WEBINAR VIDEO TRANSCRIPT

Partnership for Care HIV TAC

Peer to Peer: Moving Towards a Medical Case Management Model

19 November 2015

STEVE LUCKABAUGH: Good morning. My name is Steve Luckabaugh, and I'd like to welcome you to the Peer to Peer: Moving Towards a Medical Case Management Model webinar. This webinar is brought to you by the Partnerships for Care, HIV Training Technical Assistance and Collaboration Center or HIV TAC. Partnerships for Care Project is a three year, multi-agency project funded by the Secretary's Minority AIDS Initiative Fund and the Affordable Care Act.

The goals of the project are to, one, expand provision of HIV testing, prevention, care, and treatment in health centers serving communities highly impacted by HIV. Two, to build sustainable partnerships between health centers and their state health department. And three, to improve health outcomes among people living with HIV, especially among racial and ethnic minorities. This project is supported by the HIV Training Technical Assistance and Collaboration Center, HIV TAC.

We have four speakers today. Our speakers are Emily Levine, Edward Kayondo, Judy Lethbridge, and Karen Peugh. Edward Kayondo is the P4C project lead at Lowell Community Health Center in Lowell, Massachusetts, where he has been since 2004, working with the nursing and clinical staff in the HIV field.

Judy Lethbridge, who is the quality coordinator at Lowell Community Health Center, and has been at LCHC since 2004, coordinating medical case management services for nine years. Karen Peugh is the director of HIV services at Lowell Community Health Center. She has been at LCHC since 2001 after completing her bachelors of science and health education at the University of Massachusetts Lowell.

Karen leads the HIV program and local and community HIV/AIDS education and outreach efforts. She has helped to increase and diversify funding to enhance existing HIV services, which include prevention, screening, and treatment for HIV, HCV, and sexually transmitted infections, routine HIV testing, HIV case management, peer support, HIV specialty, primary care, and treatment adherence programming. She has also been involved in developing LCHC's Sub-Saharan Faith Based Collaborative, which was created to engage sub-Saharan African organizations of faith in HIV prevention and education.

Karen's interest in staff development has further led her to facilitate the health center's annual program manager retreat, where she has provided guidance in the areas of strategic planning, cultural competency, and professional development. In 2003 and 2007, Karen was awarded the HIV caregivers award. And in 2010, she received a Sister Willie Leadership Award for her dedication, compassion, and commitment to those living with HIV. In 2010, Karen became a graduate of The Lowell Plan's Public Matters: Empowering Lowell's Leaders program.

And our first speaker today will be Emily Levine. Emily is a graduate of Columbia University School of Social Work, and has been working in the field of HIV/AIDS prevention and care for over 10 years. Prior to working with the Massachusetts Department of Public Health, she served as the director of client services for AIDS service organization, providing case management and wellness services for people living with HIV/AIDS in the 35 cities and towns of Essex County on the North Shore of Massachusetts. Emily has worked in that MDPH office of HIV/AIDS for the last four years, first as contract manager, and most recently as the service quality coordinator. Please join me in welcoming Emily Levine.

EMILY LEVINE: Thank you. So in Massachusetts, we utilize a HRSA definition of medical case management, which is using an interdisciplinary team model. Medical case management is a coordinated set of services that our client-centered and strength-based, designed to promote access, engagement, and retention and medical care. It is inclusive of psychosocial support, and it's focused on improving health outcomes for people living with HIV and AIDS.

So in the state of Massachusetts, our medical case management services were jointly procured with our Ryan White Part A funders in 2012. The office of HIV/AIDS currently funds 38 agencies for medical case management, as well as other health-related support services. And according to the state genuine data, which is our data collection system, 8,835 unduplicated clients were served across all of our funded programs in fiscal year '15. Which, for the state of Massachusetts, is July, 2014 to June, 2015.

So the framework in which we expect our providers to provide medical case management are with these three areas. So interdisciplinary team can be comprised of medical case managers, peers, which are people living with HIV and AIDS, nurses, social workers, and doctors. We expect that all members of the team have equal access to client information. And this is especially important in a medical setting.

