
CARE DELIVERY MODEL

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**East Boston Neighborhood Health
Center**

OVERVIEW

- ◆ **Issues and goals of care**
- ◆ **Insurers requirements : A framework**
- ◆ **Fleshing out the framework**
- ◆ **Additional ingredients/lessons learned to ensure management of care**
- ◆ **An operational plan**

MANAGING CARE OF HIV/AIDS PATIENTS

◆ ISSUES:

- Medically complex
- Rapidly changing medical practice
- High utilizers of services
- Increased need for social, mental health and substance abuse services
- Need for coordination of care
- Need for support for care givers

GOALS OF CARE

- ◆ **To provide care that is:**
 - **comprehensive**
 - **coordinated**
 - **high quality**
 - **accessible**
 - **cost effective**

INSURERS' REQUIREMENTS

- ◆ **Clinical expertise**
- ◆ **Continuum of care**
- ◆ **Case management**
- ◆ **Culturally and linguistically accessible care**
- ◆ **Consumer involvement**
- ◆ **Linkages with community-based organizations**
- ◆ **Quality assurance**

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CLINICAL EXPERTISE



CLINICAL EXPERTISE

- ◆ **Improved outcomes when care is delivered by experts**
- ◆ **Definitions of expert:**
 - **experience is more important than specialty:**
 - » **case load of > 6 HIV/AIDS patients in prior 12 months; >20; >50**
 - **Provider must pass HIV/AIDS exam, submit to chart reviews, fulfill HIV/AIDS CME requirement**

EXPERTISE: SPECIALTY vs INTEGRATED APPROACH

- ◆ **Specialty based care:**
 - specialists are the PCPs - allowance made by insurer
 - PCP specialists are supported by providers expert in HIV nursing, case management, social services, etc.
- ◆ **Pros and cons:**
 - expert care more easily assured
 - specialty clinics require large volume of patients to ensure financial viability

EXPERTISE: SPECIALITY vs INTEGRATED APPROACH

- ◆ **Integrated approach:**
 - **HIV/AIDS care is integrated in general medical care setting**
 - **PCP is a general internist or family practitioner**
 - **consultation/guidance provided by HIV/AIDS specialists**

INTEGRATED APPROACH CONTINUED

◆ Pros and cons

- Utilizes PCPs' experience in managing chronically ill patients and serving as gatekeeper
- Patients' confidentiality more assured
- Alternative for practices with smaller HIV/AIDS case loads:
 - » can support the development of patient care services by having varying patient populations utilize these services

ENSURING EXPERTISE AND QUALITY CARE

- ◆ **HIV/AIDS CME requirements**
- ◆ **Treatment protocols:**
 - **Baseline evaluation**
 - **Routine health maintenance**
 - **Antiretroviral therapy**
 - **Opportunistic infections prophylaxis**
 - **Postexposure prophylaxis**
 - **Algorithms for diagnosis and treatment of HIV related diseases**

TREATMENT PROTOCOLS



ENSURING EXPERT CARE IN INTEGRATED MODEL

- ◆ **Close PCP and HIV specialist teaming**
- ◆ **Support from HIV nurse, social worker, case manager**
- ◆ **Train PCPs on how to monitor care, detect and recognize side effects and treatment failure and when to call the specialist**
- ◆ **Remove insurers' disincentives to calling in a specialist:**
 - **HIV specialty consultation is included in treatment guidelines**

EXPERT CARE AND HAART

- ◆ **Need for a prescribing and adherence protocol:**
 - **HIV specialist decides, with patient, on HAART regimen**
 - **HIV Nurse (or case manager) reviews administration and side effects, develops schedule and individualized adherence strategy**
 - **Protocol for monitoring patient during therapy**
 - **Standards for HIV specialty consultation**

