



LOS ANGELES COUNTY COMMISSION ON HIV

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October 8, 2007

To: Los Angeles County Commission on HIV

From: Standards of Care (SOC) Committee

Subject: **PROPOSED MEDICAL CARE COORDINATION FRAMEWORK**

I. INTRODUCTION

A. Purpose. The Standards of Care (SOC) Committee is proposing a new framework for the provision of case management services to patients in order:

- 1) to better coordinate care for patients and ensure that the services they are receiving are fully integrated within the patient's primary health care treatment plan(s);
- 2) to incorporate best practices and lessons learned from chronic disease management that are now more applicable to the HIV medical and service response; and
- 3) to better comply with the ongoing spirit and intent of Ryan White and other federal and state HIV service delivery directions and appropriations.

B. Justification. HIV disease has passed through several key stages that have significantly altered the medical and service response to it, and its impact.

- 1) In the early 80s, AIDS was first discovered and identified. It was usually a short-term terminal illness and the opportunistic illnesses (OIs) that resulted ravished the victims before killing them.
- 2) In the mid-90s, protease inhibitors were introduced and dramatically prolonged longevity, improved quality of life, and substantially reduced mortality from HIV/AIDS.
- 3) Currently, improved pharmaceuticals for the disease and a more effective response to OIs and other related conditions mean that patients generally live longer lives, often functioning for long periods of time as well or better than before infection.
- 4) Anticipated increasingly in the future: other systemic health conditions are becoming more prevalent among long-term survivors with HIV/AIDS, often resulting from the bodily breakdown from continuing medication use, immunological stress related to HIV/AIDS, and the impact of HIV during the aging process.

While not disputing the devastating impact and serious life-threatening nature of HIV, it is important to recognize that the response to it has been critically transformed due to pharmaceutical and medical innovation, and a better overall understanding of its effects and influences. Our medical response now follows the tenets of chronic disease management more than the urgent, emergency responsiveness of the early years that were driven by a fast-moving terminal illness. Yet, during that time, case management services, and the way they coordinate care, have not been modified commensurately.

Concurrently, federal Ryan White funding (the primary source of targeted HIV care and treatment dollars nationally) has flatlined, HIV incidence continues at level or increased rates, and the number of patients overall grows exponentially—all while medical care costs increase faster than any other sector of our economy. Those conditions beg increased advocacy and activism, but they also prescribe a review and reconsideration of our fundamental system of care.

Ryan White funding, and the local Los Angeles County HIV service delivery system that is based on those funds, is healthcare-oriented. First and foremost, HIV/AIDS is a healthcare condition. The local Continuum of Care, adopted by the Commission on HIV in 2001, surrounds a primary health care core of services. To the extent Ryan White dollars and other locally-obtained funds can be used to support psychosocial services, those services are intended to reduce barriers and increase access to primary health care. Case management services have both ensured entree into primary healthcare and have been critical to ensuring the availability of those related services.

Those case management functions must be maintained. However, they must also be better coordinated with the primary healthcare framework and context, more directly linked to medical care, and in a more efficient continuum of care and services for the HIV patient. This is clearly the national mood, and the direction of federal funding guidelines—as the role of case management services is currently at the core of a national and local discussion. Efficiency improvements are also necessary for the patient as many now have significant time pressures, cannot juggle multiple treatment plans, and have more serious health co-morbidities. Likewise, while Los Angeles County's HIV/AIDS continuum of care has promised points of entry into the service delivery system at any juncture, such a system of care is not practical nor coordinated.

The new medical care coordination framework is intended to address these inconsistencies, improve overall care for the patient, but not reduce levels of care or service.

II. MODELS OF CARE COORDINATION AND CASE MANAGEMENT

The Ryan White CARE Act was developed to build a continuum of care for underserved people living with HIV (Ashman, Perez-Jimenez, & Marconi, 2004). In recent years the HIV epidemic has shifted towards even more vulnerable populations, ethnic minorities, the poor and people living with co-occurring chronic illness, substance abuse and/or mental health diagnoses. As HIV evolves into a chronic illness, treatment of these complicated subpopulations becomes even more challenging, requiring integrated and coordinated approaches to care (Stoff, Mitnick, & Kalichman, 2004). The task of integrating medical services with the necessary support services that these subpopulations require is an ongoing challenge for providers (Gardenier, Neushou, & O'Connor-Moore, 2007). The task is worthwhile—programs that have successfully integrated services using case management and care coordination services have demonstrated improved health outcomes (Goldberg, 2005; Knott, et al., 2006).

Recent changes in the Ryan White HIV/AIDS Treatment Modernization Act of 2006 require that case coordination services further integrate medical care with psychosocial service provision (Wilson, 2006). As a result, the Commission on HIV has completed this literature search on case coordination strategies utilized in the treatment of HIV and other chronic illnesses.

The terminology used for these case coordination approaches are similar and often used interchangeably. Information below is grouped according to the specific terms found in the literature.

A. Case Management. The Case Management Society of America defines case management as “a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality, cost-effective outcomes.” Case managers (or care managers) “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” (Moro & Nash, 2003).

Though definitions for case management vary, there is general agreement that coordination of care is a primary goal. Other activities include linking clients to appropriate services to improve quality of life and to reduce the costs of expensive inpatient care, therein ensuring that more resources will be available for a larger number of people who may need them (Barney, Rosenthal & Speier, 2004).

Case management provides individual care plans for patients who are at risk for medical, social and financial challenges. Case managers provide functional assistance to patients and facilitate communication among patients and providers, but often do not possess the training necessary to address complex physiological (or psychological) issues (Krumholz, et al., 2006).

A Wisconsin program (Schifalacqua, Ulich & Schmidt, 2004), led by nurse case managers, collaborated with the patient, physician, pharmacist and social worker to develop the following components:

- Comprehensive functional, social, health and resource assessment
- Interdisciplinary plans of care
- Client education and training in health, disease and self-care behaviors
- Ongoing monitoring of client’s health, knowledge and progress toward goals
- Ongoing review of community and medical services throughout the continuum of care
- Ongoing reassessment and revision of care plan as needed, along with expected outcomes
- Discharge planning and transition out of case management

This program was successful both in clinical and financial outcomes, significantly reducing intervention costs and inpatient utilization.

Case management is critical to HIV care because people living with HIV have needs that exceed mere medical care and may include emotional, financial, legal and social problems at some time during their disease process (Sonsel, 1989). The effect of case managers is felt both directly and through their role as gatekeepers to a variety of other supportive services (Messeri et al., 2002).