So our expectation is from doctors and nurses all the way to our direct service staff of peers and medical case managers, anyone working with a client should have access to an electronic health record, or any records for the client, and be allowed to participate in all meetings. The goal is to maximize service access and coordination by offering a comprehensive approach to service provision through a team of people with complimentary skills.

Medical case management services are expected to be provided within a harm reduction framework. And as such, they should be flexible and low threshold. Medical case management is expected to be provided in homes, [INAUDIBLE] treatment facilities as well as medical

settings. And anyone with a documented HIV diagnosis living in the state of Massachusetts should be eligible to receive some level of support from one of our funded programs, if requested. And medical care managers are required to ensure that clients are reassessed for their needs for services regularly, as well as to complete individual service plans along with other types of documentation.

And in Massachusetts, we are currently moving the state's medical case management system towards an acuity-based system. So based on need in which our limited resources are able to be focused on those clients who are in most need of the services. We at the state understand that need amongst clients fluctuate over time, and that services should be responsive to that need. And the services can be either ongoing, or provided at a time limited basis. And again, really, it should be based on client need.

So here are all the components of medical case management. Our case management-- funded case management programs are expected to provide these in some way, shape, or form. So medical care coordination. We expect that case managers are tracking medical appointments, communicating with providers, coordinating appointments, and most of all, ensuring that there are no barriers to attending these appointments. In particular, transportation. So we fund programs to be able to provide transportation to appointments if necessary. And that is an integrated component into case management.

Medical accompaniments and supporting and coordinating access to other ancillary services, such as other medical specialists or even dental visits are expected. Additionally care coordination can extend to nonmedical services like substance use treatment and mental health. Benefits counseling is to facilitate and coordinate access to the various benefits. In particular, health insurance and assistance with prescription drug coverage. And in Massachusetts, we call that HDAP.

Adherence support is ensuring clients know how and why they need to take medication and providing support if they need assistance. This is particularly where I think we can highlight the advantage of these interdisciplinary teams. So while some programs have adherence nurses, medical case managers and peers can also provide this support. And peers are particularly helpful in this area where they can be called in to really sit with a client, spend a lot of time with the client talking about their lived experience, how they have learned how to take their medication as prescribed, and again, really speak from experience.

Housing advocacy. So any activities relating to assisting clients to remain stably housed. We think of that as like rental assistance, utility assistance, or housing [INAUDIBLE] certification. And it should be noted that for any of the more complicated cases, we actually fund, regionally fund agencies to provide additional housing support as needed for folks who require it.

Social service coordination is really-- it's a catch-all for all those other services that a client might need. Substance use risk reduction and sexual health promotion. Case managers will provide education, guidance, and practical support when talking to clients about facts and

sexual health, as well as other risk reduction activities. They must be comfortable talking about sex, sexuality, and sexual health, as well as drug use. And to do so in an appropriate way and in keeping with our expectation that the work be client-centered and provided within a harm reduction framework.

The final thing to note is that we fund medical case management in a variety of settings. So in nonmedical sites, like community-based organizations and outpatient mental health clinics, as well as medical sites, community health centers, hospitals, and smaller infectious disease practices.

It's important to note that regardless of where these services are provided, the expectation is that a client will receive the same set of medical case management services. And so it's in this way that we seek to reduce the duplication of services across our service system, but it also reduces the necessity of a client needing to go to multiple sites to get their needs met. It's expected that clients who receive medical case management at medical sites don't just receive that support during medical appointments, although it can be coordinated in such a way that allows the client to only make one trip.

We really want to make sure that the services are provided as needed, when they're needed, and where they're needed, and not just on the provider's time frame. And I think our next presenters at Lowell Community Health Center really exemplify how our funded medical case management services are operationalized in a community-based medical setting. So with that, I'll turn it over to Edward.

EDWARD KAYONDO: Thank you, Emily, for that presentation. We thank HIV TAC for giving us this opportunity to participate in this Peer to Peer discussion about the case management model. It has worked for us and our clients at Lowell Community Health Center. And also [INAUDIBLE] would like to let everybody know that our mission at Lowell Community Health Center is to provide carrying, quality, cultural [INAUDIBLE] services to the people of greater Lowell, regardless of their financial status, to reduce health disparities and enhance the health of the greater Lowell community, and to empower every individual to maximize their overall well being.