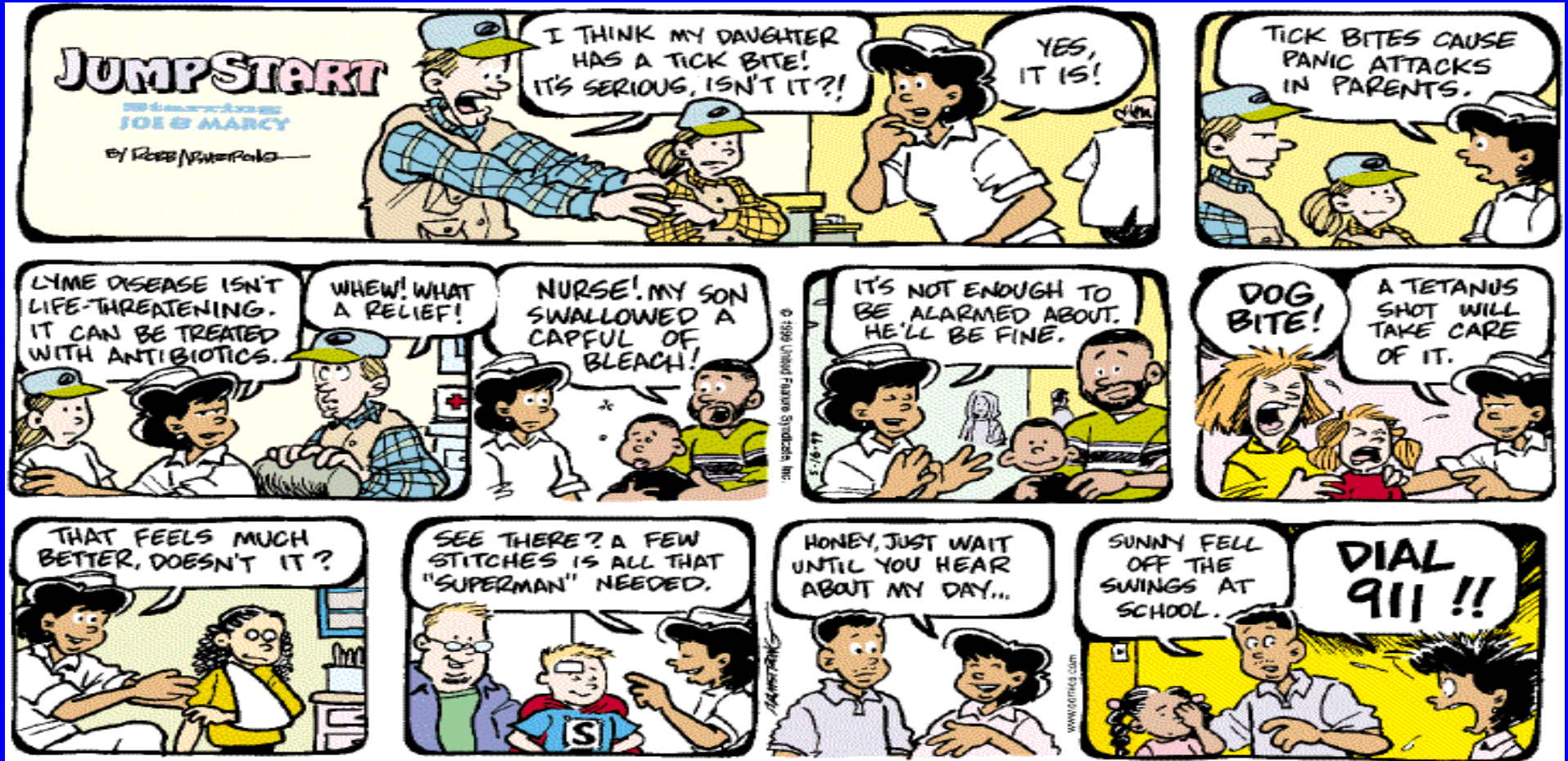
CONTINUUM OF CARE

- ◆ **Outreach, prevention/education**
- ◆ **Full range of medical/specialty and diagnostic services**
- ◆ **Access to HIV therapeutics and clinical trials**
- ◆ **Mental health and substance abuse services**
- ◆ **Home health care**
- ◆ **Transportation**