Case management has been demonstrated as an effective means to address the complex needs of people living with HIV (Katz, et al., 2001; Mitchell & Linsk, 2001). Even brief interventions by case managers have been associated with significantly higher rates of linkages to HIV care services (Gardner et al., 2005). Clients who have contact with case managers report less unmet need for income assistance, health insurance, home care and emotional counseling (Katz et al., 2001).

Connecting clients to resources is time-consuming and complex, often involving a mix of advocacy and mediation (Chernesky & Grube, 2000). In addition to linking clients to services, case managers assist their clients in developing personal support systems, often using themselves as the center of that support (Chernesky & Grube, 2000). A recent Canadian study demonstrated that case management services have reduced client isolation and improved health-related quality of life (Crook, et al., 2005).

Case management services are important in promoting adherence to treatment (Office of HIV Planning, 2002). Case managers help patients overcome fears about medical treatment, adhere to medication regimens, and advocate for themselves with physicians (Katz, et al., 2001). Gasiorowicz and colleagues (2005) found that case management with a prevention focus significantly decreased reported risk transmission behaviors, including unprotected vaginal intercourse, insertive anal intercourse, and needle sharing.

Case management is integral to medical care. Messeri and colleagues (2002) found that case managers strengthen connections to care by informing clients of the availability of appropriate medical resources, educating them about their benefits and serving as advocates in coordinating medical services and accessing insurance to cover their costs (Messeri et al., 2002). This same New York City study found formal client assessment, the development of a care plan and assistance in securing public benefits to be key factors in a significantly increased likelihood of a client's entering and maintaining medical care (Messeri et al., 2002). The Wisconsin study demonstrated that pregnant women receiving prenatal care that included medical case management by a specialized nurse were significantly more likely to receive appropriate treatment and deliver infants with a lower rate of HIV infection than women whose care did not include services provided by nurse case managers (Havens, 1997).

B. Integrated Care. Integrated treatment actively combines interventions in order to treat presenting disorders, related problems and the needs of the whole person more effectively (Klinkenberg & Sacks, 2004). The most common components of integrated care programs include: patient education, case management, self-management support and multidisciplinary patient care (Owens, et al., 2005). Integration of services can be achieved in any of several different ways (Klinkenberg & Sacks, 2004):

- Communicating among providers and agencies
- Cross-training staff from different disciplines
- Consulting with professionals of other disciplines

- Coordinating treatment planning (staff of different agencies meeting to discuss needs of particular clients and developing a consistent treatment plan)
- Co-locating of services (all services located at the same sight)
- Integrating treatment teams (members of different disciplines provide coordinated direct service to the same client)

A recent literature review of integrated care programs for chronically ill patients found that integrated care programs generally had positive effects on the quality of patient care (Owens, et al., 2005).

C. Disease Management. A shift toward a model of disease management, emphasizing coordination of care, evidence-based interventions and outcome evaluation is a relatively new phenomenon in the care of people living with chronic diseases (Krumholz et al., 2006). Key disease management strategies include an integrated approach to assessment and care planning that addresses medical, psychosocial, environmental, prevention and disease management needs while coordinating care across providers, settings and services (Fisher & Raphael, 2003). Disease management requires that practitioners not only identify physical risks, but also psychological and social risks that may affect medical, cost and quality of life outcomes (Claiborne & Vandenburg, 2001). Along with physicians, nurses and social workers serve case coordination functions in the disease management model (Krumholz, et al., 2006).

Basic principles of disease management include (Krumholz, et al., 2006):

- Improvement of quality of care and outcomes
- Scientifically derived guidelines
- Focus on treatment adherence
- Clinical outcomes

All of these factors should be present in an integrated and comprehensive system of care in which the provider/patient relationship is central (Krumholz et al., 2006). Several studies have documented significant benefit from positive treatment relationships to outcomes; such relationships can contribute to a client's interest and pursuit of further treatment (Sells, Davidson, Jewell, Falzer, & Rowe, 2006).

Effective disease management requires a shift from the traditional practice of single providers treating specific episodes of illness to an interdisciplinary team coordinating all services for patients throughout the course of their illnesses (Claiborne & Vandenburg, 2001). Providers that approach this multi-disciplinary collaboration from a biopsychosocial conceptual base and prioritize services based on patients' expressed needs may experience improved engagement and retention in primary care (Soto, Bell & Pillen, 2004). Disease-specific management programs have also demonstrated significantly improved outcomes and fewer readmissions (Krumholz et al., 2006).

Social workers can provide important contributions to disease management programs because of their awareness of the psychosocial and mental health issues that affect their clients (Claiborne & Vandenburg, 2001). Under managed care-dictated time-frames, physicians often must restrict their focus to physiological functioning and may not have time to fully explore the mental health, psychosocial and environmental needs of their patients. Social workers can help make the linkage between unmet patient needs and medical care (Claiborne & Vandenburg, 2001).

D. Chronic Care. Chronic disease is managed inadequately in the United States (Dorr, et al., 2006; Berenson, 2006). Chronically ill patients are often left to initiate and coordinate their own care. Although autonomy and fragmentation of the care delivery system may thwart it, regular communication with healthcare teams, including patients, nurses, physicians, social workers and others, is crucial to successful care management (Dorr, et al., 2006). To make matters more complicated, nearly one half of patients with chronic diseases seen in outpatient care settings have multiple chronic conditions (Dorr, et al., 2006).

In order to positively affect quality-of-life outcomes for people living with chronic conditions, medical and supportive services must be systematically interwoven (Leutiz, Greenlick & Nonnenkamp, 2003). Chronic care models that access home and community-based services shift from acute episode-based service delivery to an increasingly holistic approach that includes biological, psychological, social and environmental needs commonly beyond the reach of traditional medicine (Alkema, Reyes, & Wilber, 2006).

