Ryan White Case Management Coordination and Models for Sustainability

Holly Hanson, Iowa Department of Public Health
Biz McChesney, Iowa Department of Public Health
Kathye Gorosh, AIDS Foundation of Chicago
IOWA CASE MANAGEMENT PROGRAM

Iowa Department of Public Health
Ryan White Part B Program
Holly Hanson
Biz McChesney
Steal Shamelessly...
Share Senselessly...
Inspiration from all Directions
What is Case Management?

A client focused process that expands and coordinates existing services to clients.

Referral or “brokering”  Team-based approach

Overarching goal is to facilitate clients’ autonomy to the point where they can obtain needed services on their own.
HIV case management exists in part to connect an often-fragmented system. It can serve as a catalyst for quality, cost-effective care by linking the patient, the physician, and other members of the care coordination team, the payer and the community. **Without the coordination provided by case managers, some clients can become confused about how the system works and frustrated by the time and effort involved. Consequently, many clients can become detached and ultimately disengage from care services.**
Consequences of fragmentation

It is important to remember, however, that though the absence of case management can hamper client access to needed services, *multiple case managers working in an uncoordinated system can contribute to the fragmented service delivery that case management is meant to alleviate.*
Case Management Along Iowa’s 2014 Continuum

Iowa Comprehensive HIV Plan 2012-2015

Goal 4 – Improve Retention in Care and Adherence to Medications

**Objective 1 – Strengthen the medical case management program**

Develop a tiered system to reflect different levels of need by PLWHA
Iowa Case Management History

- 2003: IDPH establishes Case Management Standards
- 2006: Ryan White Reauthorization – Move to MCM
- October 2013: Pilot tiered CM model
- June 2013: Ryan White Annual Retreat – Begin tiered CM model development
- April 2014: Full implementation of tiered CM model
- May 2015: Final Client Services Manual released
Iowa Case Management Program

1. Team-based approach
   - Medical Case Management (MCM)
   - Non-Medical Case Management (Non-MCM)

2. Referral or “brokering”
   - Brief Contact Management (BCM)

3. Maintenance Outreach Support Services (MOSS)
Iowa Case Management Program

**Medical Case Management**
Intended to serve, in collaboration with medical provider, persons in with multiple complex medical issues. Clients need ongoing support to actively engage in medical case, and continued adherence to treatment.

**Non-Medical Case Management**
Intended to serve persons with multiple complex psychosocial needs. Clients manage their care well enough to avoid chronic disruption to their medical care but require psychosocial support to maintain a stable lifestyle.
## Iowa Case Management Program

<table>
<thead>
<tr>
<th>Brief Contact Management</th>
<th>Maintenance Outreach Support Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intended to assist persons living with HIV/AIDS to independence in decision-making and accessing services for their health-related and/or psychosocial needs. Designed to assist individuals whose needs are minimal and infrequent.</td>
<td>Intended for people who were formally engaged in more intensive levels of case management and have progressed to self-management. Designed to assess the sufficiency of self-management and to provide additional services, when appropriate, to prevent lapses in care.</td>
</tr>
</tbody>
</table>
### Acuity Scale

Review **ALL** levels of Case Management below, select boxes that best reflect client’s current situation. Enroll client in appropriate level of case management. If client is enrolled in ADAP, client must be enrolled in Level 1, 2, or 3 of Case Management.

#### Level 1: Medical Case Management (MCM)

- [ ] Newly Diagnosed (w/in 1 year)
- [ ] Viral Load > 200 copies/ml
- [ ] Not in HIV care
- [ ] Not on ARV’s (if recommended)
- [ ] Medical emergency/hospitalization
- [ ] Not adherent to ARV’s
- [ ] Not adherent to HIV medical appointments
- [ ] Other medical conditions not addressed (i.e. Hepatitis C, diabetes)
- [ ] Pregnant
- [ ] No access to ARV’s

*If 1 or more boxes are selected, consider enrolling client in MCM*

#### Level 2: Non-Medical Case Management (Non-MCM)

- [ ] Isolation
- [ ] No insurance or Public Insurance (Medicaid, IHWP, etc.)
- [ ] Unstable housing
- [ ] Current domestic violence and/or abuse
- [ ] Post incarcerated re-entering
- [ ] Mental health needs (not being addressed)
- [ ] Financial needs identified (i.e. utility assistance, HOPWA, etc.)
- [ ] Current substance abuse
- [ ] Linguistic challenges
- [ ] Legal issues impeding other areas of life
- [ ] Transportation needs
- [ ] Income insufficient to meet needs
- [ ] Needs frequent assistance navigating the system
- [ ] No stable support network

