Integrating Medical Care Coordination Services into HIV Clinic Medical Homes

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Background

- DHSP funds HIV Clinics to provide Ambulatory Outpatient Medical (AOM) and Medical Care Coordination (MCC) Services in an Integrated Approach
- Funding for AOM and MCC began November 2012.
- AOM services began immediately; MCC had rolling implementation

Implementation Progress

- 20 Providers at 41 sites Providing HIV Care
- 20 Providers at 41 sites Providing MCC
- All AOM Providers Attended Casewatch Registration and Invoice Trainings
- All MCC Providers attended the Four Day Programmatic and the MCC Casewatch trainings.

Medical Home Program Goals

- **Reduce New HIV infections**
  - Lower the number of new infections.
- **Increase Access to Care**
  - Increase the number of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis
- **Reduce HIV-Related Health Disparities**
  - Improve access to prevention and care services

Target Population for MCC

- HIV+ clients who:
  - Are not in medical care
    - Recently diagnosed <6 months
  - Have fallen out of care
  - Are currently in care and having trouble adhering to care plan
  - Are adherent but have poor health status
  - Are at risk for transmitting HIV

Rationale for Program Integration

- Integrated care is essential for HIV treatment
  - Effective for patients with multiple co-morbidities and changing conditions
- Treat the whole patient
  - Care team provides clinical care services
  - MCC addresses supportive service needs:
    - Substance abuse, mental health, prevention counseling, housing, etc.
- Integrated Data
  - Seamless for patient flow
  - Reduce redundancy

Medical Home Team Members

Primary Clinical Care

- Primary Care Provider
  - Medical Doctor
  - Physican's Assistant
  - RNP
  - Nurses,
  - Medical Assistants
  - Referral Specialists
  - Other clinic staff

Medical Care Coordination

- Patient Care Manager (PCM)
  - Master Level Social Worker
- Medical Care Manager (MCM)
  - Registered Nurse
- Case Worker (CW)
  - Bachelor's or LVN

Integrated Program Design

- Screening Clinic Patients for MCC need
  - AOM Clinic Patients should be screened to determine need for MCC
- Assessment and Care Plan Developed
  - MCM and PCM conduct together
- Multi-disciplinary team case conferencing
  - PCP, MCM, PCM, etc.
- Provision of Brief Interventions
  - Treatment Adherence
  - Risk Reduction

MCC Evaluation Plan

- Implementation Evaluation
  - To describe and monitor fidelity to the MCC protocol
  - To identify best practices to refine MCC
  - To determine program costs

- Outcome Evaluation
  - To evaluate the impact of MCC on health outcomes among high risk patients from baseline to 6 and 12 months

Evaluation Plan continued

- All funded agencies are included in evaluation
- Uses data entered into Casewatch as part of intake and MCC service delivery
- Annual reports will be produced
- Provider input critical to assure the utility of reports and interpretation of findings

MCC Screening and Assessment

- From March 1 through November 30, 2013
  - 5,925 patients had screening data entered into Casewatch
    - 1,896 (32%) patients were identified as needing active MCC services
  - 1,001 patients had an initial assessment completed

Baseline Characteristics

Patients in Active MCC, March-November 2013 (N=1,001)

PATIENT DEMOGRAPHICS	n	%
Race/Ethnicity		
Latino	499	50
African-American	266	26
White	199	20
Age 40 years and older	513	51
Gender		
Male	843	84
Female	137	14
Transgender	21	2
Foreign-born	367	27

Source: DHSP, Casewatch, Years 22-23 and Assessment data

Baseline Characteristics

Patients in Active MCC, March-November 2013 (N=1,001)

PSYCHOSOCIAL ISSUES	n	%
Ever diagnosed with a mental health issue	484	48
Ever in counseling/treatment for ongoing mental health issue	594	57
Possible depressive disorder (PHQ9 ≥ 9)	396	40
Possible anxiety disorder (GAD8 ≥ 10)	297	30
Homeless in the past 6m	220	22
Ever incarcerated	368	37