MENTAL HEALTH AND ADDICTIONS TREATMENT

- ◆ **Must address these issues to have effective medical care and quality outcomes**
- ◆ **Even if not capitated for MH/SA; if not addressed adequately, affects medical utilization and outcomes**
- ◆ **Our intervention, SPNS 2: Better integrating MH/SA into primary care**

CASE MANAGEMENT



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CASE MANAGEMENT

- ◆ **Clinical care coordination**
 - medical
 - mental health/substance use
- ◆ **Goals:**
 - development of a care plan
 - ensure implementation of care plan:
 - » ensure timely and coordinated access to full range of services
 - » ensure communication among providers

CASE MANAGEMENT

◆ Concrete services case management

housing

benefits

transportation

food, clothing

referrals for :

» legal assistance, vocational assistance and counseling, patient and family support services , etc

CULTURALLY AND LINGUISTICALLY ACCESSIBLE

- ◆ Outreach to all members of HIV/AIDS community
- ◆ Bilingual/bicultural providers
- ◆ Interpreter service
- ◆ Cultural sensitivity trainings
- ◆ Consumer involvement

CONSUMER INVOLVEMENT

- ◆ **Goal:**

- to ensure that the needs of consumers are met

- ◆ **Forms:**

- Consumer Advisory Board
- Focus groups
- Patient satisfaction surveys
- Public hearings/forums

- ◆ **Examples: model changes, operational changes, patient orientation manual**

LINKAGE TO CBO'S

- ◆ **Utilize and support the infrastructure of CBO's to ensure access to a full range of services:**
 - **concrete services case management**
 - **school-based health clinics**
 - **HIV counseling, testing and risk reduction**
 - **needle exchange**
 - **services for victims of domestic violence**
 - **local public health departments**
- ◆ **Participate in Ryan White Planning Councils**

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MANAGING CARE



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CHANGING CLINICAL PRACTICE FOR CAPITATION

- ◆ Prevent illnesses/hospitalizations
- ◆ Manage hospitalizations and specialty care
- ◆ Improve communication
- ◆ Learn from experience: case reviews, QI and utilization evaluations

PREVENT ILLNESSES/ HOSPITALIZATIONS

- ◆ Treatment protocols, adherence strategies and quality assurance
- ◆ Provide care in the community:
 - creative use of home care nurse, outreach worker, volunteers
- ◆ Integration of mental health and substance abuse treatment into primary care
- ◆ Cooperative health care clinics
- ◆ Provide 24 hour telephone access to a provider
- ◆ Use safe alternatives to inpatient care

HOSPITALIZATION ALTERNATIVES

- ◆ **Use outpatient Urgent Care Clinic**
 - improved communication and consideration of hospitalization alternatives
- ◆ **Safe alternatives:**
 - observational care
 - day treatment: infusions, transfusions, chemotherapy
 - subacute nursing facility
 - comprehensive home care services
 - transitional housing, adult day health

MANAGE HOSPITALIZATIONS

- ◆ **Physician rounder in hospital all day, 7 days/week**
- ◆ **Practice based inpatient nurse case manager partners with the rounder and:**
 - **identifies all admissions to ensure management by practice team**
 - **directs discharge planning from time of admission, working with the practice HIV nurse**

MANAGE HOSPITALIZATIONS

- ◆ **Specific inpatient ward**
 - Nursing staff is oriented to practice philosophy and community resources
- ◆ **Rounder directs all clinical decisions**
- ◆ **Co-management during specialty admissions**
- ◆ **Daily communication: rounder and PCP**
- ◆ **Weekly inpatient case management meetings**

MANAGE SPECIALTY CARE

- ◆ **Identify 2 or 3 hand-picked specialists in each discipline who will provide both outpatient and inpatient care**
- ◆ **Orient specialists to philosophy of care, nurse case manager and patient co-management**
- ◆ **Jointly develop extended clinical pathways for common conditions**