Systems accustomed to treating patients with acute illnesses struggle to provide consistent, quality care throughout the continuum of a chronic disease. Such care requires continuity of providers, attention to outcomes, observation of emerging patterns and intense support of patient self-management knowledge and skills. Global Nursing Exchange members have assembled a list of principles upon which chronic care management programs should be based (Bower, 2004). Among them are:

- Teaching patients and their caregivers how to manage their health is a cornerstone of effective care management programs
- Coaching, educating and mentoring clients are critical skills to possess as programs shift from acute care models to chronic care management
- Understanding adherence as a complex interplay between knowledge, economics, social support, culture, values, emotional health, etc.
- Developing knowledge of community resources is key; creativity and persistence are often required to develop new resources for patients with chronic care conditions

In its report on chronic care, the California HealthCare Foundation (Berenson, 2006) notes:

“The fully implemented Chronic Care Model encompasses multidisciplinary teams of professionals who collaboratively educate, counsel, and empower patients with self-care techniques to manage their chronic conditions (utilizing) individually tailored evidence-based treatment plans.” (p. 14).

The report further emphasized the importance of patient/provider relationships. Engaging a patient's primary physician is crucial to the success of chronic care management programs. Comprehensive assessment and the careful distinguishing among patients based on their clinical conditions and specific needs were also noted as key to successful chronic disease management (Berenson, 2006).

- E. **Care Coordination.** Coordinated care integrates the efforts of medical and social service providers by developing and implementing a therapeutic plan. Traditionally, coordinated care efforts have been in an attempt to reduce inappropriate use of resources (Krumholz, et al., 2006).

Coordinated care models typically provide patients with a comprehensive assessment as they enter medical treatment and coordinate and integrate all related medical and support services (Liegel, 2006). Such coordinated care requires that interacting biological, psychological and social needs should be addressed simultaneously, rather than separately and episodically. Behavioral interventions and support services must be coordinated with medical care to be fully responsive to clients' needs and to promote treatment adherence and health outcomes (Soto, Bell, & Pillen, 2004).

Continuity of care and care coordination are especially important as clients move across multiple service systems over time (Klinkenberg & Sacks, 2004). Any system attempting to provide care to the complex populations of people living with HIV must develop systems that ensure continuity of care and that include:

- Consistency between primary medical care and other support services
- Seamlessness as clients move across levels and intensity of care
- Coordination of present and past treatment episodes (Klinkenberg & Sacks, 2004)

Programs instituting care coordination services have demonstrated improved clinical assessments, provider communication and care planning (Liegel, 2006). A 2006 study which evaluated the effectiveness of systematically integrating biopsychosocial interventions with coordinated delivery of care for outpatients recovering from stroke found that mental quality of life was significantly improved for those receiving care coordination services from the social workers and posits that care coordination may also be an important intervention for enhancing the quality of life for individuals with disabilities from causes other than stroke (Claiborne, 2006).

The interface between care coordination and flexible, comprehensive data systems used to track assessments, services and referrals was noted by several studies as key to successful coordination efforts (Liegel, 2006).

- F. **Assessment.** While not a specific approach to care management, all of the above-referenced approaches stressed the importance of detailed, comprehensive, biopsychosocial assessment. Because of the consistency of this finding, notes on assessment have been included here.

An accurate assessment completed by a medical or social work professional ensures that services are warranted and appropriate—"good treatment follows from good assessment". A complete

assessment also ensures efficiency of service provision, allowing the service intensity (or amount) to vary based upon individualized need. Accurate assessment also ensures that needs can be realistically met and determines the provider skill level necessary for each service. Assessment can also successfully screen for emotional distress and mental health problems.

Social work assessment must be flexible enough to identify all the problems that a client may be encountering, not only those that have been validated by standardized research protocols. An accurate assessment of chronically ill patients is challenging because of the many domains of interest and the frequently changing circumstances of a given client (Vourlekis, Ell & Padgett, 2005).

Programs have demonstrated success in using comprehensive assessment to determine intervention levels and service intensity, as well as predicting the expertise level of practitioner required to provide such services. Several chronic illness studies have demonstrated improved adherence to treatment in programs that begin with a comprehensive, evidence-based assessment protocol. (Vourlekis, Ell & Padgett, 2005).

III. PROCESS TO DEVELOP AND IMPLEMENT NEW MEDICAL CARE COORDINATION MODEL

- A. Concept.** The Commission convened two focus groups with case management staff from various agencies on November 28, 2006. Those discussions were followed-up by discussions at SOC Committee and Standards Subcommittee meetings from December 2006 through June 2007, ongoing conversations with the Case Management Task Force, the Medical Outpatient caucus, and with Service Provider Network (SPN) coordinators.
- B. Framework.** The SOC Committee approved a final proposed framework for presentation to the community at its July 5, 2007 meeting, and subsequently presented it to the full Commission on July 12, 2007. The Commission approved the proposed framework, and accepted the plan and timeline to introduce the framework to the community for dialogue and feedback through the Summer and Fall 2007. Formal presentations of the framework were given at each SPN meeting, to the Case Management Task Force, the HIV Medical Outpatient Caucus, and two presentations specifically for consumers were convened during in that timeframe. The SOC Committee began reviewing and considering public comment and feedback from presentations and written communications in August 2007, convened several special meetings to explore all concerns raised during the public comment period, and made significant changes to the proposed framework to respond to the public's recommendations and input.
- C. Standards of Care.** The framework was presented to the Commission for formal adoption at its Annual Meeting on October 11, 2007. Upon adoption, the SOC will begin the development of a standard of care with expert review panels. The standard of care will replace three approved existing standards of care (medical and psychosocial case management, and benefits specialty),

and necessitate revisions to several other standards (*see Section VI, Recommendations*). The final standard of care is expected to be adopted by the Commission by February 2008.

D. Implementation. The Commission intends for the new medical care coordination programs to be implemented by Year 19. Concurrent with the development of the standards of care, the Commission will collaborate with the Office of AIDS Programs and Policy (OAPP) to perform financial and caseload simulation modeling to assess projected costs for the program's implementation. The Commission's Priorities and Planning (P&P) will use the findings from those simulations to determine allocations for the new service categories, and allocate funding for Year 19 implementation in the first quarter of Year 18, accompanied by directives to OAPP to conduct the appropriate solicitation during Year 18 for full implementation in Year 19.

IV. COMPONENTS OF THE PROPOSED MEDICAL CARE COORDINATION FRAMEWORK

A. Conceptual Premise. The proposed framework reflects a "biopsychosocial" orientation, illustrating a symbiotic relationship between medical and health care delivery with psychosocial services. The new emphasis merges functional responsibilities and consolidates widespread case management responsibilities.

