

HRSA CARE ACTION



NOVEMBER 2008

Why Now?

The Connecticut Model

Nashville, TN

Indianapolis, IN

REDEFINING CASE MANAGEMENT

I might only spend 15 minutes with the doctor every 3 months, but my case manager calls me in between to see how I'm doing, remind me of doctor's appointments, and to see if I need anything. We have a relationship.

—An HIV-positive consumer, Nashville, TN

Every day, the interaction between client and case manager affects whether an individual or family accesses and remains in primary medical care. Indeed, the relationship mentioned in the quotation above from the Nashville consumer exists between people living with HIV/AIDS and case managers in community-based agencies, clinics, hospitals, homes, correctional facilities, and even parking lots all across the country.

DID YOU KNOW?

- Medical case management is considered a core medical service.
- In 2006, the Ryan White HIV/AIDS Program spent approximately \$135 million on case management.¹

ONLINE RESOURCES

Towards a typology of case management: <ftp://ftp.hrsa.gov/hab/Typology.pdf>

Applying elements of the chronic care model to HIV/AIDS clinical care: moving CARE Act clients from intensive case management toward self-management: www.hab.hrsa.gov/special/ccm/ccm.htm

Los Angeles Part A grantee standards of care: www.hivcommission-la.info/soc.asp

Oregon Part B grantee standards of care: www.puc.state.or.us/dhs/ph/hiv/services/cmstdrds.shtml

Ohio Part B grantee case management outcomes tool: www.careacttarget.org/library/tools/ohiooutcomemeasures.pdf

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DIRECTOR'S NOTES

Case management is the glue that holds the many services, people, and parts of the Ryan White HIV/AIDS Program together—and rightfully so. Case managers are often the most familiar “face” of the Ryan White HIV/AIDS Program for consumers. In both medical and nonmedical support capacities, case managers make sure that patients get from point A to point B in their care—often literally driving them there to do it.

The place of medical case management and non-medical case management has long been recognized by Ryan White providers working in the trenches. Although case managers come from many different backgrounds and can hold various degrees, one thing is certain: They help consumers remove roadblocks on the way to better health.

As the HIV/AIDS epidemic continues to change, so do the roles case managers play. Today, medical case management is considered a core medical service—a reflection of the increased emphasis on treatment and treatment adherence. HRSA encourages providers across the country to continue to examine ways they can improve their care delivery and the vital role of case managers in that care.

*Deborah Parham Hopson
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HIV case managers go to great lengths to assess client needs and design individualized client-centered service plans to mitigate crisis situations and stabilize individuals and families in the HIV care system. Case management activities occur in a variety of settings. They are conducted by dedicated professionals with nursing degrees, masters in social work and, in some cases, no degree but the knowledge only life experience can bring.

Case managers are an essential part of the Ryan White HIV/AIDS Program service delivery system, yet many are reexamining their roles and functions in light of recent changes in the legislation, which encourage Part A and B grantees to review their case management system and to make adjustments.

Some communities have used the legislative change as an opportunity to collaborate across Ryan White programs to develop standards for medical case management. Others are considering the changes necessary to shift from a psychosocial to a medical model of case management. And others are increasing funding for medical case management as a core service and increasing the number and availability of medical managers.

The programs discussed in this article are considering ways to strengthen and enhance services for people most in need and to foster better life sustaining relationships between medical providers and patients.

Why Now?

In December 2006, the Ryan White HIV/AIDS Treatment Modernization Act changed to include medical case management as a core service and allow other models of case management to be funded under support services. Parts A and B of the Treatment Modernization Act require at least 75 percent of funding available for services to be spent on core medical services, leaving a maximum of 25 percent for support services.²

According to the FY 2006 Allocations Reports submitted by Part B programs, case management services nationwide constitute 33 percent of State Direct and Consortia Services. For that same year, Part A Programs submitted Planned Allocations Tables indicating that case

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Cover: A client (left) in consultation with a provider at Albuquerque's Truman Street Clinic. © See Change.
Pages 3, 5, and 7: Clients with case managers and clinicians at the Grady Family Clinic, Atlanta. © See Change.