IMPROVE COMMUNICATION

- ◆ **Essential communications:**
 - PCP, HIV specialist and HIV nurse
 - PCP and other specialists
 - PCP and inpatient rounder
 - PCP and Urgent Care staff
 - Care coordinator and inpatient nurse case manager
 - Care coordinator and concrete services case manager
 - Care coordinator and mental health/addictions treatment providers
 - Care coordinator and PCP

IMPROVE COMMUNICATION

- ◆ **HIV team meetings**
 - development of care plans with input from multidisciplinary providers
 - documentation in medical record
 - interval assessments on status of care plan implementation and necessary revisions
- ◆ **Care coordinator serves as key central communicator:**
 - day to day input from inpatient team, home care, mental health/substance abuse agencies

LEARN FROM EXPERIENCE

- ◆ **Perform case reviews:**
 - **Identify and address systems problems**
 - **Identify and address unmet service needs, eg. housing alternatives for homeless patients**
 - **Use case reviews to re-acculturate clinicians to think capitatedly, e.g. alternative ways to safely manage patients in the community**

LEARN FROM EXPERIENCE

- ◆ **Utilization and QI assessments:**
 - **Close the loop between program evaluation and clinical care - Utilize information from evaluations to improve care:**
 - » **improve management of care at SNFs if lengths of stay are increased**
 - » **hire a home/community based RNP if Emergency Room utilization is increased because patients aren't engaged with PCP**
 - » **improve mental health/SA care if evaluation of low HAART rates identifies depression and drug use as significant factors**

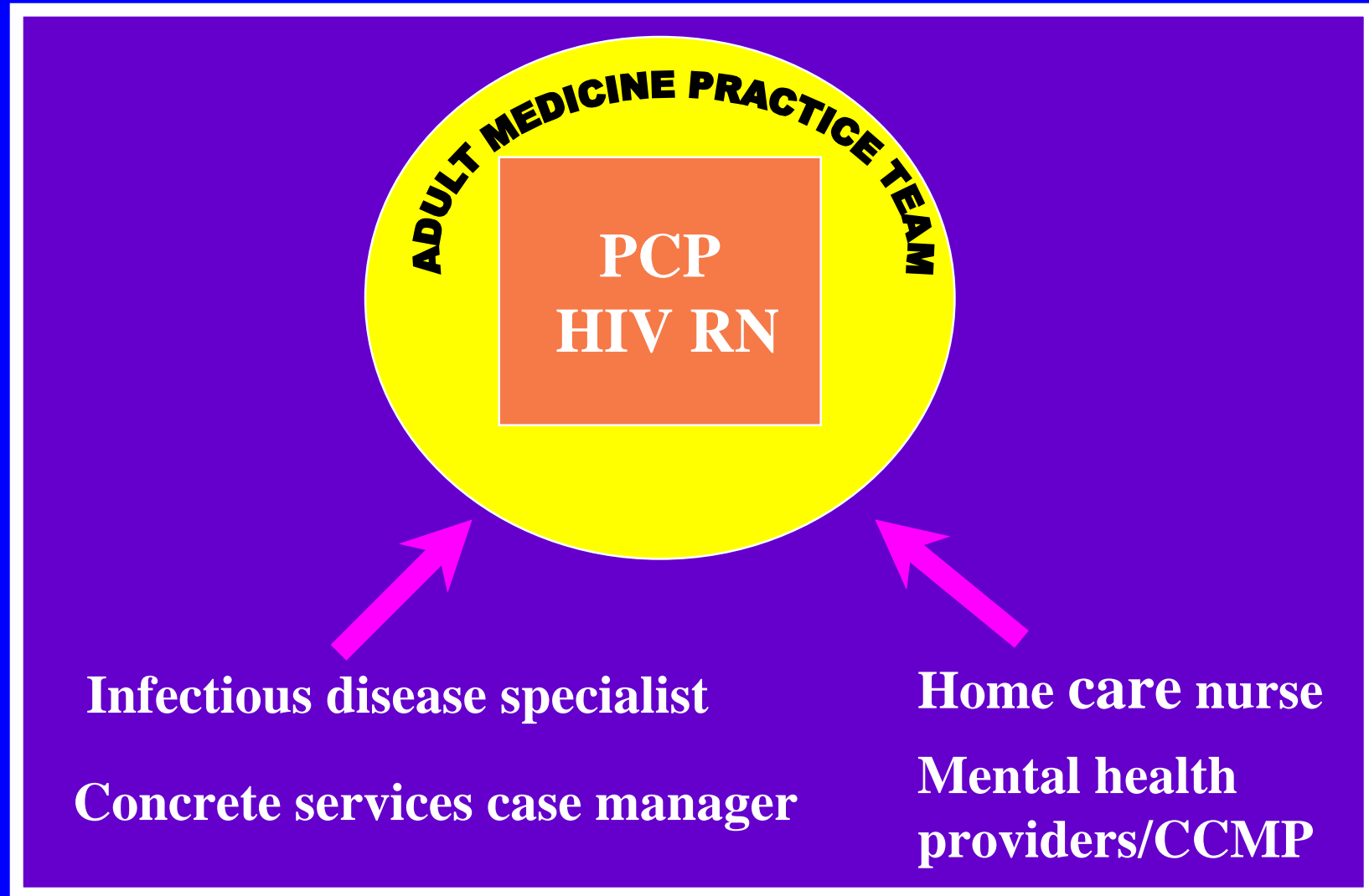
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CORE MODEL ELEMENTS