Source: DHSP, Casewatch, Years 22-23 and Assessment data

Baseline Characteristics

Patients in Active MCC, March-November 2013 (N=1,001)

RISK BEHAVIORS	n	%
Ever used drugs or alcohol	864	86
Used drugs or alcohol in the past 6m	635	74
Possible SA problem (SA screener ≥ 3)	228	23
Primary mode of HIV exposure		
MSM	568	56
MSM-IDU/IDU	247	25
Heterosexual	41	4
No identified risk/ other*	64	6
Diagnosed with an STD with in the past 6m	225	22
Sexually active in the past 6m	532	53
Did not use a condom with any partner(s)	314	59

*Other includes perinatal transmission, transfusion and hemophilia/coagulation disorder

Source: DHSP, Casewatch, Years 22-23 and Assessment data

County of Los Angeles Public Health

Baseline Characteristics

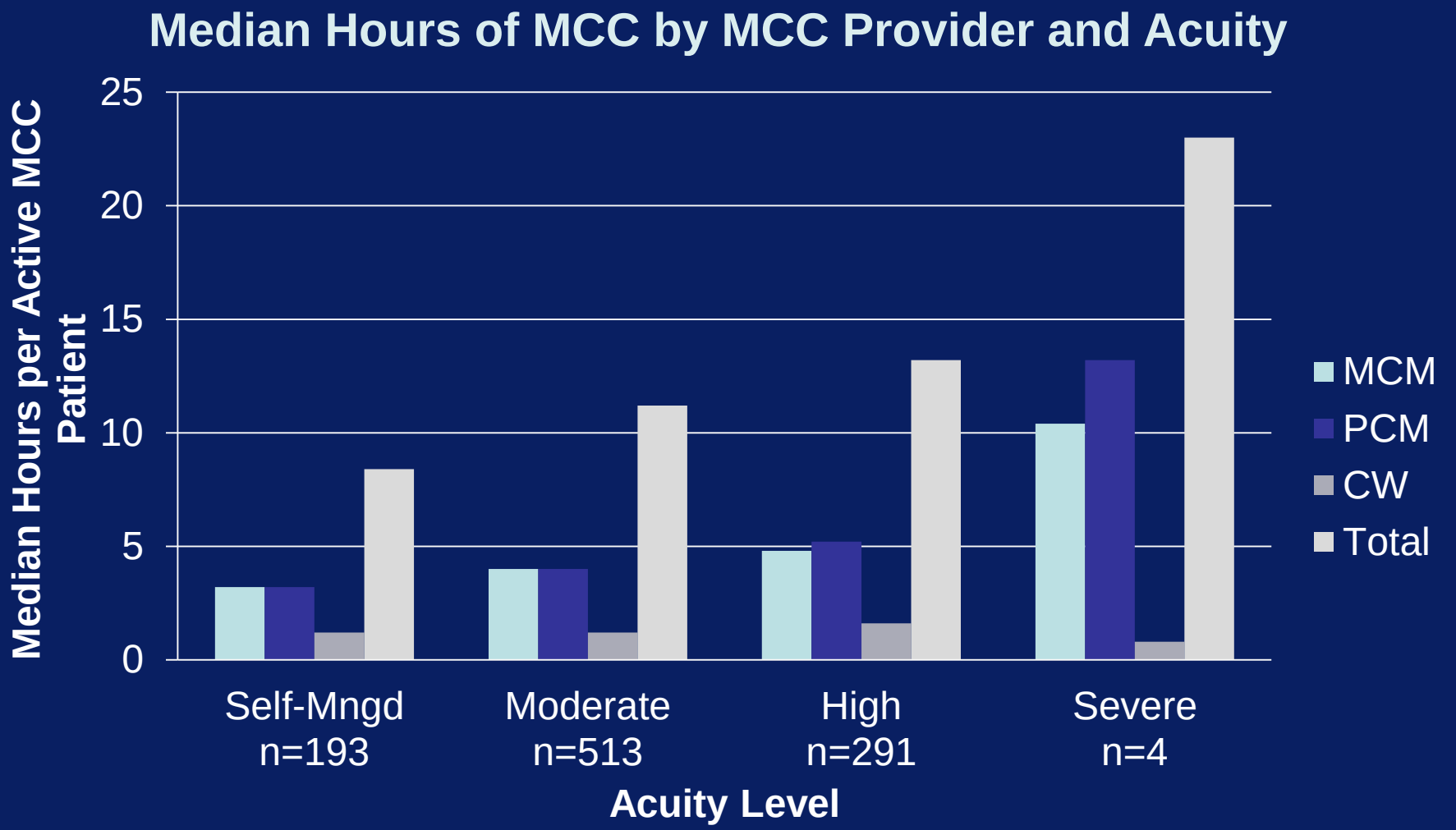
Patients in Active MCC, March-November 2013 (N=1,001)