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management services were expected to total approximately \$83.5 million. These reports were submitted before the change in the legislation and may not capture some types of medical case management previously considered part of ambulatory outpatient medical care. Also, treatment adherence services, now considered part of medical case management, were reported separately in 2006. In the 2008 program and fiscal reports, it is expected that a higher percentage of dollars will be reported under the medical case management category.¹

The current service definition from the HIV/AIDS Bureau (HAB) defines the critical services included in

medical case management and the competencies needed by medical case managers (see box below). It does not specify or require a terminal degree. The definition takes into account the variety of case management models, settings, and difficult system changes that could occur with a more stringent definition.

Yet, the change is much more than a new name for a set of service activities. To qualify as medical case management, activities must be tied to providing, facilitating, and keeping a client in primary medical care. The requirements include ensuring that medical case managers are part of clinical care teams to help clients navigate medical care. They also include a comprehensive



MEDICAL AND NONMEDICAL CASE MANAGEMENT

HAB DEFINES MEDICAL CASE MANAGEMENT as a range of client-centered services that link clients with health care, psychosocial, and other services. Coordination and follow-up of medical treatments are components of medical case management. Services ensure timely, coordinated access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of clients' and key family members' needs and personal support systems. Medical case management includes treatment adherence counseling to ensure readiness for and adherence to complex HIV/AIDS regimens. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic reevaluation and adaptation of the plan as necessary over the life of the client. It includes all types of case management, including face-to-face meetings, phone contact, and any other forms of communication.

NONMEDICAL CASE MANAGEMENT includes advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Nonmedical case management does not involve coordination and follow-up of medical treatments, as medical case management does.

clinical assessment of need that is reassessed and reevaluated periodically. The medical case manager need not be located in the primary care facility, but he or she must work closely and directly with the primary care provider.

Failure to address this paradigm shift could result in case management activities that are impermissible under core medical services, thus jeopardizing the ability of providers to meet the requirement that 75 percent of service dollars be allocated to core medical services.

Through the use of future evaluation projects, HAB will work to further define core competencies and identify measures to assess the quality of Ryan White case management services.

Collaboration Across Programs

Connecticut and Medical Case Management

HIV case management in the State of Connecticut is funded by Ryan White HIV/AIDS Program Parts A–D. During FY 2007, 39 agencies received more than \$4 million in Ryan White HIV/AIDS Program funding to provide case management services.³ Last summer, the Part B program took the lead in convening representatives from Parts A–D to discuss the creation of statewide medical case management standards. With the assistance of a facilitator, the group began discussing current models of case management and the needs of different geographical areas across the State to obtain a statewide perspective on the issue.

At the time of the first meeting, the Part B provider had not made final funding decisions for the year. The Part B program had had internal discussions about medical case management centered on the need to create efficiencies in the model(s) of case management, the possible use of an acuity scale to assess need, data collection, and the creation of performance indicators. Connecticut had begun a series of training meetings for case managers entitled “Introduction to Medical Case Management.” The goal was to familiarize case managers with the new medical model.

Connecticut has two transitional grant areas (TGAs): Hartford and New Haven. (TGAs are cities with a total population of at least 50,000 and between 1,000 and 1,999 reported AIDS cases in the past 5 years.)² The State includes several urban, suburban, and rural areas.

HIV service delivery is always challenging in rural areas. Stigma, transportation, and a lack of services are just a few of the major barriers affecting access and

retention in care services. To address the need for primary medical care, a significant portion of the medical care in Connecticut’s rural areas is provided by private physicians. The State also has a large network of community-based case managers in rural and urban areas; many of them already perform some, if not all, service components of medical case management. Ryan White HIV/AIDS Program providers across the State often receive funding from more than one Ryan White Program component.

Part A Programs

Part A TGA programs in New Haven and Hartford had already developed service definitions, which were approved by their respective Planning Councils when this collaboration first began. Both Part A programs acknowledged that service definitions were only a small part of the work ahead; other tasks included the development of standards, the need for training among providers and clients, and discussions of the need to create or enhance linkages of medical case management to other service categories. They welcomed the opportunity to work with others in completing this task and made the group aware of the role of the Planning Councils and other timeframes and deadlines specific to their local city procurement and quality management processes.

Part C Providers

Several Part C providers discussed their work and the role of medical case managers in their programs. Because of the focus on primary care for the Part C program and its origins in the Bureau of Primary Health Care, medical case management is the predominant model of case management. The processes and procedures, forms, standards, and best practices were already in place, as was the requirement to spend at least 75 percent of funding on core medical services in place. The Part C representatives agreed to share their knowledge and expertise in the effort to create statewide standards.