As a result, some of the terminology has been altered to accommodate this shift in direction. Rather than referring to these services as "case management", the new model is characterized as "care coordination"—more accurately reflecting the disease management and chronic care methods of integrated patient services (and reducing confusion between the former case management and the proposed care coordination services). Similarly, while "patient" has been used to define the consumer of primary health care services and "client" refers to the consumer of psychosocial services, "patient" will also refer to the consumer of "care coordination" services.

The central tenets of the new medical care coordination framework are:

- integrated service and system design
- interdisciplinary, team-oriented service delivery
- medical and primary health care accountability
- a patient-centered focus.

B. Financial Impact. There is general agreement that the new care coordination model "may" cost more than currently allocated for case management services in Los Angeles County, but the improvements do not appear to be cost-prohibitive. Similarly, there is strong likelihood that the new model will generate savings due to more effective and efficient care, and those returns will benefit both the Ryan White-funded system and the broader health care system beyond Ryan White. As a result, the Commission has first advanced its programmatic considerations of the new care coordination framework.

In determining the programmatic features of the care coordination model first, the possible fiscal and cost implications have not been ignored. However, true fiscal impact cannot be assessed until the program design has been resolved. In short, the jurisdiction cannot define how much a new model of care will cost until it has determined what the new model of care will be. Likewise, the Commission believes that decisions about the new care coordination framework should be approached from a patient focus first, based on factors such as clinical outcomes, programmatic design, and quality control. The financial ramifications should be addressed only after ideal model of care for consumers has been ascertained.

As described in the foregoing section, this framework will lead to governing standards of care. Only once the standards of care have been adopted, the Commission can truly begin the process of assessing the cost and financial implications of a new care coordination model. The Commission intends to run financial and caseload simulations to better define program financing needs once the specific cost variables are known (through the standards).

C. Continuum of Care. The Commission's current continuum of care indicates that any patient can enter the continuum at any juncture of service. While a worthy goal and intention, without proper follow-up, it does not yield the best care for patients. The introduction of the medical care coordination framework, underscores the importance of all patients in the Ryan White-funded system having access to and being enrolled in medical care coordination services. Conversely, there should not be patients enrolled in Ryan White-funded medical care who are not also being medically care coordinated (in other words, all medical outpatient facilities must have a medical care coordination program, either as part of or attached to their services). The proposed medical care coordination services encompass a continuum of high-frequency interaction to no necessary interaction with patients, where their only involvement with the program is a communication channel open to them if and when they need it.

- 1. Points of Entry.** Patients may enter the continuum of care from any service (e.g., food pantry or housing)-and will be linked to a medical care coordination program at that time. It is understood that the Ryan White-funded system will always strive to get patients the services they need when they need them, and every effort should also be made to get them into care coordination as soon as possible thereafter (see the later section on "Unmet Need"). This will entail all Ryan White and County services having detailed medical care coordination programs to which they will assign those patients who are first introduced to the system of care through their respective services.
- 2. Provider Outreach/Communication.** The requirements are not one-way (other services to medical care coordination). Medical care coordination programs will also be required to detail and conduct outreach activities to other medical and supportive service providers and services in the local service delivery area. Outreach plays two roles in the new medical care coordination framework: as detailed further in later sections of this framework for follow-up with clients/patients, and as intended in this context to ensure that all providers are actively participating in patients' care coordination. Service Provider Networks (SPNs) will play a

critical role in overall service coordination and in helping to coordinate these service interactions between providers.

- 3. Patient Choice.** Patient choice is a critical component of our system of care, and mandated by the Ryan White program and the Health Resources and Services Administration (HRSA). As the designated “payor of last resort”, patients should be enrolled in other payor programs (e.g., Medi-Cal, VA) if eligible and willing. Within the Ryan White-funded system, the medical care programs are expected to routinely offer patients the opportunity to transfer to other medical care coordination programs—especially to larger programs where more specialty services may be available. Clients and patients will continue to retain choice of other services as well, and the medical care coordination programs must be able to support those choices.

D. Program Design. While the medical care coordination design entails new requirements, it leaves much room for creativity and innovation at the program-level. All medical care coordination programs must be linked with clinical programs (physicians). The medical care coordination program must be a single, unified program—even if it involves multiple providers—but may not be physically co-located on-site at a medical clinic.

- 1. Primary Health Care Core.** If homelessness, substance abuse and/or mental illness (three of the foremost factors in the multiple diagnosis equation) are prevalent among the population a program serves, the program may choose to engage additional providers for specific mental health or substance abuse services. While care coordination programs will not be required to offer side-by-side mental health or substance abuse services, they will be expected to establish comprehensive service agreements with mental health and substance abuse programs that will facilitate the program’s access to those services.
- 2. Program Specialization.** Similarly, a medical outpatient provider serving more than one special population may design a separate medical care coordination programmatic response for each separate patient population (for example, one medical care coordination program for Latino patients and one for Native American patients). However, a program from a provider who pledges to serve patients, but is not part of a medical care coordination programmatic response with a medical outpatient clinic(s) will not be acceptable.
- 3. Site Requirements.** Physical co-location of the medical outpatient clinics and medical care coordination programs may not always be necessary, and will be determined based on the needs of the program, the patient population and the provider(s) delivering the service. Whether or not co-located on-site at a medical facility and/or comprising satellite program sites, the medical care coordination program must operate from a central location. That central location serves as the administrative hub and primary program venue, even if intake, treatment and outreach are also performed from other locations or venues.
- 4. Management Requirements.** While the number of case workers and staff who provide direct services to patients may vary per program, every medical care coordination program must be

co-directed by both a medical care manager and a patient care manager. Depending on the size of the program and volume of patients/patient visits, the program may employ additional case workers, who are supervised by the one or both of the care managers. The care managers will assign patients to the case workers based on patient need. Or, the program may be small, or may only serve a small subset of the patient population, and the medical and patient care managers both work directly with all of their patients on an ongoing basis.

