame realistic?

_____(MCM)
_____(PCM)
_____(Case Worker)
MCC Team Signatures

_____
Patient Signature

_____
Date

(DHSP, 2013)

Interventions

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Promoting behavior change

- Engagement in care
- ART adherence
- Risk reduction
- Nutrition counseling
- Dental
- Housing
- TAP care
- Food bank
- Disclosure
- Mental health treatment
- Substance abuse treatment

37

Case Conference

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- MTM
- Care Coordination
  - Within MCC team

(DHSP, 2013)

Acuity Driven Service

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- Re-assessed based on acuity
- Goal: Reduction in acuity level until self-managed
- Screened every six months once self-managed

(DHSP, 2013)

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Case Presentation

40

PATIENT A
34/F/CAUCASIAN/F/HETEROSEXUAL

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- Dx HIV 2000
- Provider Referral
- Enrolled 6/2013
  - Depression; HEP C; Unhealthy Living Environment
  - Contemplative
- Icp: Mh, Hiv 101, Alanon,
- Ongoing MI To Assess Patient Goals And
- Readiness To Change

PATIENT B
37/M/LATINO/HOMOSEXUAL

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- Dx HIV 2001
- Benefits Referral
- Enrolled 12/12/2013 Based On VL
- Challenges Identified In Assessment
  - Homelessness, ETOH Use, Hx Std's, Knowledge, Depression, Unemployed
- Icp
  - Referrals: MH, Substance Use, Housing, TAP Card.
  - Interventions Focused On HIV Education And Risk Reduction

LIFE Program

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LIFE

History

Purpose: Living Independently, Feeling Empowered (LIFE) Program provides in-home case management for individuals living with HIV/AIDS

What is LIFE Program?

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The LIFE program utilizes an interdisciplinary team approach to case management.

Each client is assigned to a **Nurse Case Manager** (NCM) and **Social Work Case Manager** (SWCM)	Assist client's with disease management, prevent disease transmission, stabilize health and improve quality of life Increase coordination among service providers Provide **home- and community-based services** for persons with disabilities who would otherwise require institutional services	Services Offered: In addition to case management, the LIFE Program provides: Homemaker/Attendant Care Counseling and Medical Monitoring Nutritional Supplements Treatment Education Durable Medical Equipment

Staff Roles

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Appropriate staffing is key in ensuring the success of the program

Registered Case Manager	Assure that each client enrolled in the LIFE program meets medical and functional eligibility criteria
	Assessments/Reassessments every 90 days
	Empower clients in decision-making for health care and service planning
	Advocate for the needs of the client

45

Staff Roles

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Appropriate staffing is key in ensuring the success of the program

Social Work Case Manager	Psychosocial assessments, every 90 days
	Assist client's in accessing benefits, resources, information and referral services for psychosocial needs.
	Promote understanding of the psychosocial factors impacting individuals living with HIV
	Consult with providers to coordinate plans of treatment

46

Objectives

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1. To coordinate the efficient use of community resources in a cost-effective, high quality manner acceptable to the client
2. To foster continuity of services throughout the continuum of care
3. To promote understanding by the client, family, and the client's representative of the HIV disease or AIDS process and the use of health promotion practices
4. To decrease fragmentation of care

47

Functions

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- Comprehensive assessment of the client's physical, psychosocial, environmental, financial, and functional status
- Development, implementation, monitoring, and modification of a comprehensive individual service plan through an interdisciplinary team process in conjunction with the client and his/her caregivers
- Evaluation of the service plan and specific services through reassessments and case conferences
- Transition to less intensive case management services when health and functional status improves and stabilizes

48

Eligibility

- Be Medi-Cal Eligible or receive Ryan White Services.
- Must not simultaneously receive other case management services
- Must have a written diagnosis from attending physician of HIV/AIDS, including current symptoms related to HIV/ AIDS
- Must have a CFA score of 60 or less
- Have a home setting that is safe for both the client and the service providers.

49

Referral Process

- Referral can be made my PCP or case manager within the clinic.
- Referral can be made by outside agencies.

50

Initial Assessment/Reassessment

Assessments are completed every 90 days

Assessments cover:

Nursing: Impact of illness, comprehensive systems review, client's medical and sexual history, health habits, nutritional assessment, medication review

Social: Psychosocial impact of illness on patient, legal and financial assessment and home assessment.

Resource Evaluation: Screening of benefits

51

Case Conference

- Assess the multi-service needs of clients
- Plan for services to meet the needs of clients
- Evaluate the effectiveness and ongoing need for interventions that have been identified in the service plan.

52

Care Service Plan

- Identify Problems or Needs
- Goals and Objectives are set:
  - Short term/Long term
  - Review with patient
- Services and Interventions

53

54

Challenges

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- Treatment non-adherence
- Prioritizing and budgeting for services in order to meet the patient's needs
- High acuity patients served under this program with complex co-morbid issues, substance abuse, mental health and psychosocial barriers (limited financial resources, housing)
- Non- insured clients
- Meeting the needs of non-insured clients

55

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LIFE PATIENT: CASE #1

42 year old Latina female, monolingual Spanish speaking
Problems: HIV/AIDS , Anemia, Hodgkins lymphoma, Pancreatitis
– AIDS Dx in 1994
Housing, Finances, Legal, referral to mental health services

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LIFE PATIENT CASE #2

48 year old, Trans Latina, monolingual Spanish speaking
Problems: HIV , neuropathy , limited mobility, access to hormones
Victim of a hate crime, Legal, finances, transportation

MCC vs LIFE

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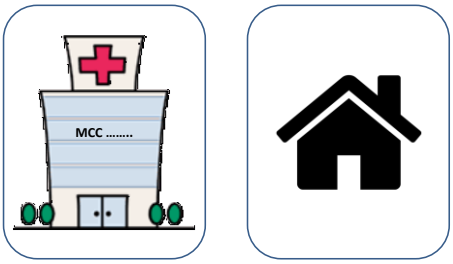

58

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Questions?

59

Contacts

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60

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