Part D Programs

Part D programs are structured on a family-centered model that allows providers to work with the affected family member. Medical case management for these programs involves partnerships between case management service providers and nursing or clinical coordination. Some of these partnerships involve other Ryan White-funded clinics. The close connection between case management and clinical care is integral to Part D

programs and has also allowed them to develop and track clinical indicators for their patients. The Part D programs, too, offered to share their experience and knowledge with the working group.

Process and Results in Connecticut

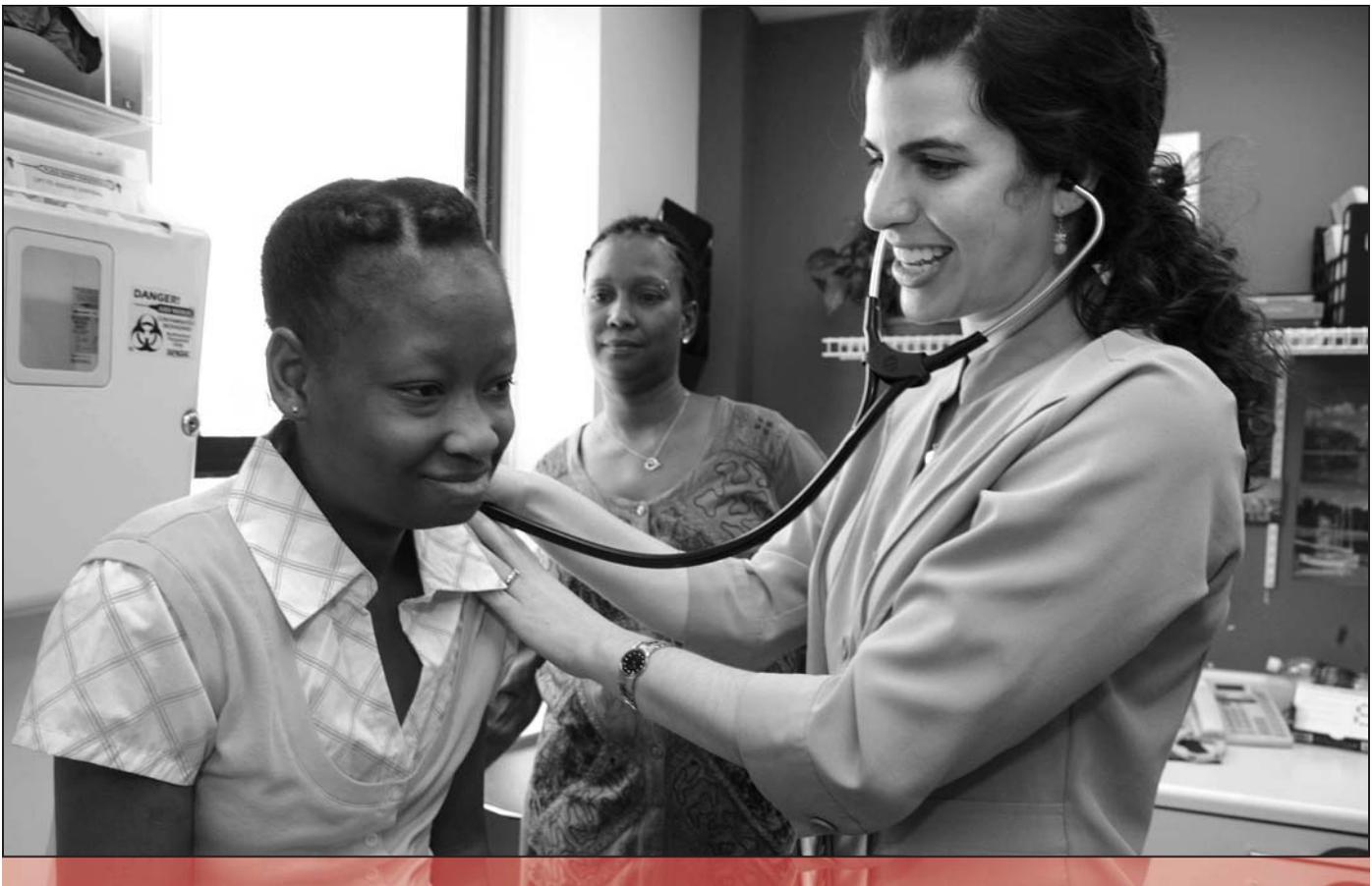
Over the course of several meetings, the group agreed on a uniform definition of medical case management that contained all the critical activities as defined by HAB. The collaborative working group developed a set of core standards of care, with indicators and outcomes reflecting the minimum expectations for the delivery of medical case management in Connecticut for all Parts. Core standards are applicable in both community and clinic-based case management programs. Each Part was given the option of adding to (but not deleting from) the core standards to meet the needs of its service populations. The standards will also go through an approval process by the Part A planning bodies. The group agreed to reconvene in 6 months to discuss successes and challenges and make adjustments to the core set of standards as needed at that time.