5. **Staffing Specialization.** On the medical side, a larger volume of patients may dictate that most of the medical care follow-up is coordinated by medical case workers who report to the medical care manager. On the patient care side, the larger the program, possibly the more specialized the case workers. A small program may only employ one or two case workers, who act as “generalists”. A larger program may employ several case workers, each of whom specializes in a specific area of case management, such as benefits, substance abuse, housing, homelessness, home-based, population-based specialties, etc.
6. **Program Agreements.** The medical care coordination programs will not only be expected to initiate “service agreements” to strengthen their own programmatic responsiveness (e.g., mental health, substance abuse referrals), but also to establish linkages with other Ryan White-funded services “network agreements” within the program’s service area (e.g., supportive service agencies). The SPNs can play a critical role facilitating the development and establishment of the “network agreements”. The medical care coordination programs will also be required to participate in “system agreements” (e.g., MOUs, service agreements) with the other funded medical care coordination programs. The “system agreements” will be necessary to facilitate transfer of patients between the programs, when necessary, and to accommodate clients’ needs when clients access other Ryan White-funded services beyond the immediate reach of a specific medical care coordination programs. The specifics of the subcontracting and working provider relationships and agreements will be left to OAPP, providers and other program partners to determine in situations where there might be multiple agency participants as part of a single programmatic response, in a service network, and among the funded medical care coordination programs. Those decisions will be left to the providers to justify and work out during the solicitation process.
7. **Operational Thresholds.** In order to ensure that there is a minimal level of care coordination services available to all patients in the system, there will be no program funded that does not maintain at least a .5 FTE (one half-time equivalent) medical care manager and .5 FTE patient care manager. All programs will be required to be open at least 40 hours per week (with normal business hours to be determined, in part, by the client population needs), and there will be at least one program per SPA contracted.

E. Staffing Plan/Structure. Each medical care coordination program is led by a medical care manager (clinical) and a patient care manager. The medical care manager will need to be, at a minimum, an RN. Other variations may entail a supervising primary care physician serving as the medical care manager and/or residents performing the initial assessments, especially in

programs with university or academic affiliations. The patient care manager is expected to be a Master's-level medical social worker (LCSW, MSW, MFT or related social work degree).

1. **Scopes of Responsibility.** The medical care manager is responsible for the patient's clinical needs, and is expected to directly track and address the care, treatment and adherence issues and oversee the medical components of the Comprehensive Treatment Plan (CTP). The patient care manager will be responsible for addressing the other aspects of the patients' disease-related needs, and access to other non-medical services, inside and outside the Ryan White-funded system (benefits specialty).

Even if the program uses a specialty case worker model, all patients are expected to be assigned a "primary" case worker (or the patient care manager in small programs). In the specialty context, the patients would be assigned primary case workers based on the predominant concern in their care, as assessed by the care coordination team (for example, if they are homeless, assigned to the homeless specialist). Managers and case work staff are allowed to work in the field, at their professional discretion, in order to be more responsive to patient needs. Management of a program's field work will be determined by that program.

2. **Benefits Specialty.** The patient care coordination arm of the new program design will also be responsible for ensuring that "benefits specialty" services, as defined by the current standard, are made available for clients. Benefits specialty comprise services where more intensive attention and follow-up are required to help clients access benefits outside the Ryan White-funded system of care. In larger programs, that may entail employing a specific "benefits specialist" on staff; in smaller programs, it may mean ensuring that case workers have adequate time and training to provide those more time-consuming services when needed. Treatment education services—while they will not be merged with care coordination—will be considered an important complement to these services because they are supervised by medical staff and due to their focus on treatment adherence and retention.
3. **Case Worker Qualifications.** Aside from the new nurse and social worker supervision component requirements, current case management qualifications and education are applicable for the patient care "case worker" positions. A new possible program component, medical case workers (who report to the medical care manager) would entail LVN or "specialized medical personnel" qualifications. Qualifications for the LVN case workers and specialized medical personnel will be detailed in the standards of care.

F. Coordinated Care. Standardized intake/assessment and Comprehensive Treatment Plan (CTP) tools must be developed for use system-wide by the medical care coordination programs (and incorporated into OAPP's patient-level data management system). The CTP is intended to serve as an "algorithm of care". As a comprehensive patient assessment and need-driven plan, it will depict the coordination of all care and treatment and service delivery to the patient.

1. **Intake.** All patients will receive an initial intake, "triaged" for their greatest and, perhaps, immediate needs, followed-up by an assessment. Ideally, the medical care manager will

triage patients as they enter medical care coordination services. The intake tool will consolidate a number of identifiers and indicators across a variety of services throughout the continuum (e.g., medical assessment, patient, mental health, behavioral, substance use), but will focus primarily on the patient's medical needs and the most convenient way of facilitating the patient's entry into care. The triage phase of intake will focus on addressing any immediate care and service needs of the patient. The assessment phase will emphasize determining the patient's acuity level and assigning a "primary contact". As in all services, patient needs vary, and intake may happen quickly in one visit, or may entail more elaborate work in more than a single visit to ease the patient's comfort with the process.

2. ***Home-based Case Management/Home Health Care.*** During the triage and assessment phases of the patient's entry into care coordination, the patient care manager or designated staff must determine if the patient should remain in care coordination or needs to access home-based case management (and home health care). Both programs are similar in design, so a patient receiving both types of services represents redundant service delivery. Home-based case management and home health care services are necessary for patients "on the brink of institutionalization or wellness" (provided to prevent institutionalization or to improve wellness) and demonstrate the importance of the combined medical/social work approach. If successful, the home-based case management/home health care services may improve a patient's wellness to the degree s/he can be transitioned into care coordination services. Every program will need to detail service agreements and the relationships with home-based case management/home health care providers to ensure that patients entering the care coordination system but who need home-based case management/home health care services will not fall through the cracks, and can be transitioned to services that are more responsive to their particular home health needs.

3. ***Comprehensive Treatment Plans (CTPs).*** One of the most cumbersome aspects of the current system of care occurs when patients are enrolled in multiple services and are burdened with multiple service plans. The CTP is intended to replace multiple plans and combine them into one effort to which the patient can more easily adhere. As a result, it will be necessary for the CTP to address all aspects of service delivery, and the CTP may be quite complex for some patients (high acuity). Once the patient has been triaged, s/he will need to begin developing his/her CTP with staff. The process to complete the CTP will be varied: in some cases, it can be done at the same time as intake; other cases, may require a return visit; and others, yet, may necessitate multiple visits (due, for example, to patient acuity level and possible patient reluctance). Due to the type of treatment, immediacy of services and/or their confidential nature (e.g., mental health, legal services), however, the CTP may be limited to referencing, rather than detailing, a specific treatment plan and/or the patient's agreement to seek and access those specific services.

It is intended that CTPs should be developed for all patients in the system. Recognizing the immensity of that task, it is anticipated that it will take three to five years to develop CTPs for all patients currently in the system (either creating the plans from scratch, consolidating patients' multiple treatment plans, or transferring current information into the

new standardized format). With implementation of this new service, however, CTPs should be developed for all new patients entering the system.

