Partnerships for Care

HIV TAC TEAM

Peer to Peer: Moving Towards a Medical Case Management Model

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Medical Case Management in Massachusetts

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Medical Case Management Definition

- Using an interdisciplinary team model, MCM is a coordinated set of services that are:
  - Client-centered and strength-based
  - Designed to promote access, engagement and retention in medical care
  - Inclusive of psychosocial support
  - Focused on improving health outcomes for PLWH/A

Medical Case Management Background

- Jointly procured with Ryan White Part A in 2012
- Currently funding 38 agencies for MCM and other health related support services
- Last year served approximately 8835 clients

Medical Case Management Framework

- Interdisciplinary team model
- Flexible, responsive and low threshold
- Acuity-based

Medical Case Management Components

- Medical care coordination
- Benefits counseling
- Adherence support
- Housing advocacy
- Social service coordination
- Substance use risk reduction
- Sexual health promotion

Medical Case Management Settings

MCM is provided in a variety of settings

- Non medical sites
  - Community organizations
  - Out-patient mental health providers
- Medical sites
  - Community health centers
  - Hospitals
  - Infectious disease medical practices

HIV MEDICAL CASE MANAGEMENT
LOWELL COMMUNITY HEALTH CENTER

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November 19, 2015

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Lowell CHC- HIV Positive Patient Demographics

- 395 Active clients
- 58% Males, 42% Females, <1% transgender
- Approximately 35-40 new clients per year
- 5%- 00 – 19 years old
- 54%- 20 – 49 years old
- 41%- 50 – 79 years old
- 38%- Latino
- 62%- Non-Latino

Lowell CHC- HIV Positive Patient Demographics continued

- Diverse Race and Ethnicity
- 42% English is not listed primary language
- 41 % have CDC defined AIDS diagnosis
- 72% are virally suppressed <20
- 88% are virally suppressed <200
- 46% report Heterosexual contact as the exclusive mode of exposure

Lowell CHC- HIV Positive Patient Demographics

- 17 % exclusively reported MSM as mode of exposure.
- 21 % reported MSM plus IDU as mode of exposure
- 14 % of clients were specifically tested through our Prevention and Screening site.
- 71 % of our population have Medicaid, CHIP or other public funding
- 60% are below 100% of Federal Poverty Level
- 72 % report stable/permanent housing

Why do we have Medical Case Management?

- Intended to be a temporary support, not a lifelong relationship
- The goal is for clients to develop self-sufficiency
- Being integrated into clinical practice, it provides more comprehensive services
- MCMs are coaches, facilitators, supporters, advocates, and educators.

Who are Lowell CHC Medical Case Managers?

- One FTE nurse for complex care management
- Two Medical Assistant/Referral Specialists
- 5 MCM’s with various special skills

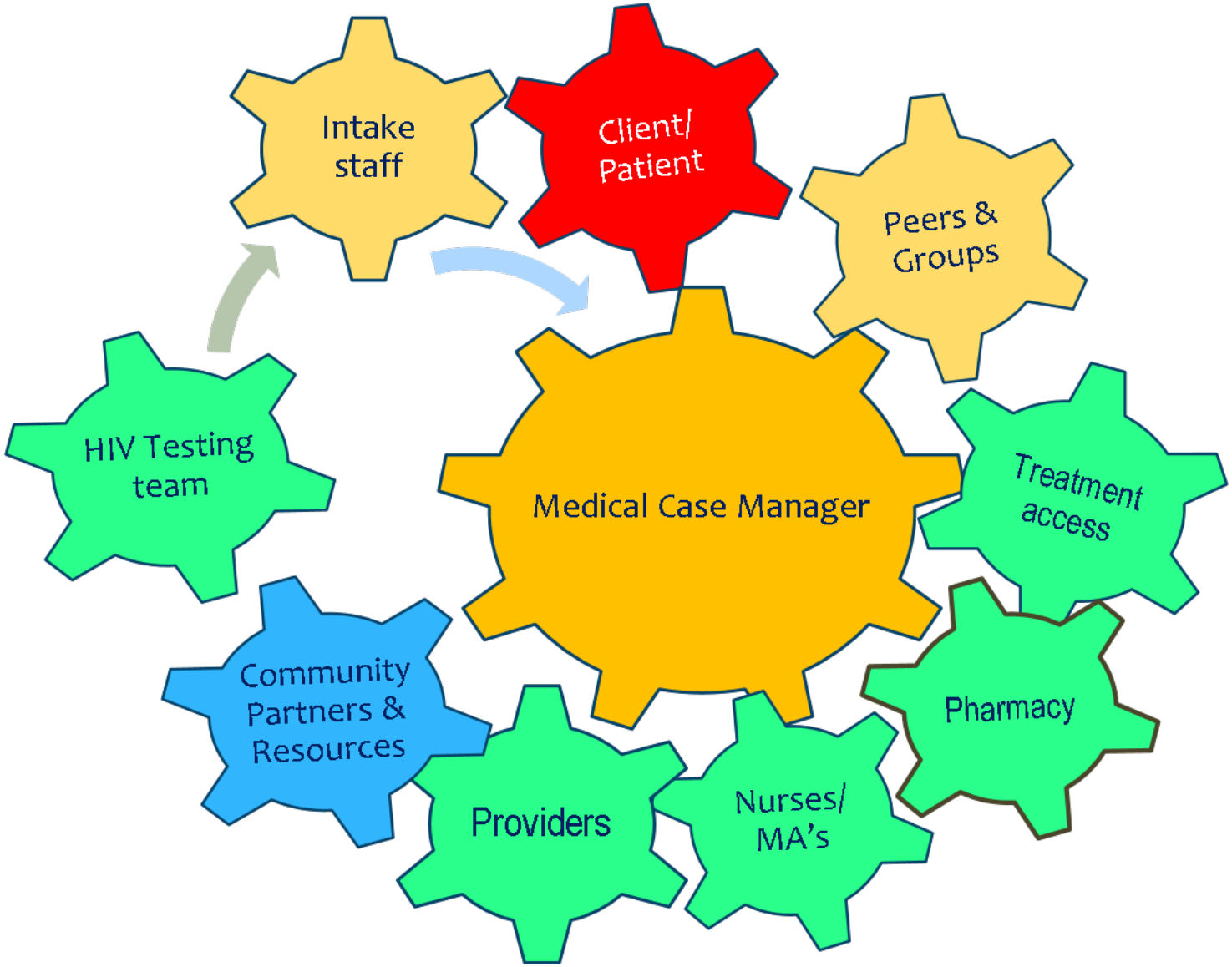
What skills do Lowell CHC MCMs bring?