*If 1 or more boxes are selected, consider enrolling client in Non-MCM*

#### Level 3: Brief Contact Management (BCM)

- [ ] Moving from other HIV/AIDS Case Management provider
- [ ] Adherent to ARV’s
- [ ] Adherent to HIV medical appointments
- [ ] Stable housing
- [ ] Insurance (If client has Iowa Health and Wellness, it is highly recommended to enroll client in BCM, at a minimum)
- [ ] No current substance abuse
- [ ] Reliable access to transportation
- [ ] Steady source of income sufficient to meet needs
- [ ] Maintaining regular dental care
- [ ] Healthy, stable support network
- [ ] No mental health needs or needs being addressed

#### Level 4: Maintenance Outreach Support Services (MOSS)

- [ ] Meets all the criteria of BCM, has zero boxes selected in Level 1 or 2, and does **not** need AIDS Drug Assistance Program, consider enrolling in MOSS
## Core Elements

<table>
<thead>
<tr>
<th>CORE ELEMENTS</th>
<th>Medical Case Management (MCM)</th>
<th>Non-Medical Case Management (Non-MCM)</th>
<th>Brief Contact Management (BCM)</th>
<th>Maintenance Outreach Support Services (MOSS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approach</td>
<td>Proactive</td>
<td>Proactive</td>
<td>Responsive</td>
<td>Responsive</td>
</tr>
<tr>
<td>ADAP</td>
<td>All clients enrolled in ADAP must be enrolled in MCM, Non-MCM, or BCM</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bill to/ Service Category</td>
<td>Medical Case Management</td>
<td>Non-medical Case Management</td>
<td>Psychosocial Support Services</td>
<td>Outreach Services</td>
</tr>
<tr>
<td>Care Plan</td>
<td>Required</td>
<td>Required</td>
<td>Not Required</td>
<td>Not Required</td>
</tr>
<tr>
<td></td>
<td>The care plan is updated when:</td>
<td>The care plan is updated when:</td>
<td>Development of a Care Plan is optional</td>
<td>Referral back into Medical</td>
</tr>
<tr>
<td></td>
<td>- Unanticipated changes take place in life</td>
<td>- Unanticipated changes take place in life</td>
<td></td>
<td>Case Management, Non-Medical Case Management, or Brief</td>
</tr>
<tr>
<td></td>
<td>- When a change in the plan is identified</td>
<td>- When a change in the plan is identified</td>
<td></td>
<td>Contact Management if client shows a need for more</td>
</tr>
<tr>
<td></td>
<td>- When progress occurs</td>
<td>- When progress occurs</td>
<td></td>
<td>intense level of service</td>
</tr>
<tr>
<td></td>
<td>- Or at least every 6 months when reassessment occurs</td>
<td>- Or at least every 6 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Units</td>
<td>A “service unit” is documented in 15 minute increments, entered as “Medical Case Management”</td>
<td>A “service unit” is documented in 15-minute increments, entered as “Non-Medical Case Management”</td>
<td>A “service unit” is documented in 15-minute increments, entered as “Psychosocial Support Services”</td>
<td>A “service unit” is documented in 15-minute increments, entered as “Outreach Services”</td>
</tr>
<tr>
<td>Client Contact</td>
<td>Case manager will have client contact a minimum of 1 time per month</td>
<td>Case manager will have client contact a minimum of 1 time every 3 months</td>
<td>Case manager will have client contact a minimum of 1 time every 6 months</td>
<td>Case manager will have client contact a minimum of 1 time annually</td>
</tr>
<tr>
<td>Eligibility Determination</td>
<td>Eligibility documentation is reviewed every 6 months</td>
<td>Eligibility documentation is reviewed every 6 months</td>
<td>Eligibility documentation is reviewed every 6 months</td>
<td>Eligibility documentation is reviewed annually or as additional services are requested</td>
</tr>
</tbody>
</table>
Case Manager Feedback

“I love the new “tiered” system! It has allowed me to prioritize my clients in a way that best fits their needs all while helping me manage a large case load better. A win-win!”

-Tomika from Davenport, Iowa
Training and Capacity Building

• Regional Collaborative (Iowa, Minnesota, and Nebraska)
  • Annual Medical Case Management Certification
    • Online Modules
    • 2-day in-person course
  • Continuing Education
    • Expanding the HIV Prevention Framework for Gay and Bisexual Men and other MSM, Mental Health First Aid, Financial Health for Case Managers

• Trauma Informed Excellence
  • 6 month online program
Training and Capacity Building

• Regional Meetings (within Iowa)
  • Case managers and other partners
  • Linkage, managing case loads, adherence, etc.