Our main vision for the health of the greater Lowell Community being for everyone to have sufficient access to high quality, holistic health care, education on prevention, health care priorities, and everyone should be knowledgeable about and responsible for his or her own health. Most of our clients come from areas farther than the greater Lowell area, and the details are in the handouts that you have. So I'll just briefly speak about the highlights of most of the data that you have in the handout.

As you see there, currently within that period of October 14 to September the 15 of this year, we had 395 active clients. As reported by the MDPH 2012 records, Massachusetts had over 18,000 HIV/AIDS clients, and of those 505 reported in Lowell, Massachusetts. And you see we served a bulk of those clients.

The demographics are nearly as we have at the national level. Although if you translate those numbers, a percentage of our male clients is about 58%, whereas at the national level, it's about 76%. We have about 42% female with nationally about 23%. And less than 1% transgender. Overall, we have about 35 to 40 new clients per year, and some of these are just coming in from different areas. They are HIV positive, whereas others are new diagnoses, of which about 14% [INAUDIBLE] tested through our prevention and screening services.

5% of our patient population is under 19 years old. About 54% 20 to 49 years old. 41% are 50 to 79 years old. And [INAUDIBLE] 38% are Latino compared to the 21% at the national level. So we have a very high Latino population. And 62% are non-Latino. And most of these are also Asian population.

We do serve diverse races and ethnicities, and that is within the details given. So we have clients throughout all races and different countries as far as Uganda, Zimbabwe, and Russia. 42% of our clients list English-- English is not listed as their primary language. So we use a lot of interpretation within our clients.

41% have a CDC defined AIDS diagnosis. So we are [INAUDIBLE] about 72% are virally suppressed. That's under 20. And that speaks much about our case management and medical team. 88% were suppressed, under 200. 46% report heterosexual contact as the exclusive mode of exposure.

17% of our clients exclusively reported MSM as the mode of exposure. In Massachusetts, most of the MSM clients tend to gravitate towards Boston. And 41% reported MSM plus IDU as a mode of exposure, compared to a national level which is about 57%. So we have more heterosexual and IDU modes of exposure within our community.

14% of our clients were tested, as I said, through our prevention screening sites. We have these from different sites. And as far as from within the health center from all kinds of providers. Others come when they [INAUDIBLE] or are referred from different areas within the state.

71% of our population have Medicaid or children's health insurance programs, or other public fundings. 60% are below 100% of the Federal Poverty Level, compared to about 75% nationality. And we find that 72% report stable and permanent housing compared to around 82% at the national level. Which, again, shows how much work our case managers and clinical team put into these clients. And with those few slides, I will be happy to yield to Judy to give us the details of our case management model. Thank you.

JUDY LETHBRIDGE: Thank you, Edward. Good morning. Why do we have medical case management? Medical case management is intended to be a temporary support and not a lifelong relationship. Case manager support is especially valuable when individuals are newly diagnosed, when they're struggling with addiction, and when the client's world seems to be coming down around them. Along with the peer advocates, the medical case manager can provide both emotional support and guidance in this time of transition.

The goal of medical case management is for clients to develop self-sufficiency. During their sessions, the medical case manager can provide perspective as well as concrete assistance while building the client's coping skills and capacity. They help move the clients through their challenging circumstances into a hopefully less turbulent present and future.

Being integrated into clinical practice, it provides more comprehensive services. Providers have 15 or 20 minutes to spend with each patient. The medical case manager is a resource who has time to talk about his or her medical and social challenges, prepare the patient for subsequent appointments, and generally be on their team.

Medical case managers are coaches, facilitators, supporters, advocates, and educators. The medical case manager can offer opportunities for individual and group-peer support. They can educate the client about available services, they can teach social skills, and they can provide role playing, preparation for disclosure, and improved medical fluency.

Who are Lowell Community Health Center's medical case managers? We have one full time equivalent nurse for complex case management care. We have two medical assistance referral specialists, and we have five medical case managers, whose titles are case managers, with a various special skills. Our medical case managers are from many regions of the world with various skills and training. They're male and female, Asian, Latina, Middle Eastern, African, and white, straight, and gay. They are trained as medical assistants, nurses, and health educators. They have varying levels of education and expertise.