- **Language competencies:**
  - ✓English
  - ✓Spanish
  - ✓Khmer
  - ✓Arabic
- **Cultural competencies:**
  - ✓Addiction services
  - ✓LGBTQ
  - ✓Immigrant/Refugee
  - ✓Women and youth

What skills do Lowell CHC MCMs bring?

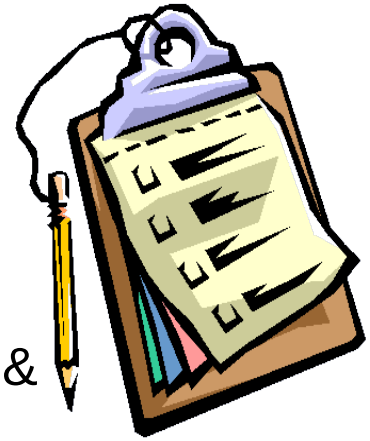
- **Personal Competencies**
  - ✓Non-judgmental
  - ✓Caring
  - ✓Client centered
  - ✓Organized
  - ✓Flexible

- **Other Competencies**
  - ✓Medical Assistant training
  - ✓Housing knowledge
  - ✓Immigration knowledge


Intake staff
Client/ Patient
Peers & Groups
HIV Testing team
Medical Case Manager
Treatment access
Community Partners & Resources
Pharmacy
Providers
Nurses/ MA's

What do Lowell CHC MCMs do?

- **Coordinate with Prevention and Screening staff for new diagnoses**
- **Complete intake and initial assessment of need**
- **Facilitate Treatment Adherence**
  - ✓ Schedule medical appointments
  - ✓ Attend clinic visits, off site and on
  - ✓ Contact pharmacies
  - ✓ Encourage/assist clients with medical visit attendance & ongoing treatment adherence
  - ✓ Access to EHR documentation and treatment planning
- **Participate in Care Team Meetings**

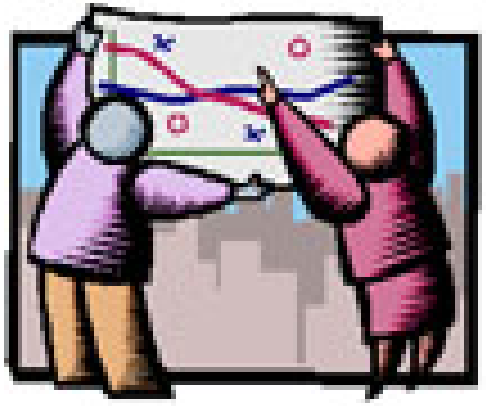


What do Lowell CHC MCMs do?

- Co-facilitate support groups
- Provide emotional and social support
- Outreach and reengagement in care
- Make home visits, with appropriate security measures
- Complete semi-annual reassessments and service plans
- Coordinate care and services

What do Lowell CHC MCMs do?

- **Educate clients in:**
  - ✓HIV life cycle
  - ✓Correct, consistent condom use
  - ✓Risk Reduction
  - ✓Visit preparedness
  - ✓Goal setting and achievement
  - ✓Budgeting
  - ✓Coping strategies
  - ✓Social skills
  - ✓How to fill out forms
  - ✓Activities of daily living



What do Lowell CHC MCMs do?