• Monday Messages
  • Weekly e-mail to contractors
  • Updates, policy changes, resources, announcements, etc.
HOLLY HANSON, MA
IOWA PART B PROGRAM MANAGER
HOLLY.HANSON@IDPH.IOWA.GOV
515-242-5316

BIZ MCCHESEY
CLIENT SERVICES COORDINATOR
ELIZABETH.MCCHESEY@IDPH.IOWA.GOV
515-242-5149
IGNITE ACTION. FUEL CHANGE.

Ryan White Case Management Coordination & Models for Sustainability
NASTAD  July 2015

Kathye Gorosh, MBA
SVP Strategy & Business Development
KGorosh@aidschicago.org
I. The Environment

- Transformation
- Sea change
- Collaborative
- Sustainable

ACA Managed Care
Devil is in the Details:

Here's some of the many ways the Affordable Care Act helps people living with HIV/AIDS:

- Ensuring coverage for people with pre-existing conditions
- Expanding Medicaid coverage
- Providing more affordable private health coverage
- Lowering prescription drug costs for Medicare recipients
- Ensuring coverage of preventive services, including HIV testing
- Ensuring coverage of essential health benefits
- Increasing coordinated care for people with chronic health conditions
II. Care Coordination: Case Management

HIV/AIDS Case Management Network

• Founded in 1988, AFC operates the nation’s first and only coordinated case management system for people living with HIV/AIDS.

• *Braids public and private funds* to create seamless case management system.

• *Trains* all case managers to provide consistent, high quality services.

• Adhere to *quality standards* and compliance with federal regulations.

• Provides *centralized data base* to ensure conformity in care and achievement of standardized health outcomes.

Person-centered care -- evidence-based interventions
Benefits of Coordinated System

Through a coordinated system, AFC ensures:

- Seamless and continuous care throughout a client’s periods of health and illness
- Non-duplication of services; Ensures that each client is assigned only one case manager
- Provides centralized data base to ensure conformity in care and achievement of standardized health outcomes
- Standardized policies and procedures across all sites
- Consistent quality throughout all regions of the Eligible Metropolitan Area (EMA) through standardized training and technical assistance
- Direct data entry of client-level reporting, allowing for consistent and timely data collection
- Maximized resources available to support case management (CDPH/IDPH/DRS/HUD/etc.).
**Service Model**

**Systems Integration**
- Link Health and Human Services Sectors
- Training and continuing education
- Contract and grants management

**Partnerships**
- Convening diverse partners for collaborative efforts
- Building multi-agency systems and partnerships

**Quality and Data Management**
- Program evaluation
- Training and certification
- Data and performance management for funded services
AFC’s Coordination Role

• Contract Management
• Technical Assistance
• Data Collection
• Training

• Quality Improvement/Quality Management: Site Visits, monthly review of data, viral load

• Consumers’/Sub-contractors’ Input: Client satisfaction survey, case management satisfaction survey

• Insurance Enrollment
• Process/Track Grievances
Services

• Assist clients in **applying for benefits** (Medicaid, SSI, etc)
• Support clients **accessing and adhering to treatment** by assessing treatment readiness and supporting treatment decision-making
• Facilitate **access to emergency funds and treatment resources**
• **Identifies medical and social service needs** (Food, MH, SA)
• **Facilitates appropriate referrals** to meet service needs; all services have specific eligibility criteria.

• **HIV education**
• **Client education**
• **Client advocacy**, and navigation support
• **Client emotional support** (coping, disclosure)
AFC Medical Case Management

Performance Indicators

- Assessment
- HRSA Demographics
- Case Management Visits (2 visits 90 days apart)
- Medical Visits (2 visits 90 days apart)
- Care Plan
- Adherence Counseling (2 sessions 90 days apart)
- Primary Care Provider Communication (2, 90 days apart)
Current RW Challenges

1. RW Reauthorization and **Longevity** uncertain

2. **Proving** that coordinated CM works

3. AFC **must contract with agencies that are Medicaid-certified** to meet payer of last resort.

4. Clients may be medically stable but have **supportive needs**

5. Transitioning to Medicaid Managed Care

6. More clients **covered by ACA**
III. OUR APPROACH

DOING BUSINESS WITH US
WHY IS AFC GOING THIS ROUTE??

- Continuity: to serve some/many (?) of the clients we have been serving

- Expand: To apply our experience and expertise to be able to serve thousands more

- Diversify: funding sources

- Adaptability & Sustainability
WHAT IS OUR VALUE?