The language competencies that we currently have are English, Spanish, Khmer, which is the Cambodian language, and Arabic. Our HIV team as a whole adds access to French, Portuguese, and several African languages. In the broader health center, we have 28 different languages spoken, and the phone access to specific interpreters is always available.

Our cultural competencies. In addiction services, we have some medical case managers with more experience providing addiction services. They also have received Narcan training, and we'll refer to our testing program to enroll interested clients. As I'm sure most of you know, Narcan helps reverse opioid overdoses.

LGBTQ. Lesbian, Gay, Bisexual, Transgender, and Questioning. One medical case manager identifies as gay and participate in a regional subcommittee looking at concerns of LGBTQ individuals. Also, our agency annually requires cultural competency training, and this may include LGBTQ topics.

Immigrant/refugee. We have several staff who themselves have been through the naturalization process prior to citizenship, and who are familiar with the challenges that accompany being part of an immigrant or refugee community. Women in youth. One of our medical case managers' roles is to provide services to HIV positive women during and after pregnancy, to HIV positive children, and to their affected but HIV negative family members. Cultural competency is critical to connecting with clients, whether that is based on spoken

language or knowing norms of various subcultures. We try to have a great deal of diversity in the people providing our case management care.

What skills do the medical case managers bring? They bring personal competencies. Being non-judgmental, caring, and client-centered are important personal characteristics for our medical case managers. Organized, yet flexible. Medical case managers can be pulled in several different directions at once by multiple clients, and it is important that they being organized to perform high quality work, but flexible enough to meet the client's needs.

Other competencies. Our current internal competencies include two medical assistants who have experience in referrals and medical case management. These competencies help inform their clinical work. Another medical case manager was formerly part of a local homeless shelter and has experience at a methadone clinic. Each team member has some housing experience, but we work with HOPWA funded agencies in the city to expand our patients' access to housing. As previously mentioned, several of our staff are familiar with immigration issues, and can be a resource for our medical case managers.

This diagram shows how I see the medical case manager's role. There is a central gear to connecting everything else. And if it's missing, things cannot work easily for the client. In the diagram, you can see some of our internal process. Our testing team will refer a newly diagnosed individual to an intake staff member, who then connects the patient to a medical case manager.

A medical appointment is scheduled, usually within seven to 10 days. The client is brought to our health benefits staff to apply for insurance if needed. And an application is completed to our HIV drug assistance program. As Emily said earlier, we call it HDAP. It's ADAP in many other states.

By the time of the first medical appointment, the client usually has insurance and medication access in place. The medical case manager may attend part of that first medical appointment, as well as subsequent medical appointments. The medical case manager often acts as a go-between for the clients and the providers. The medical case manager encourages the client to connect with a peer advocate who can share his or her personal experiences living with HIV. The medical case manager also can help the patient connect with community resources as needed.

What else do medical case managers do? They coordinate with the prevention and screening staff for new diagnoses. When a new diagnosis is made within our department, the intake staff, who happens to be the lead medical case manager, coordinates with the testing team to be available when the client receives their diagnosis to affect a seamless transition to care. If she for some reason is not available, we have backups that will provide that assistance. We complete an intake and initial assessment of need. A detailed intake is conducted within 60 days of entering the program to assess needs in a systematic fashion.

Facilitating treatment adherence. Medical case managers schedule medical appointments, usually within the clinic but also with medical referrals. They may schedule nonmedical appointments as well. They attend clinic visits, off-site and on-site. Site This can provide support, and sometimes they provide interpretation if language is an issue for compliance with necessary referrals. Because while we are multilingual here, many of the people-- the providers in the area do not have the language capacity that we do.

They contact pharmacies. If a client is having difficulties with obtaining his or her medication, a medical case manager may act as an advocate and resolve whatever barriers exist for the patient, as well as verifying if the medication has been picked up. They encourage and assist clients with medical visit attendance and ongoing treatment adherence. This may include ongoing reminder phone calls or assisting with transportation. Access to the EMR and treatment planning is critical to what medical case managers can do. With access to the EHR, medical case managers can see the provider's and nursing notes with regard to this patient, and are able to follow up as needed.