Lessons Learned

Having an outside facilitator help explain HAB's expectations provided everyone with an opportunity to hear the same message regarding the issue of medical case management and thereby helped unify the group around a common understanding. This approach enabled the group to begin its tasks with clear direction and purpose. The process also enabled participants to share their expectations and then come to a consensus on a set of medical case management standards and outcomes that could be used statewide and adapted to the specific needs of each Part and geographic area.

The expertise of the Part C and D grantees helped enrich the process and may have enabled the group to complete its tasks in less time than expected. These programs brought important working knowledge of existing medical case management practices and assessment tools to the meetings. The "real-life" perspective focused discussions as the group brainstormed on what to include as part of the core standards.

The assistance of staff and program support was invaluable to the group in compiling and analyzing data



The close connection between case management and clinical care is integral to Part D programs.

from the programs; geomapping case management services; and tracking changes and updates as the group moved through the process of revising draft standards, outcomes, and indicators. The work group always remained client centered in its approach and gave careful consideration to specific actions that might affect clients if those actions were included as standards.

With the development of new medical case management standards, the State Department of Public Health has developed and initiated several trainings to increase the core competencies of current case managers to provide medical case management services. These trainings (which include a component on the new standards of care) are now part of a mandatory comprehensive training curriculum for all new Part B medical

April of this year, the grantee hosted a 1-day medical case management meeting to help providers of case management services understand the new definition and discuss the key activities now included in the definition of medical case management. The grantee wanted to create a welcoming environment where providers felt free to raise issues and concerns to foster an honest discussion of case management services.

Process and Results

A facilitator helped manage the meeting and move the discussion forward. The meeting was not held at a service agency, nor was it held at the grantee's office. A conference room at a city-owned golf course was the selected venue. Taking participants out of their offices

Twenty percent of [Indianapolis] respondents indicated that case management, including medical case management, was the single service most necessary to ensuring good health.

case managers. The plan is to provide training for all medical case managers funded by Part B. Those funded by Ryan White Parts A, C, and D are invited to attend.

Workgroup discussions have included approaching the AIDS Education and Training Centers regarding some of the training needs. The Part A Planning Councils in New Haven and Hartford have acknowledged that this paradigm shift requires education and training for their current case managers and clinicians who may not be accustomed to working with consumers in this manner. The work group also acknowledged that consumers need training on how to use medical case managers effectively. Many consumers may have to adjust their assumptions or let go of past experience with case managers with the change to a chronic disease management model.

Medical Case Management and the Continuum of Care in Nashville

The Nashville TGA program recently completed its first year of operations. During FY 2007, everything—including hiring staff, forming a Planning Council, developing contracts, and learning the Ryan White HIV/AIDS Program and legislation—had to happen quickly. In

helped them focus more on the topics for discussion. It was also important that providers not feel that they were being summoned to the grantee's office to be reprimanded. Judi Grimes, the clinical quality manager for the Nashville TGA, said, "I think the neutral territory changed the climate, and then the timbre of the conversation became more acceptable for everyone."

In addition, the meeting opened with a panel of three Nashville consumers, who talked about their case managers, medical services, and the activities their case managers perform to help keep them in care. They presented their impressions of case management and reminded the meeting participants of the important role these services play in the lives of clients.

The session clarified the difference between medical and nonmedical case management. Information on HAB's intent and expectations regarding medical case management was also shared with all participants.

There was positive interaction between the providers and a discussion of tasks that could be done to move community- and clinic-based case managers in the direction of HAB's definition. Several good models currently exist in the TGA, and future meetings will focus on the ability to replicate key components at other agencies.