4. **Primary Contact(s).** Every care coordination patients will be assigned a “primary contact”, depending on his/her acuity level and the prevalence of his/her particular needs, and the program specialties and design. In small programs with no case workers, one of the care managers will serve as the primary contact for the patient. In those programs employing case workers (e.g., generalists and/or specialty case workers), a case worker from either the medical or patient care arm will be selected as the primary contact. Determining the primary contact for any patient will be done in consultation with that patient, based on whether the patient’s medical or psychosocial needs are weightier, and (in programs with specialty case workers) the specific types of medical or psychosocial needs that are most significant. Criteria for determining who the primary contacts are for patients should be determined by the program in order to ensure consistency of response and service delivery. The number of patients for whom a case worker has been designated as a primary contact will largely indicate that case worker’s caseload. Assigning “primary contacts” is not intended to impede a patient’s access to other program staff, but is meant to improve efficiency of care and communication for the patient.
5. **Case Conferencing.** Multi-disciplinary case conferencing is another important feature of care coordination. Case conferencing is the effort to convene the physician and the patient’s other care providers to strategize and assess responses to the patient’s comprehensive needs in accordance with the CTP. To the extent possible, and appropriate to the situation, the patient should be involved in his/her case conferences. Case conferencing is a reflection of the program’s professionalism, and provides a mechanism to oversee the provision of care and services, illuminates important details that might have otherwise been missed, shows “due diligence” on the part of the program, and that improves the quality of service delivery by highlighting an intensive, integrative approach to care.

It is understood that the ideal case conferencing practices are not achievable in all instances for logistical reasons, or due to lack of cooperation from non-funded care providers, or the patients themselves. However, case conferencing should be considered the objective and preserved for all those who need it, and program performance should be measured against the program’s ability to regularly engage case conferencing when it is determined a patient needs it. Program staff will determine if a patient, at any level, needs case conferencing and its frequency. Assessment/re-assessment of case conferencing needs will be expected annually for patients or others who have been determined will benefit from it during the assessment/re-assessment phase (e.g., “check-off box” on the assessment/CTP formats). Case conferencing is also an opportunity to address major life transitions for the patient, and should be conducted when possible in those scenarios, regardless of any predetermined case conferencing frequencies. The care coordination standards of care will further detail a scale(s) to assess the client’s potential need and benefits from case conferencing.

6. **Outreach.** Each medical care coordination program will be expected to detail and implement an outreach plan that will guide the program's efforts to communicate and engage the following types of patients:

- Non-active patients,
- Patients who have fallen out of care/services,
- Patients who are aware of their HIV diagnosis, but not in care ("unmet need").

Further information about outreach considerations for these specific consumer populations is included in the following section(s). SPNs are expected to help facilitate outreach activities in conjunction with the medical care coordination programs in each of the County's eight Service Planning Areas (SPAs).

7. **Transitional Case Management.** Transitional case management services will not be merged with the care coordination program. Primarily defined as a "bridge" between services for populations in significant transition (currently defined as "adolescents" and "incarcerated/post-incarcerated", others may be added), transitional case management is not intended to coordinate care as much as it is to provide patients with immediate services in order to enroll them in care. From that perspective, transitional case management more resembles outreach or Early Intervention Services (EIS).

8. **Coordinating with Other Ryan White Providers.** Occasionally, patients may choose to receive services from providers in different care coordination programs (e.g., medical care manager in one program, patient care manager in another program). Due to the patient choice mandate described earlier in this framework, the patient must be allowed access to those different services. In those situations, the medical care coordination program where the patient's medical care manager resides will be considered the primary contact and will be the program reimbursed for services to that patient. It will be left to the two programs, through their system agreements, to negotiate the appropriate share of the reimbursement for services to the patient from each program. This is an especially important consideration during the transition from case management to care coordination services, as it is expected that there will be patients interested in maintaining services with psychosocial case management providers different from the medical care coordination programs affiliated with their medical providers.

9. **Coordinating with Non-Ryan White Providers.** In particular, case conferencing will be more challenging when the patient receives their medical care outside of the Ryan White-funded system. Since the Ryan White-funded system has no authority to require medical personnel outside of the continuum to conform to case conferencing requirements, case conferencing when the patient receives his/her medical care from other than Ryan White-funded providers will be more challenging for medical care coordination programs. It should not be assumed that all non-Ryan White providers will be unwilling to cooperate; there has been significant experience in LA County of non-Ryan White-funded providers willingly collaborating for the patient's benefit. In most cases, though, the care coordination program will need to prove the benefits its services can yield. Similarly, the care coordination programs will be most effective in this arena when they are able to empower their patients to engage their private

practitioners in the care coordination process. A possible solution to mitigate the additional effort in those cases is to reimburse those situations at higher rates.

10. ***Integrating Prevention and Care.*** It is this jurisdiction's goal to integrate the prevention and treatment continuums of care, and, as a result, to enhance the seamlessness of service delivery and responsiveness to at-risk and HIV-infected consumers' needs. While this framework does not specifically address the full process of integrating prevention and care, it is believed that steps taken here will do so. While this framework does not propose merging prevention case management under the auspices of medical care coordination, there are existing standards for prevention case management, outreach (in and outside of care settings) and counseling and testing (in and outside of care settings). Relevant portions of those standards will be incorporated into the new medical care coordination standards, and all of them will be revisited to ensure that continuity of the continuum of care from prevention through treatment has been sustained once medical care coordination services are implemented. Similarly, the proposed outreach components of the new care coordination model will address many prevention needs. In addition, the care coordination standards will include secondary prevention (e.g., re-infection, infecting others), and the medical outpatient standards will be reviewed to ensure there is continuity between prevention messages in the medical outpatient and care coordination programs and settings.

F. Patient Acuity. There is no question that varied acuity levels among patients and complexity of the factors contributing to disease/condition acuity make any type of solution challenging and eliminate the possibility of a "one size fits all" program design. In the standards phase of this initiative, acuity levels will have to be fully and quantitatively defined, but, for purposes of the framework, it is understood that patients range in low to high acuity and, consequently, require different frequencies and types of service responses. Determining the patient's acuity level early in the program will also dictate the need and immediacy of care.