- **Interact with:**
  - ✓Nurses/Medical Assistants/Referral Specialists
  - ✓Providers, internal and external
  - ✓Quality Team members
  - ✓Peer staff members
  - ✓Other agencies providing HIV case management
    - On behalf of patients
    - For annual event planning
      - ✓**World AIDS Day**
      - ✓**Boston AIDS Walk**
  - ✓Other social service agencies

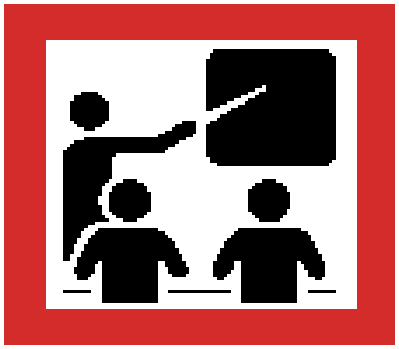
What do Lowell CHC MCMs do?

- **Connect clients to:**
  - ✓Medical Insurance (Health Benefits on site)
  - ✓Treatment copayment assistance (HDAP /ADAP)
  - ✓HIV specific support services: utility, housing, rental assistance
  - ✓Support groups
    - ✓HIV support groups, internal or external
    - ✓Topic specific support groups, such as anger management, bereavement

What do Lowell CHC MCMs do?

- **Connect clients to:**
  - ✓Addiction services: detox, overdose education and Narcan distribution and training, needle exchange
  - ✓Behavioral Health Services
  - ✓Educational opportunities
  - ✓Legal assistance
  - ✓Community support services: food pantries, shelters, etc.

MCM training



- **In addition to specific Case Management trainings, MCMs may participate in:**
  - ✓Motivational Interviewing
  - ✓Bridging the Gap- certified medical interpreter training
  - ✓Community Health Education Center (CHEC) trainings- Comprehensive Outreach Education Certificate Program
  - ✓Training with community liaisons from pharmaceutical companies
  - ✓Internal and external trainings, conferences & webinars
    - – computer skills, cultural competency, health disparities etc., relevant to job responsibilities

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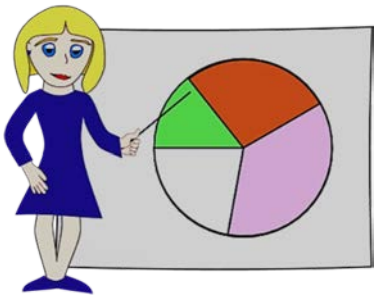
How do we incorporate MCMs in our work? - Ex. Pap Testing

The **Quality Team** reports that cervical Pap Smear testing numbers are low for our patient population

Training given to the entire team to understand the standards and importance of pap testing for HIV+ women

MA's and Nurses follow-up and schedule appointments.

MCMs



- ✓review with female clients the status of their pap testing when clients come in for reassessments
- ✓explore the client's barriers and educates client on the importance of Pap testing
- ✓incorporate completing a pap test as a six month goal in the ISP as appropriate
- ✓sets a Pap appointment with the help of the medical team
- ✓reminds the client of her appointment a day or two before
- ✓arranges transportation if needed

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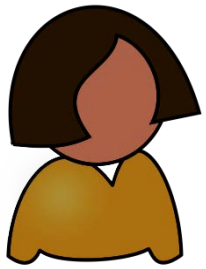
How important are MCMs in our work? Ex. Emma



1992 – Emma acquires HIV

2005 – Emma comes to Lowell CHC – high VL; CD4 <200.

2005 – 2012 – Emma struggles with adherence to medical visits and medications. Interventions repeatedly fail.

Dec. 2012 – MCM and Emma develop an ISP together. Emma's goal is to buy a home in her native country in 3 – 5 years. MCM and Emma discuss steps to make this a reality.

April 2013 to August 2015 – V.L. remains continuously **<20**

August 2015 – Emma's CD4 exceeds 200 for the first time since joining Lowell CHC.

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What makes it work?

1. **MCMs & Peer Support staff are respected as contributing members of the team** – clients tell their MCM things they don't tell their provider, providing a more complete picture

2. **MCMs** bring a community competency – improves understanding of the rest of the team AND works towards solutions

3. **MCMs** bring a wealth of knowledge about resources of which providers may be unaware.

What makes it work?

4. **Viral Load and CD4 Lab values** are integrated into the Reassessment/ISP
5. **Cooperative relationships** with other agencies in Lowell serving HIV+ clients
6. A shared **Electronic Medical Record** so MCMs & medical staff can easily communicate and access one another's notes
7. **Outreach and Home Visits** allow the **MCMs & Peer Staff** to connect with clients differently in the home environment – may be instrumental in reengagement

Final Views & Questions

LOWELL COMMUNITY HEALTH CENTER

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Main Facility - 161 Jackson Street

Metta Health Center - 135 Jackson Street

School Based Health Centers:

Lowell High, Stoklosa Middle School, DYS

www.lchealth.org

Thank you for participating in this Webinar. We hope that you are able to find the information provided useful as you continue your P4C project. We ask that you take a few moments to complete the feedback survey you will receive in a message following this webinar.

Partnerships for Care

HIV TAC TEAM

Thank you for participating in today's webinar

Please email if you have any question(s):

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