- ◆ **Primary care providers are managers of care**
- ◆ **Comprehensive on-site services**
- ◆ **Service integration through a multidisciplinary team approach**
- ◆ **Network of contracted specialists and services**
- ◆ **Focus on prevention, health maintenance and rehabilitation**
- ◆ **Goal of providing care in the community with support of PCP and family to that end**

PROJECT SHINE: MODEL OF CARE



CONTINUUM OF CARE

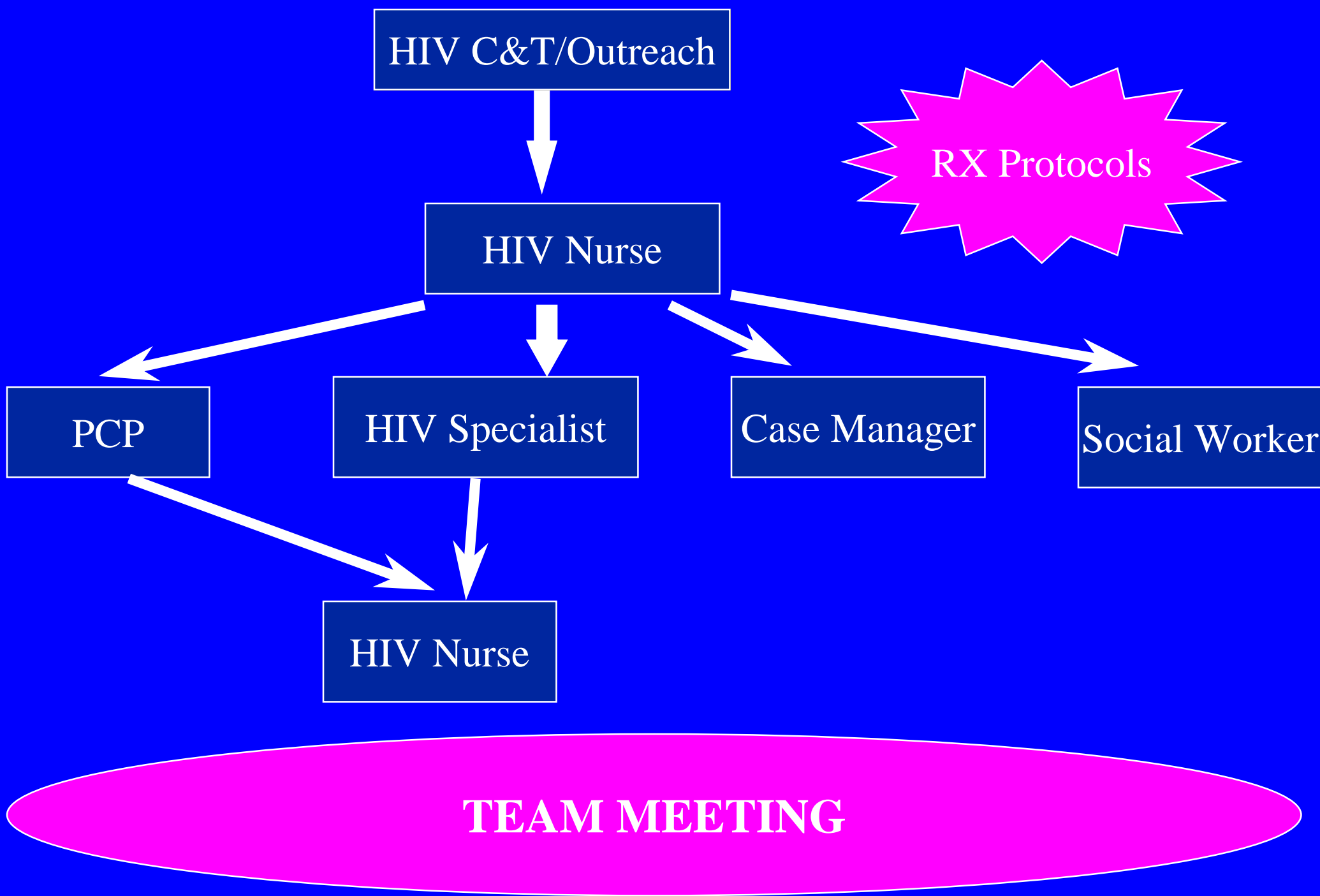
- ◆ **Outreach/HIV Counseling and Testing**
- ◆ **Primary, specialty and urgent care**
- ◆ **Laboratory and expanded radiology**
- ◆ **Nutritional care**
- ◆ **Dental referral**
- ◆ **24 hour access to an HIV nurse or physician**
- ◆ **Managed care inpatient units**
- ◆ **Chronic care facilities**