1. ***Caseloads.*** It is difficult to estimate caseload parameters that are relevant or applicable to all patients, and, instead, a range will better characterize caseload expectations: caseloads will span 30 (where all patients present high acuity needs) to 175 (where all patients are low acuity and who only require periodic contact). Since most programs rarely have only one type of acuity level patient, individual program and practitioner case loads are expected to fall within that range depending on the multiple acuity levels among the patient population being served. Caseload specifications will be further defined in the care coordination standards of care. While "pilot testing" is not a feasible strategy when planning a program design implementation, caseload modeling during Year 18 may help further refine caseload benchmarks. Eventual reimbursement rates should also consider reflecting multiple acuity levels.
2. ***"Non-Active Patients"***. One subset of the lowest acuity patients are those determined to be "non-active." Legally, the Ryan White-funded and County healthcare systems cannot discharge patients (although individual providers still can). However, many patients feel they do not need care coordination services (either upon entry, or later after a certain amount of

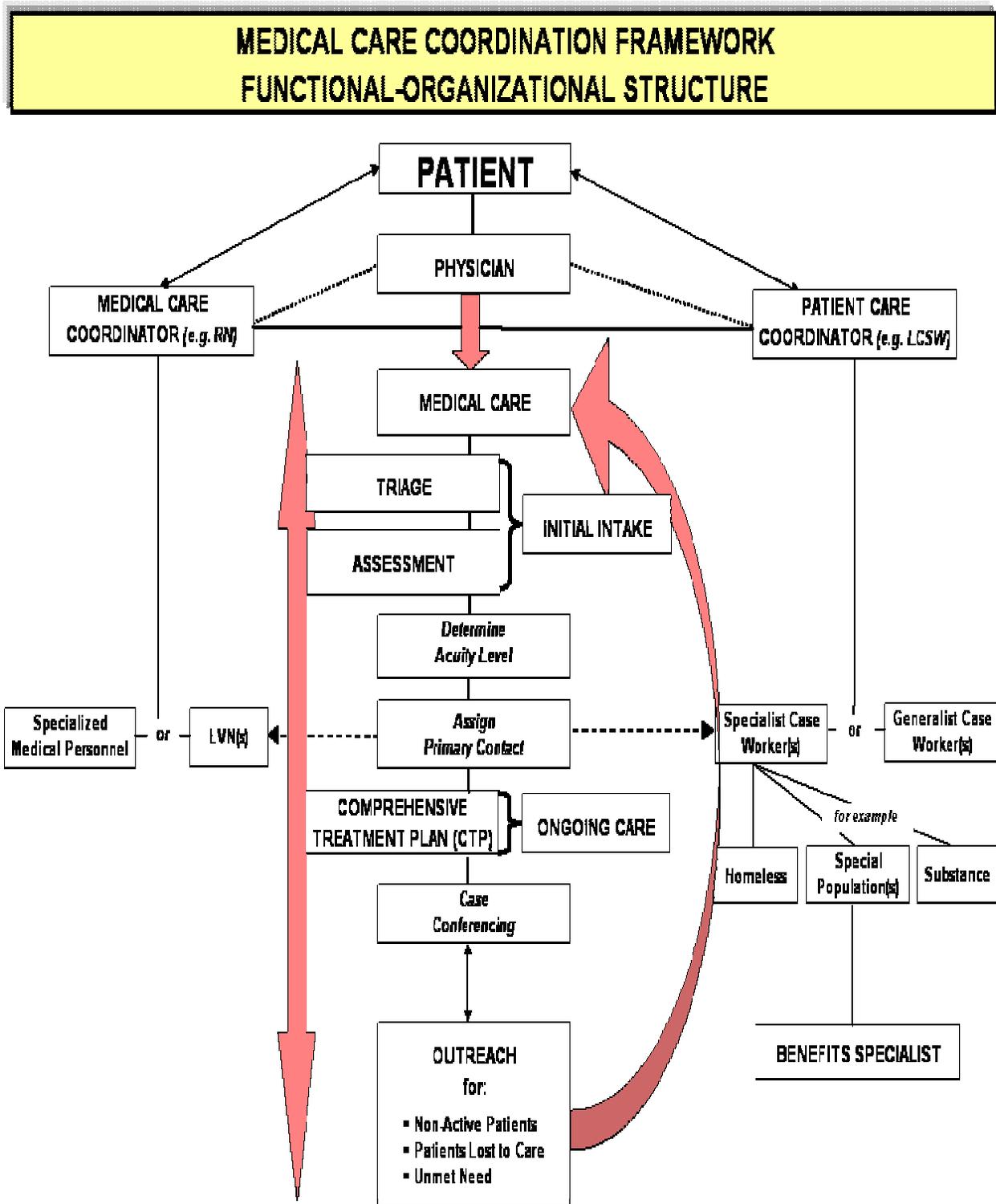
time spent in the system). When the care coordination team agrees with this patient self-assessment, the patient becomes “non-active.” While not discharged, the “non-active” designation indicates that the patient does not need the follow-up or monitoring appropriate for other patients. Officially still part of the system of care, but not requiring standard care coordination services, it is still not in the system’s or the patient’s best interest to end all care coordination contact.

3. ***Outreach for Non-Active Patients.*** Each program will be expected to define and engage outreach activities to help address the needs of and maintain ongoing community with “non-active” patients:
 - annual or biannual check-ins/ups on patients to ensure that they are continuing to do well and not needing care coordination services,
 - available to patients for simple informational requests,
 - for patients to get “sign-offs” for other services, and
 - when, and if, circumstances change and the patients find themselves needing renewed attention.
4. ***Unmet Need.*** It is also understood that there are certain patients who will refuse medical care, in spite of, in many cases, their apparent need of it. Certain patients only want services that they have identified they need (e.g., legal, substance abuse), but will not consider other services for a variety of reasons (e.g., fear, stigma). Both Ryan White legislation and HRSA advise local jurisdictions that they must orient all of their services towards getting patients into medical care. Ethically and legally, local jurisdictions are prohibited from discharging patients who will not access medical care. Similarly, HRSA has been instructing jurisdictions to address “unmet need”, defined as patients who know their HIV status but are not in medical care. Given this target population (“unmet need”), it would not be wise to remove them from care coordination services when we should be making every effort, repeatedly, to enroll them in medical care—even in the face of their initial reluctance. As a result, it is recommended that a pool of funds for “Unmet Need” be allocated annually, against which care coordination providers can bill their services for patients who they keep in care coordination but who are unwilling to engage medical care. Corresponding to Prochazka’s transtheoretical “readiness to change” model, a separate unmet need allocation allows the system to “keep the door open” so that when clients are ready for change (e.g., access medical care), the providers are ready to help them do so.
5. ***Special Populations.*** There are distinct cultural and geographic populations that may be prevented from accessing medical care coordination and other services if specific steps are not taken to address their “special” needs. The Commission has termed these “Special Populations”, has initiated a process to identify “special populations” in our community, and has begun developing Special Population Guidelines to help providers better accommodate and respond to them, and to help OAPP target more funding, if needed. The Special Population Guidelines review all services (through their standards), and detail necessary or prudent modifications to the services when dealing with members of the specific special populations. The existing Special Population Guidelines for women, youth and transgenders

will be updated to address any specifics for the new medical care coordination services, and additional special populations will be determined and guidelines written (incorporating medical care coordination) within the forthcoming year. The Commission will also need to review the intersection of these services for special populations and the current Minority AIDS Initiative (MAI) allocation for medical case management.