Medical case managers also participate in care team meetings. Care team meetings give the opportunity for medical case managers to share their insights for specific patients, as well as learn more about the standards of care expected of HIV service providers. Medical case managers then are able to do outreach and to work with clients toward improving the quality of care they are receiving.

What else do they do? In our facility, medical case managers co-facilitate support groups. Teamed up with our peer advocates, our medical case managers act as co-facilitators in our weekly support group. They provide emotional and social support. Often we find that a medical case manager is the only person in a client's life besides the doctor who is aware of his or her HIV status. This makes the medical case manager's role very valuable to the client when he or she has questions, concerns, and fears regarding their illness.

They're engaged in outreach and reengagement in care, and part of that is making home visits. Our medical case managers conduct outreach to patients who seem to have fallen out of care. If attempts are made to contact the client by phone and telephone fail, then the medical case managers may do a hospital or home visit paired with nurses, peers, medical assistants, or other medical case managers.

They complete semi-annual assessments and service plans. Semi-annual assessments may serve clients in a couple of ways. They can help a patient in crisis by making measurable and achievable goals that are short term.

It is also for the medical case managers to touch base with less acutely needy clients and to keep them stable and keep their problems from becoming crises. For example, a client who is a little behind on his or her rent can get budgeting help and maybe some housing assistance before they get too far behind and result in an eviction notice. Then medical case management,

as we've said through all of this, coordinates care and services to help them be adherent to their medical care.

Medical case managers also educate clients in these areas listed below. Not limited to these, but these are some examples. The HIV life cycle, correct, consistent condom use, risk reduction, medical visit preparedness, goal setting and achievement, budgeting, coping strategies, social skills, how to fill out forms, and activities of daily living.

And what else do they do? They interact with nurses, medical assistants, referral specialists, internal and external providers, quality team members, peers staff. They interact with other agencies providing HIV case management. They interact on behalf of patients and for annual events. Within Lowell, we have other medical providers and other agencies providing support services to our mutual clients, including HIV case management.

Our patients are not required to have their entire care team at Lowell Community Health Center. They may need only a peer advocate, only medical visits, or only receive case management. This is ideal for the patients and can present some complexity for care coordination. Fortunately, the individuals from these same agencies work with us on our two big annual events, World AIDS Day in December and the Boston AIDS Walk in June. The fosters a constructive relationship between our agency and theirs.

What do Lowell case managers do? They connect clients to medical insurance, treatment, copay assistance, HIV specific support services, support groups, whether the support groups are internal or external. I think we have support groups in the Boston area, for example, that are HIV positive Africans. We don't have enough here to do that, so we are able to refer out to them.

We also have our internal support groups. We have a weekly group that's a general group. We have a biweekly group that is addressed to those under 30. And we have a monthly group that is our women's group. They also refer people to topic specific support groups. Anger management, bereavement, domestic violence, rape crisis, AA, et cetera. We also connect clients to addiction services, detox, overdose education, and Narcan distribution, needle exchange.

Behavioral health services. We connect clients both internally with our behavioral health services department and externally to local community providers. We connect clients to educational opportunities, including English language learning, adult ed, and local community college courses. We connect clients to legal assistance, and then community support services such as food pantries, shelters, et cetera.

Medical case management training. You must be saying, with all these things that they do, what kind of trainings do they get? So they get specific medical case management trainings, and they also can participate in some internal trainings that are available here at Lowell. Motivational interviewing. We have a certified medical interpreter training called Bridging the Gap. We have

what we call check trainings at the Community Health Education Center. And they can go for a certificate that they are a certified community health educator. We have trainings with community liaisons from pharmaceutical reps. And we have internal and external trainings, conferences, and webinars such as computer skills or cultural competency or health disparities if they're relevant to job responsibilities.

How do we incorporate medical case management in or work? Our example here is pap testing. Earlier this year, the quality team reported that the cervical pap smear testing numbers were low for our patient population. Training was given to the entire team to understand the standards and the importance of pap testing for HIV positive women.