CONTINUUM OF CARE

- ◆ Home and hospice care
- ◆ Primary care based mental health and social services, including concrete services case management
- ◆ Pastoral care program
- ◆ Volunteer program
- ◆ Interpreter Services
- ◆ Consumer Advisory Board

CASE MANAGEMENT

- ◆ **Multidisciplinary team:**
 - PCP, HIV Specialist, HIV Nurse, Case Manager, Social Worker,
 - also, home care nurse, nutritionist, psychiatrist, outside service providers
 - also serves a QI function
- ◆ **HIV Nurse is Medical Care Coordinator and CCMP Social Worker is Coordinator of MH/SA treatment**
- ◆ **Partnering of two coordinators**



HIV C&T/Outreach

HIV Nurse

RX Protocols

PCP

HIV Specialist

Case Manager

Social Worker

HIV Nurse

TEAM MEETING

OPERATIONAL PLAN: STAFFING

- ◆ **PCP panel sizes:**
 - **AHF- 1 MD +1 Midlevel: 500 AIDS patients**
 - **NY SNPS- Plans must define panels while ensuring designated access standards**
- ◆ **Productivity: JHU- 9 units/half day session**
- ◆ **Case management panel sizes:**
 - **Medical: CMA- 1 RNP: 40-50 patients**
 - **AHF- 1 RN: 150 patients**
 - **New Jersey- 1 case manager: 60 patients**

CONCLUSIONS

- ◆ **Managed *CARE* is ideal for patients with chronic diseases, such as HIV/AIDS.**
- ◆ **Insurers' requirements serve as a framework for HIV/AIDS care models.**
- ◆ **A multidisciplinary team approach with a designated Care Coordinator is essential to ensure comprehensive, yet seamless care.**

CONCLUSIONS

- ◆ **Changes in clinical practice, centering on illness prevention, inpatient management and improved communication, must be made in order to manage care effectively.**
- ◆ **Capitation frees providers from restrictions of fee for service billing, permitting the development of creative care models.**