Core Competencies: Systems Integration & Advocacy

Proven track-record:

- Coordinate service networks: HIV prevention & care; housing, transportation, social services
- Coordinate and braid multiple funding streams to maximize services
  → Manage quality and data systems
  → Administer grants and contracts
  → Educate providers, community stakeholders
  → Demonstrated commitment to high-quality, culturally competent care coordination and care delivery
  → Shape and lead advocacy and public relations campaigns
WHAT DOES THIS REALLY MEAN?
HOW WILL WE/YOU BE IMPACTED?

1. Staffing Capacity: Prevention, Care, Housing
2. Data: Collection, Analyze, Transmit
3. IT: hardware, software for data; fiscal; MCO reports
5. Evaluation: Outcomes; ROI
6. Communications: Website - different “visitors”
7. Funding: $ for Business Development
8. Operations
9. Policy
Consequences of Nonadherence to Antiretroviral Therapy (ART)

Although adherence is important in all chronic-disease management, it is crucial in HIV treatment because:

- Nonadherent patients are more likely to experience virologic failure and resistance\(^1,2\)
- Failure and resistance are often associated with disease progression, complications, and the need for alternate therapies\(^3\)
- Adherence may result in decreased health care utilization and associated costs\(^2,4\)

### Barriers to Adherence

<table>
<thead>
<tr>
<th>Concomitant substance abuse</th>
<th>Difficulty taking medication (i.e. trouble swallowing, scheduling issues)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low level of health literacy</td>
<td>Cognitive issues</td>
</tr>
<tr>
<td>Age-related challenges (i.e., polypharmacy, vision loss)</td>
<td>Side effects</td>
</tr>
<tr>
<td>Psychosocial issues (i.e., depression, homelessness)</td>
<td>Not keeping clinical appointments</td>
</tr>
<tr>
<td>Stigma</td>
<td>Cost and insurance issues</td>
</tr>
<tr>
<td>Regimens too complicated</td>
<td>Treatment fatigue</td>
</tr>
</tbody>
</table>

AFC Case management viral load data

80%  Ryan White Part B - Cook and Collar counties
74%  Ryan White Part A - Cook and Collar counties
Unique Selling Proposition (USP)

• Consequences of Non-adherence to ART
• Barriers to Adherence
• “The Cascade”
• Case Management impact on VL Suppression (80% Part B, 74% Part A)
TRIPLE AIM

The best care
For the whole population
At the lowest cost

Improve individual experience
Control inflation of per capita costs

Improve population health

D. Berwick, Institute of Healthcare Improvement, 2007
Prepare for increased amounts of financial risk:
Know your costs
Know your capacity
Define your competitive advantages
Know your market & define it for each MCE
Understand the requirements & standards of each MCE
And....Strategic Process

Prior to approaching Health Plans:

• Assessment of Managed Care landscape
• Reviewed IL HIV specific claims data
• Provided Series of workshops for network partners – Managing Change; SSP; Securing New Business
• Developed Lines of Business
• Prepared material for Managed Care proposals
Meetings with MCEs

Active Solicitation started December 2013

- Prepared a priority list
- Asked for meetings w/ Exec & Program staff to introduce ourselves
- Presented “Who We Are & What We Do”
- Made the “ask” (w/ HIV metrics)
- Identified next steps
- Follow up; Follow up; Follow up and MORE
CHALLENGES:

• Different Language
• Need to meet MCOs where THEY are at
• Making “braided services” REALLY work (RW services; ADAP, Housing; Testing; L2C)
• Compatible database systems; exchange data
• Staffing Capacity
• Risk Management
AND.....Our Partners?

Readiness is Challenging:

1. Secured Data Transfer
2. New Contracts/BAA
3. Payment structure: units of service vs grants
4. Staffing Capacity
5. Increased Accountability – documentation; reports; tracking
6. Willingness to join AFC on this journey??
IV. What Can You Do NOW??

1. Understand your State Medicaid plan – where/how does Managed Care fit?

2. Assess Needs, Identify appropriate partners

3. Educate/engage Medicaid leadership, MCOs, new partners

4. Determine level of risk you can take

5. Determine Community Providers’ level of readiness
   a) How do their services fill an unmet MCE need?
   b) Can Value-add be demonstrated?
   c) Infrastructure to support new service delivery & payment models?

6. Identify $ or personnel for TA/Coaching
   a) Can you offer 1:1 and/or group support?

7. Collaborative Options for “Network Formation”:
   a) Management Services Organization (MSO)/Provider Services Organization (PSO)
   b) Independent Practice Association (IPA)
   c) Mergers/Strategic Alliances
   d) Data Exchange Coordination
Shifting Gears

BE PART OF THE SOLUTION.

MAKE AN IMPACT.
So….TOGETHER……
CLOSING: - In the end....

It's about change and....

moving forward w/ a broad vision of "health"

Thank You!