The MAs and the nursing staff followed up and scheduled appointments, but the medical case managers did something additionally to keep this ongoing and to make this sustainable. They would review with clients, when they came in, the status of the pap testing, when they came in for reassessments. They would explore any barriers and educate a client on the importance of pap testing. They would incorporate a pap test into their six month goal at appropriate. They would set an appointment with the help of the medical team. They would remind the appointment of the client a day or two before, and arrange transportation.

Our process intervention began in April of 2015 and ended in October of 2015. During that time, we were able to increase our annual pap compliance from 47% initially to greater than 67%. And that's a six month time frame, so we were very pleased with that.

Another example of how important medical cases are in our work. Emma was affected in 1992. She came to us in 2005. And from 2005 to 2012, she struggled with her adherence to medical visits and medication.

In December of 2012, the medical case manager she had and this patient developed in ISP together. And then the case manager was able to get at what really Emma. Emma's goal was to buy a home in her native country, and it was within three to five years. The medical case manager and Emma discussed steps to make this a reality, and one of those steps was taking her medication so she could continue to work.

From April of '13 to the most recent labs in August, the viral load remained below 20 for the first time since we had seen her. And for the first time since we had seen her, her CD4 finally climbed over 200. This goal remains an important part of Emma's ISP. And as she is able to work and her health improves, she may actually be able to achieve that. She's got another couple of years to go.

This is an unusual case, because normally our client's goals are not so global. But this client needed a vision of a long-term goal, and the case manager worked with the patient until they found a goal.

Most commonly, medical case managers try to help clients form goals that are more Specific, Measurable, Achievable, Results-focused, and Time-bound, otherwise known as SMART goals. That framework provides the opportunity for small successes, which when built upon, may ultimately lead to self-sufficiency.

What makes it work? Medical case managers and peer support staff are respected as contributing members of the team. Clients tell things to their medical case manager that they don't tell to their provider, providing a more complete picture. Medical case managers bring a community competency to improve the understanding of the rest of the team, and they work towards solutions.

What do we mean by community competency? [INAUDIBLE] cultural beliefs influence behaviors in ways that providers cannot anticipate. Medical case managers may identify barriers that medical providers do not have time to explore and address. Medical case managers can sometimes learn about and explain different beliefs client might have.

A couple of examples from our experience. One patient showed intermittent viral blips, alternating with being undetectable. As a result, the patient was forced to have labs drawn monthly. Through conversation with this patient, the medical case manager learned that some Asian cultures believe that drawing blood weakens a person, so he hated having his blood drawn so often. The medical case manager explained to the patient that if you took every dose of his medications and was undetectable every time, they would not take his labs so often. The patient has been undetectable for years since.

Viral load and CD4 values are integrated to the reassessment. The reassessment we use has been created to touch on specific points of discussion with the client, along with financial, legal, housing, substance abuse, sexual behavior, and support system questions. There's a section entitled Access to Health Care. In this section, medical case managers review scheduled medical appointments, recent viral load and CD4 values, and ask about the challenge of adherence to medication.

Cooperative relationship with other agencies serving the client. As we said earlier, working with other agencies in these big events help draw the agencies together in service of clients. A shared electronic medical record is very important so that communication can be facilitated across locations within the health center so that we can help the clients.

And outreach and home visits. Outreach and home visits allow the medical and case management staff to connect with clients differently in a home environment. It's not a part of every patient, but it may be a part of the care plans for patients. Our assessment includes a question, asking if the client is willing to receive a home visit. And if so, by whom. Medical case management staff initially expressed concerns about the feasibility of home visits when this was introduced. But their concerns have been alleviated by having a cell phone with them and going in pairs when on a home business.

KAREN PEUGH: Hello, everyone. My name is Karen Peugh. I'm the program director here at Lowell Community Health Center for HIV and Prevention Services. I think I want to just thank Edward and Judy for such a great presentation. And I'm exhausted by all that medical case managers do, and excited to see it all in one place and remind me of the importance of medical case managers.

I think just the final comment that I'm going to make is that I truly believe the role that the medical case managers play in the retention in care is absolutely significant and crucial to the work that we do. Patients come in and see their providers every three or four months. But they're coming in and being connected with a medical case manager on a regular basis, and having all of their needs met and building relationships with them that connect them.

So having medical case managers that are connected to the mission and the values and the goals that Edward had explained at the beginning of Lowell Community Health Center is absolutely critical. And having a representative of the community has been what has made our program very successful. So I think we're open to taking any questions or comments at any point.