HEALTH STATUS, HIV CARE HISTORY AND ACUITY	n	%
Diagnosed with HIV in the past 6 months	243	24
Most recent viral load suppressed < 200 copies/mL[a]	337	34
Prescribed ARTs	725	72
Reports missing at least 1 ART doses in past week	240	33
Acuity Level		
Severe	4	<1
High	291	29
Moderate	513	51
Self-Managed	193	19

[a]Missing=41 patients without viral load

Source: DHSP, Casewatch, Years 22-23 and Assessment data

Active MCC Service Delivery

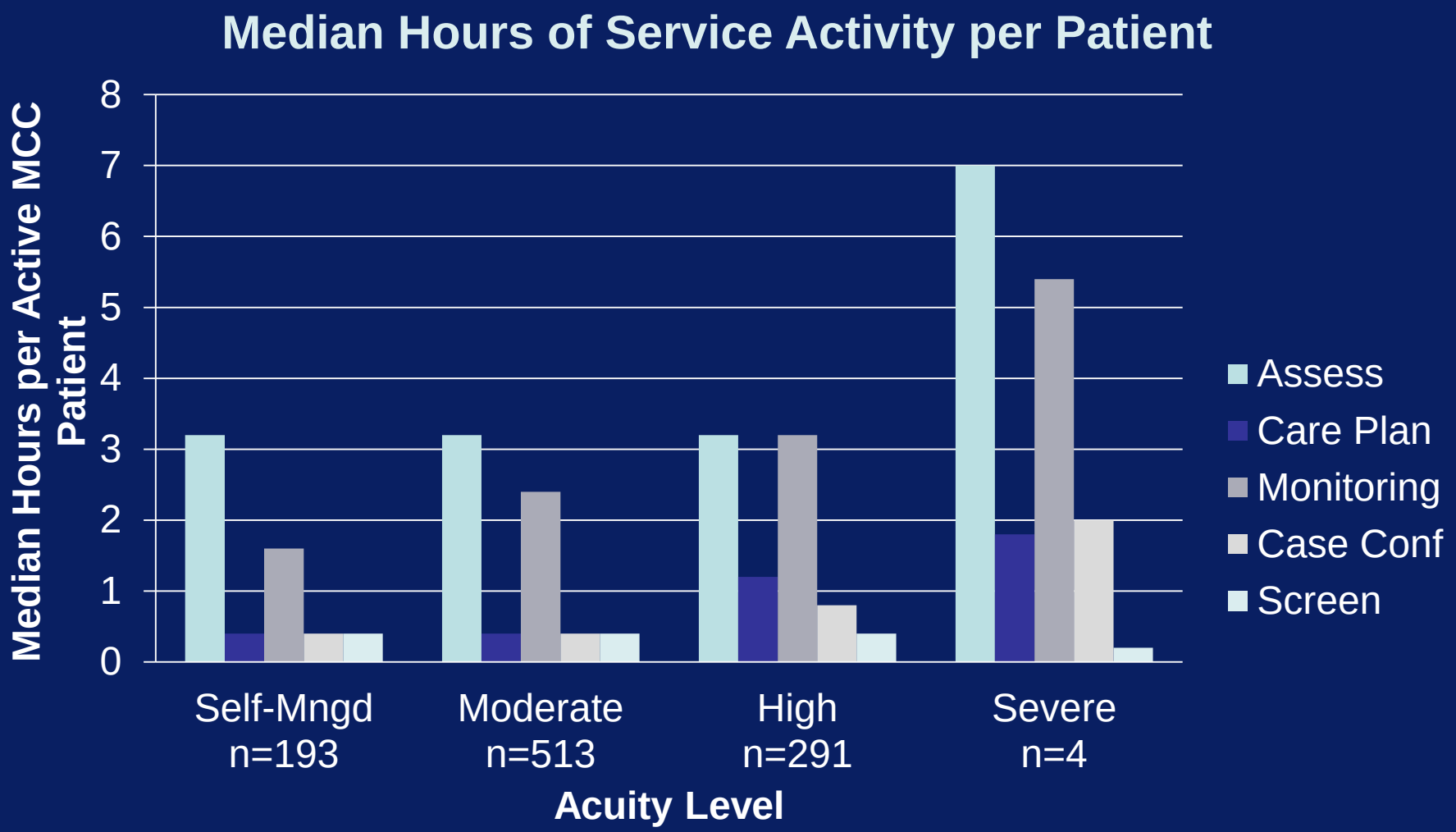


*Includes services delivered during face-to-face and telephone contacts

Source: DHSP, Casewatch, Years 22 and 23, March-November 2013

County of Los Angeles Public Health

Active MCC Service Delivery



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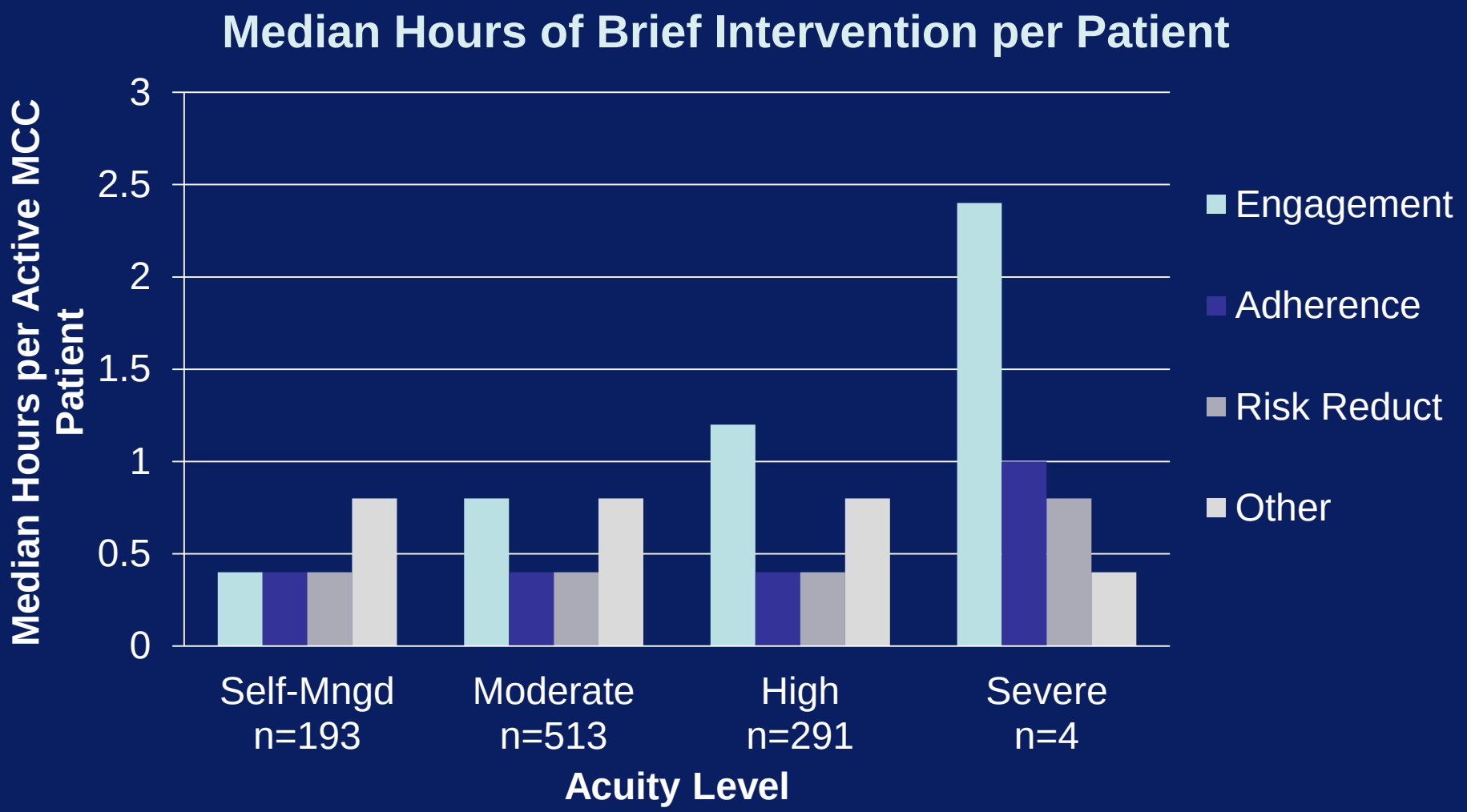
Source: DHSP, Casewatch, Years 22 and 23, March-November 2013