- 6. *System Financing.*** In conformity with HRSA's "core medical" and "supportive" service definitions, the medical care coordination program would be classified as a core medical service, while the Unmet Need Services would be interpreted as supportive services. For this new model to be most effectively implemented, this program will depend upon the development and application of the rate reimbursement structure for the care coordination services, as is currently being readied for other core medical services. Given the logistical complications of coordinating care for varied patient acuities, it is recommended that the rates reflect different acuity levels and possibly other factors.
- 7. *Service Effectiveness.*** It is imperative to measure the success of this new service model within a reasonable timeframe after implementation, and in order to modify program components if they are not effective. The new standards will include outcomes and benchmarks, which will be measured through OAPP's quality management program. The SOC Committee is also developing a new methodology to measure service effectiveness in the near future. Client satisfaction will be a key indicator in these quality measurements.

V. FUNCTIONAL-ORGANIZATIONAL STRUCTURE DIAGRAM



IV. RECOMMENDED PLANNING COUNCIL AND ADMINISTRATIVE AGENCY ACTIONS

- 1) **Commission:** Adopt the proposed medical care coordination framework, after public comment has been appropriately incorporated under the direction of the Standards of Care (SOC) Committee.
- 2) **Commission:** Consolidate the medical and psychosocial case management and benefits specialty standards of care into a single medical care coordination standard of care by the end of Ryan White Year 17 (March 2007 – February 2008). Among other elements, the new care coordination standards of care should include the following:
 - detailed acuity level scales,
 - caseload ranges with more specific guidance,
 - minimum staffing ratios,
 - case conferencing assessment requirements,
 - provider-to-provider outreach instructions,
 - detailed provider-to-patient outreach guidance,
 - items for inclusion in service/network/system agreements,
 - staff qualifications,
 - guidance from program interaction with non-Ryan White providers,
 - recommended practices to reduce barriers to access,
 - primary/secondary prevention information consistent with other standards, and
 - new outcomes, indicators and benchmarks.
- 3) **Commission:** Revise other standards of care to address system changes resulting from the introduction of the care coordination framework:
 - Case Management, Home-based: to better reflect the distinction between actual home health care and home-based case management, and to complement the new care coordination framework.
 - Treatment Education: to serve as a core medical service supplementing the care coordination framework.
 - Outreach in Care Settings: to ensure continuity between outreach activities in care coordination settings and outreach activities from other services.
 - Medical Outpatient: to ensure the consistency of care and prevention messages in medical outpatient and medical care coordination programs.
- 4) **OAPP:** Create standardized “Care Coordination Intake (CCI)” forms and “Comprehensive Treatment Plan (CTP)” formats to begin using with new services in Year 19, and update the patient-level data management system to incorporate those forms into the appropriate care coordination module.
- 5) **Commission and OAPP:** Conduct a financial analysis projecting the increased costs of the new framework, including an estimate of costs for unmet need, additional comprehensive treatment plans, and additional outreach.
- 6) **OAPP:** Conduct financial and patient flow simulation modeling alongside current case management services during Year 18 to better assess the volume and cost of care

coordination activities, to instruct service allocations for the new service category, and to identify potential challenges of implementing medical care coordination services.

- 7) **OAPP:** Accommodate the new medical care coordination service category in the medical case management rate structure, by revising the variables in the rate study architecture, and consider rate variations for the following service factors:
 - CTP and case conferencing for patients who received their medical/primary healthcare outside of the Ryan White-funded system,
 - Varied acuity levels and co-morbidities.
- 8) **OAPP:** Solicit new medical care coordination services during Year 18 (March 2008 – February 2009) to start in Year 19 (March 2009 – February 2010).
- 9) **Commission:** Reinterpret the new medical care coordination service category as a “core medical service” in conformity with HRSA’s service definitions.
- 10) **Commission:** Allocate funding for Year 19 for medical care coordination equal to the following components:
 - Current allocations/funding for the four case management service categories (medical, psychosocial, transitional and home-based),
 - The cost of medical case managers currently on medical outpatient contracts,
 - The additional cost of program outreach and communication for non-active clients.
 - The estimated cost of the new framework beyond existing allocations.
- 11) **Commission:** Allocate additional funds under the medical care coordination service category for:
 - the cost of consolidating and bringing the service/treatment plans of existing patients in conformity with the new CTP format and up-to-date over a three-year period, and
 - Special populations, especially given the current MAI allocation for medical case management.
- 12) **Commission:** Allocate supportive service funds for “unmet need” and outreach to clients characterized by “unmet need”.
- 13) **OAPP:** To the extent possible, dedicate program support, technical assistance (TA) and capacity building/development funding in the upcoming years—especially in Years 18 and 19—to help-providers/programs migrate to the new medical care coordination services. That assistance will be particularly effective used in the following ways:
 - to conduct financial and patient flow analysis/simulation modeling;
 - training for providers in the continued use of on-site and real-time data management systems to support the new services;
 - proactive communication about the procurement, solicitation, decision-making and contracting processes;
 - adherence to and guidance from the appropriate standards of care;
 - building appropriate staffing structures;
 - determining and defining business models/design and partnering relationships;
 - strengthening the Service Provider Network (SPN) role in SPA-based program design;

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- eliciting and engaging community dialogue on the design and implementation of standardized tools;
- updating service utilization and client reporting practices;
- development of care coordination (including the medical case management portion) training and certification activities;
- development of benefits specialty training(s);
- transitioning patients/clients into the new system; and
- the development of appropriate and responsive data management and interface (“bridge”) programs.

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