STEVE LUCKABAUGH: OK, if anyone has any questions, please enter them into the Questions pane on the GoToWebinar toolbar. We have a few minutes here. We could take some questions. Also a reminder that if you click on the handout section, you should see copies of the documents mentioned today. Also the slide presentation is there.

JUDY LETHBRIDGE: I'd also love to hear if anybody else is doing some really interesting things as well, if people want to post comments rather than just questions.

UNIDENTIFIED AUDIENCE MEMBER: Hi, this is [INAUDIBLE]. I wanted to ask the question, if you could speak to some of the barriers you've experienced in trying to implement medical case management, and how you've overcome some of the challenges or barriers.

KAREN PEUGH: I think that we have been very, very fortunate as a community health center, but I know that other organizations have barriers around the level of acceptance of a medical case manager into the care team. And we haven't experienced that as much, but we do have some providers that would maybe prefer that a medical case manager not be part of the visit where we have other providers that they're very comfortable in having a medical case manager be in the visit and supporting the patient and the provider at the same time.

So I think that the expectations set upfront with our providers has just always been that we have access to the same information that they do, and that we are able to support them and provide them with further resources to benefit their patients and push their plan and agenda through. And helping the providers definitely see the value as well with the medical case managers being able to share other information with them. So that's probably the biggest barrier that we encounter.

We ran into a barrier several years ago when what had just been social services case managers were really forced to mature into medical case managers. And I don't know if that's what you're looking at. But we were able to do that because we do have a team that works very cooperatively together. And we were able to do trainings. The state graciously did an adherence training for some of us that we then came back and trained the staff so they would have that part of the medical a little more closely.

We've always had in-house speakers, for example, through the various drug companies. We've had speakers that expand people's views of what the medical piece is. And I think as newer people come on, if the expectation's in place already, then they are able to-- it just is natural to them.

STEVE LUCKABAUGH: So we have a question that did come in. Are any services offered to family members in terms of education about HIV and treatment?

KAREN PEUGH: So we will absolutely, if a patient is comfortable-- our client comfortable in signing a release for us to speak to family members, then they are welcome into a visit, and we're able to offer. We do have Part D funding, which allowed us to work with affected family members, as well as infected family members. So we definitely maximize our opportunities around that, as well as we make referrals to the State Partner Services where the health navigators are able to work with people that are impacted and potentially infected by our patients that are HIV positive in do some of that education.

STEVE LUCKABAUGH: OK. Thank you. If anyone else has any questions, please enter them into the Questions pane.

EDWARD KAYONDO: Just as a comment, that initial assessment when a client is enrolled in case management services, it's very important because at that particular time, our lead case manager can figure out not only which services the client will need, but also decide on which case managers would work best with that particular client.

And also, it's also very important that you don't only wait for the client to ask for services, together with the provider, and figure out which services the client might need, even though they have not measured them yet. And when you do something like that, the clients get to believe that you are really interested in their well being, and that keeps that bone together. And they'll open up more, and everything will work out well.

STEVE LUCKABAUGH: OK, I'm not seeing any more questions, if you have any final comments you'd like to make.

KAREN PEUGH: I think we're good.

JUDY LETHBRIDGE: I think that if anyone does come up with questions in the future, they can reach us through the P4C, and we could answer them.

STEVE LUCKABAUGH: Definitely. Yes. All right. Thank you for participating in today's webinar. We hope that you find the information provided useful as you continue your P4C project. And ask that you take a few moments to complete the feedback survey that you will receive when you close out of this webinar. You will also receive it via email.

Today's webinar was recorded, and the audio and video versions of the webinar will be available on the P4C website within the next few weeks. Copies of all of our prior P4C webinars are currently available on the website on the P4C Resource Materials page at p4chivtac.com. You will need to log in to access the materials. If you need login credentials, send an email to p4chivtac@mayatech.com.

Thank you again for participating in today's webinar. And thank you to our speakers for those excellent presentations and comments. If you have any additional questions for the P4C project, or for any of our speakers, please email us at p4chivtac@mayatech.com. Take care, everybody. And we'll see you next time.