Active MCC Service Delivery



*Includes services delivered during face-to-face and telephone contacts

Source: DHSP, Casewatch, Years 22 and 23, March-November 2013

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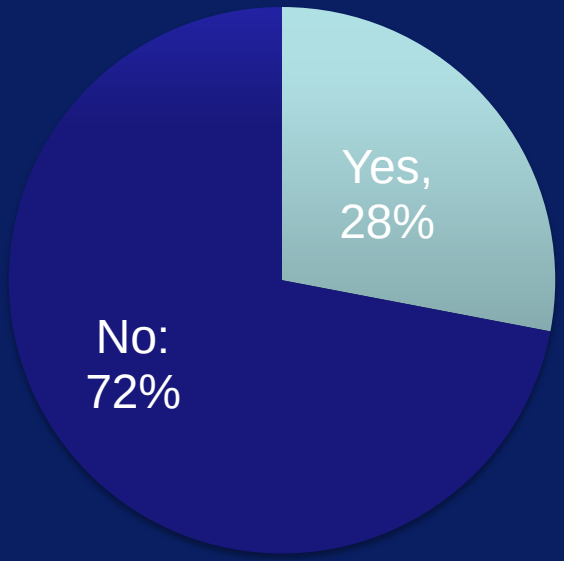
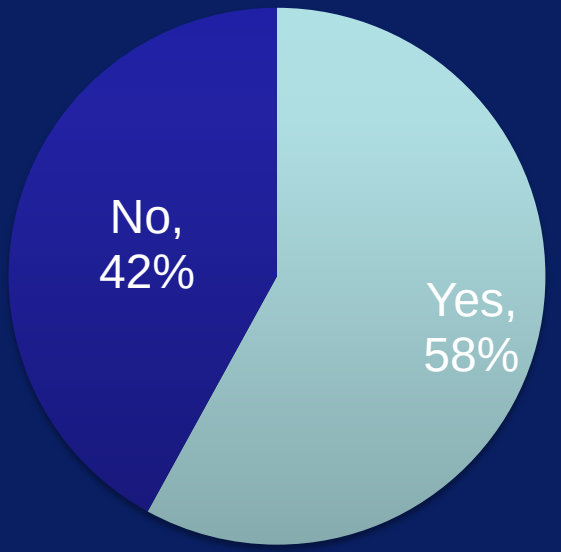
Viral Suppression in MCC at 6 Months