Consumers need training on how to use medical case managers effectively. Many consumers may have to let go of their past experiences with case managers with the change to a chronic disease management model.

The clinical quality manager shared a process for developing standards of care. In addition, she discussed the need for providers to assist the Planning Council with the development of standards as the grantee moves forward to define minimum expectations for the delivery of all Ryan White HIV/AIDS Program Part A services.

The need to continue meeting and working through some of the issues of medical case management, including models for clinic- and non-clinic-based case managers, was clear. How medical case management should coordinate with other HIV and non-HIV services still needs to be decided. Nashville is using the new service definition as a catalyst to examine several of its HIV services by asking questions and collaboratively developing the answers.

Lessons Learned

The session answered many questions, but Pam Sylakowski, Part A program director for the City of Nashville, says, "This is the beginning of a conversation

regarding our continuum of care. The session raised many questions we have yet to explore—not only defining and understanding medical case management but how it will coordinate with early intervention services and primary care to create a seamless system."

Sylakowski adds, "The answers to many of the questions are obtainable, but only if we create the opportunities and the time to continue asking key questions in order to distinguish the similarities and differences between each of our providers of medical case management. The answers to the questions may also be affected by the different populations each of the agencies serves and whether the setting is urban, suburban, or rural."

Coordination and linkage with other services is an important activity of medical case management, but the need and level of coordination and linkage may vary according to the populations served by each agency and locale.

Participants agreed that having everyone together at the meeting, including consumers, nurses, case

managers, the Part B grantee, and Planning Council members, helped foster greater appreciation for each other's role.

Part A and Part C Medical Case Management in Indianapolis

In the Indianapolis 2002-2005 needs assessment, 20 percent of respondents indicated that case management, including medical case management, was the single service most necessary to ensuring good health. The need for case management services ranked just slightly lower than dental services in the same series of needs assessments. Two different Indianapolis hospitals historically provided medical case management in their clinics.

Part A funds will expand the current Part C medical case management model to other area clinics that only have had psychosocial case managers. The new medical case managers will work to decrease system fragmentation and the number of patients lost to care. One of the new medical case management positions will focus on the Hispanic population and will include a medical interpreter as part of the clinical care team to work with newly diagnosed Spanish-speaking clients.

Helen Rominger works as a nurse practitioner at the Wishard Memorial Hospital infectious disease clinic, which receives Ryan White HIV/AIDS Program funding under Parts A, B, and C. "I welcome any effort to better assist clients and am surprised to learn that my work is defined as medical case management," she says.

Until recent conversations with the Part A program director, Rominger thought medical case managers were social workers with specific clinical skills. She is the nurse who facilitates clinical issues. At Wishard, Rominger is part of a multidisciplinary care team that

includes dentists and mental health professionals. Social workers, or care coordinators, are also part of the team. The care coordinators handle enrollment for third-party payment programs, such as Medicaid and Medicare. They also facilitate referrals for external services outside the Wishard Care system.

Sometimes, care coordinators identify medical issues for the nurses or medical case managers. Rominger does not seem to be worried about service category definitions or funding streams: "My job and my role [are] to facilitate things for the patient, particularly those things which are clinically related or affect their health. It might include prescription refills, disability paperwork, assessing the need for specialty care, handling acute health issues, or just calling and following up after a doctor's visit."

Lessons Learned

Training psychosocial case managers is critical to increase the number of people who can provide quality medical case management services. An assessment of the current skill sets is a good starting point.

Rominger also mentions that "many nurses and clinical providers will need training [because] they understand their roles and what they do but may not have considered them in terms of medical case management."

Case management continues to be an essential service that enables individuals and families to receive care. The change in the legislation emphasizes that medical case management should be used as an opportunity to examine this vital service. Many grantees are already engaged in efforts to comply with HAB service definitions and to ensure that medical case management—like all Ryan White HIV/AIDS Program services—extends and enhances life for those most in need.

REFERENCES

- ¹ U.S. Department of Health and Human Services. *Health Resources and Services Administration, 2006 CARE Spending, FY 2006*. [Unpublished data].
- ² Ryan White HIV/AIDS Treatment Modernization Act of 2006.

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- ³ State of Connecticut. *Part B 2007 program document on case management services*. 2007. [Unpublished data].