Viral Suppression pre-MCC



Viral Suppression after 6m of MCC



Receiving active MCC was associated with viral suppression at 6 months (OR=5.1; 95%CI=2.6, 9.8)

Source: DHSP, Casewatch, Years 22 and 23, March-November 2013

Next Steps for Evaluation

- Incorporate surveillance data
- Continue monthly review of data to ensure data quality and fidelity to service model
- Identify how to best share findings with stakeholders
- Developing an economic evaluation component

Quality Management
and
MCC Performance Measures

Principles of Quality Improvement

- Focus on the customer
- Measurement
- Emphasis on the system of care
- Involvement of participants

Developing Performance Measures

3 major activities for developing measures:

- Defining the measurement population
- Defining the measures
- Developing the data collection plan

MCC Performance Measures

- Retention in HIV care
- Viral load suppression on ART
- Provision of Interventions
  - *Adherence*
  - *Risk reduction*
- Linkages to support services
  - *Mental health*
  - *Substance abuse*
  - *Housing*
  - *Partner services*

Performance Measure 1.1: Retention in HIV care (ALL)	
Percentage of medical care coordination (MCC) patients who had 2 or more medical visits at least 90 days apart within the past 12 months	
Numerator:	Number of MCC patients who had 2 or more face-to-face (FTF) visits with an HIV provider at least 90 days apart within the past 12 months
Denominator:	All clinic patients who were screened for MCC within the past 12 months
Definition:	1. MCC Patients: refers to clinic patients who were screened for MCC services and determined to be either active or self-managed status 2. HIV Provider: refers to a physician or mid-level provider (PA or NP) who performs medical evaluation for patient in an HIV care setting 3. Screened: refers to any clinic patient for whom the DHSP Casewatch "MCC Screener and Outcome" screen was completed
Patient Exclusions:	1. Patients who have been incarcerated within the past 12 months 2. Any patient registered as new patient at the HIV medical home within the last 6 months of the measurement period 3. Any patient refusing services that was documented in the medical record
Data Element:	1. Is the patient HIV-infected? (Y/N) 2. If yes, was the patient screened for MCC? (Y/N) 3. If yes, did the patient have 2 or more medical visits with an HIV provider at least 90 days apart during the past 12 months? (Y/N)
Data Source:	• Casewatch or other electronic data base

DHSP Threshold for Compliance: 90%

Performance Measure 1.2: Viral load suppression less than 200 copies/mL when on antiretroviral therapy (ART) (ALL)	
Percentage of MCC patients who are prescribed ART and achieve viral suppression (< 200 copies/mL) within the past 12 months.	
Numerator:	Number of MCC patients who were prescribed ART in the last 6 months whose most recent viral load was <200 copies/mL
Denominator:	Number of MCC patients who were prescribed ART in the last 6 months
Definition:	1. MCC Patients: refers to clinic patients who were screened for MCC services and determined to be either active or self-managed status 2. Screened: refers to any clinic patient for whom the DHSP Casewatch "MCC Screener and Outcome" screen was completed 3. Viral load suppression: refers to an HIV viral load measurement that is less than 200 copies/ml
Patient Exclusions:	1. Patients who have been incarcerated within the past 12 months 2. Any patient registered as a new patient within the last 3 months of the 12-month measurement period 3. Any patient refusing services that was documented in the medical record
Data Element:	1. Is the patient HIV-infected? (Y/N) 2. If yes, is the patient screened for MCC? (Y/N) 3. If yes, was the patient prescribed ART medication in the last 6 months? (Y/N) 4. If yes, was the patient's last viral load less than 200 copies/mL? (Y/N)
Data Sources:	• Casewatch, eHARS, or other electronic data base

DHSP Threshold for Compliance: 85%

Performance Measure 2.1: Provision of antiretroviral (ART) adherence intervention to high-risk patients (ACTIVE PATIENTS ONLY)	
Percentage of **active** MCC patients who are provided the ART adherence intervention in the past 12 months	
Numerator:	Number of active MCC patients with ART adherence need identified in the MCC Assessment who are provided the ART adherence intervention by MCC staff within 30 days of identified need
Denominator:	All active MCC patients with ART adherence need identified in the MCC Assessment within the past 12 months
Definition:	1. Active: refers to patients who are enrolled in the MCC program to receive intensive services within the past 12 months 2. ART Adherence Need: refers to patients with severe or high acuity level in the "Medication Access and Adherence" domain of the MCC Assessment
Patient Exclusions:	1. Patients who have been incarcerated within the past 12 months 2. Any patients enrolled in MCC within the last 3 months of the 12-month measurement period 3. Any patient refusing services that was documented in the medical record
Data Element:	1. Is the patient HIV-infected? (Y/N) 2. If yes, did patient complete an MCC Assessment? (Y/N) 3. If yes, did the patient have identified ART adherence need? (Y/N) 4. If yes, did the patient receive the ART adherence intervention within 30 days of identified need? (Y/N)
Data Source:	• Casewatch, or other electronic data base

DHSP Threshold for Compliance: 85%

Performance Measure 2.2: Linkage to mental health programs (ACTIVE PATIENTS ONLY)	
Percentage of **active** MCC patients who were successfully linked to mental health programs	
Numerator:	Number of active MCC patients who were enrolled in a mental health program within 45 days of identified mental health need
Denominator:	All active MCC patients who were referred to mental health programs within the past 12 months
Definition:	1. Active: refers to patients who are enrolled in the MCC program to receive intensive services within the past 12 months 2. Mental Health Need: refers to refers to patients with severe or high acuity level in the "Mental Health" domain of the MCC Assessment
Patient Exclusions:	1. Any patient enrolled in MCC within the last 3 months of the 12-month measurement period 2. Any patient refusing services that was documented in the medical record 3. Patients who have been incarcerated within the past 12 months
Data Element:	1. Is the patient HIV-infected? (Y/N) 2. If yes, did the patient complete an MCC Assessment? (Y/N) 3. If yes, did the patient have a mental health need identified in the MCC Assessment? (Y/N) 4. If yes, did the patient enroll in a mental health program within 45 days of identified need ? (Y/N)
Data Source:	• Casewatch or other electronic data base

DHSP Threshold for Compliance: 85%

Performance Measure 2.3: Linkage to substance abuse programs (ACTIVE PATIENTS ONLY)	
Percentage of **active** MCC patients who were successfully linked to substance abuse programs	
Numerator:	Number of active MCC patients enrolled in substance abuse programs within 45 days of identified substance abuse treatment need
Denominator:	All active MCC patients who were referred to substance abuse programs within the past 12 months
Definition:	1. Active: refers to patients who are enrolled in the MCC program to receive intensive services within the past 12 months 2. Substance Abuse Treatment Need: refers to refers to patients with severe or high acuity level in the "Drug and Alcohol Use" domain of the MCC Assessment
Patient Exclusions:	1. Any patient enrolled within the last 3 months of the 12-month measurement period 2. Any patient refusing services that was documented in the medical record 3. Patients who have been incarcerated within the past 12 months
Data Element:	1. Is the patient HIV-infected? (Y/N) 2. If yes, did the patient complete an MCC Assessment? (Y/N) 3. If yes, did the patient have a substance abuse need identified in the MCC Assessment? (Y/N) 4. If yes, did the patient enroll in the substance abuse program within 45 days of the identified need? (Y/N)
Data Source:	• Casewatch or other electronic data base

DHSP Threshold for Compliance: 85%

Performance Measure 2.4: Linkage to housing programs (ACTIVE PATIENTS ONLY)	
Percentage of **active** MCC patients who were successfully linked to housing programs	
Numerator:	Number of active MCC patients enrolled in a housing program within 45 days of identified housing need
Denominator:	All active MCC patients who were referred to housing programs during the past 12 months
Definition:	1. Active: refers to patients who are enrolled in the MCC program to receive intensive services within the past 12 months 2. Housing Need: refers to refers to patients with severe or high acuity level in the "Housing" domain of the MCC Assessment
Patient Exclusions:	1. Patients who have been incarcerated within the past 12 months 2. Any patient refusing services that was documented in the medical record 3. Any patient enrolled in MCC within the last 3 months of the 12-month measurement period
Data Element:	1. Is the patient HIV-infected? (Y/N) 2. If yes, did the patient complete an MCC Assessment? (Y/N) 3. If yes, did the patient have a housing need identified in the MCC Assessment? (Y/N) 4. If yes, did the patient enroll in a housing program within 45 days of identified need? (Y/N)
Data Source:	• Casewatch or other electronic data base

DHSP Threshold for Compliance: 70%

Performance Measure 2.5: Linkage to partner services (ACTIVE PATIENTS ONLY)	
Percentage of **active** MCC patients who are successfully linked to partner services in the past 12 months	
Numerator:	Number of active MCC patients with identified high risk sexual behavior linked to partner services within 45 days of identified need
Denominator:	All active MCC patients with referred to partner services within the past 12 months
Definition:	1. Active: refers to patients who are enrolled in the MCC program to receive intensive services within the past 12 months 2. High Risk Sexual Behavior: refers to patients with severe or high acuity level in the "Risk Behaviors" domain of the MCC Assessment
Patient Exclusions:	1. Patients who have been incarcerated within the past 12 months 2. Any patient refusing services that was documented in the medical record 3. Any patient enrolled in MCC within the last 3 months of the 12-month measurement period
Data Element:	1. Is the patient HIV-infected? (Y/N) 2. If yes, did the patient complete an MCC Assessment? (Y/N) 3. If yes, did the patient have identified high risk sexual behavior needs? (Y/N) 4. If yes, did the patient receive partner services within 45 days of identified need? (Y/N)
Data Sources:	• Casewatch or other electronic data base

DHSP Threshold for Compliance: 100%

Performance Measure 2.6: Provision of behavioral risk reduction counseling and education intervention (ACTIVE PATIENTS ONLY)	
Percentage of **active** MCC patients who were provided the behavior risk reduction intervention in the past 12 months	
Numerator:	Number of active MCC patients with identified high risk behaviors in the assessment who are provided the risk reduction intervention by MCC staff within 30 days of identified need
Denominator:	All active MCC patients with identified high risk behaviors in the MCC Assessment within the past 12 months
Definition:	1. Active: refers to patients who are enrolled in the MCC program to receive intensive services within the past 12 months 2. High Risk Behavior: refers to patients with severe or high acuity level in the "Risk Behaviors" domain of the MCC Assessment
Patient Exclusions:	1. Patients who have been incarcerated within the past 12 months 2. Any patient refusing services that was documented in the medical record 3. Any patient enrolled in MCC within the last 3 months of the 12-month measurement period
Data Element:	1. Is the patient HIV-infected? (Y/N) 2. If yes, did patient complete an MCC Assessment? (Y/N) 3. If yes, did the patient have identified high risk behaviors (Y/N) 4. If yes, was the patient provided the risk reduction intervention within 30 days of identified need? (Y/N)
Data Sources:	• Casewatch or other electronic data base

DHSP Threshold for Compliance: 100%

Quality Improvement: Raising the Bar

- Strong provider-patient relationship
- Effective assistance from the multidisciplinary care team
- Every one has a critical role in improving the quality of patient care and service

Things to Think About

- How are these services currently being coordinated in your clinic?
- What is working well in implementing this integrated approach?
- What changes have you noticed in your patient population?
  - Are new patients getting into your clinic faster?
  - Are existing patients showing improved outcomes?

Contact Information

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http://www.ph.lacounty.gov/aids/