



INTEGRATION OF CARE COMMITTEE

February 26, 2008
3 – 5 PM
GMHC, 119 W. 24th Street

DRAFT MINUTES

Members Attending: I. Gamble-Cobb (Chair), C. Aguirre-Pellicer, B. Backofen, M. Gbur, MD, D. Greene, P. Laqueur, F. Laraque, M.D., M.P.H., C. Numa, J. Park, A. Richardson

Staff Present: *DOHMH:* D. Klotz, M. Irvine, Dr.P.H., A. Santella, Ph.D.; *AIDS Institute:* E. Mooney

I. Welcome/Introductions

Ms. Gamble-Cobb opened the meeting, followed by introductions.

II. Integrated Model of Care/Closing the Gap: Analysis of Quality Improvement Strategies

Mr. Park said that the IOC's role is to look at models of service delivery to improve care and treatment and to integrate services to improve health outcomes. To that end, two presentations will be given today that focus on quality improvement and case management models. The IOC will use the data to begin a discussion on developing new models of care that better promote access to and maintenance in integrated care.

Ellen Mooney, intern at the NYS AIDS Institute, presented on "Closing the Gap: A Critical Analysis of Quality Improvement Strategies". Care coordination is the deliberate organization of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of health care services. Identifying, implementing and measuring care coordination strategies has been impeded by the lack of a single framework, and four models have been identified that could both inform current work and act as a foundation for a care coordination framework. Care coordination goal measures include patient outcomes (viral load, CD4, quality of life) and cost outcomes.

Common strategies with an evidence base are: multidisciplinary teams, disease management, and case management. Other common strategies are integration of services and self-management. Published studies showed that with multidisciplinary teams, patients receiving case management,

transportation, or mental health treatment were significantly more likely (15%-18%) to receive regular care than patients who did not. Some clinical outcomes improved (lower viral load, increased PPD tests). A model with integration of HIV, HCV, mental health and substance abuse services (the program was composed of an integrated care team including an HIV nurse with substance-use experience, a case manager, a substance use and mental health counselor, a psychiatrist and two outreach workers) engaged a higher number of patients with co morbidities.

One study of a model using co-location of HIV and mental health care found no effect between co-location of services on service utilization or appropriateness of care. A model of case management found that a reasonable frequency of program contacts (at least 9 over 3 months at the rate of 3 per month) was associated with over 50% reduction in the rate of 4-month gaps in HIV primary care.

Dr. Laraque stated that the key points from these studies are that we need a standard definition of the standard of care and interventions and of measuring outcomes. There were questions from IOC members concerning the sample sizes of the studies, the definition of “quality of life”, and differences in treatment adherence and outcomes by race, income and age groups.

III. Ryan White Part A Case Management in NYC: Preliminary Results from a Qualitative Study

Dr. Mary Irvine presented data from a qualitative study of Part A-funded case management (CM) programs in NYC. The study attempts to describe current practices, gather information on the context of CM service delivery, learn providers’ perspectives on their programs, and identify potential gaps in NYC CM services through RW Pt. A. As way of background, there are an estimated 30,000 people who are aware of their HIV status but not in care. Black and Latino communities are overrepresented among new infections, and disparities are also evident in the quality of care and in the health outcomes of PLWHAs. Addressing disparities in HIV/AIDS calls for a wide array of services to increase opportunities for health and optimal care for all. Lower mortality and longer life expectancy means a growing consumer population and greater demand on the HIV-related service system. The evolution of HIV/AIDS into a manageable chronic illness also means a broader range of services is required to meet needs at different stages of illness and over the life course. The complexity of a mature system of HIV/AIDS-related services makes it, and CM has the potential to address some of those root causes of disparities. With improved treatment efficacy, early and continuous engagement in medical care is more important than ever to client outcomes. There are six models of CM, ranging from referrals to outside sources to systems change and coordination for quality of care and self-management.

A majority of RW Part A CM programs in NYC provide COBRA, mental health and harm reduction services. Smaller numbers also provide medical services, housing assistance, legal services and treatment adherence. Most common target populations were: general HIV+, immigrants, substance abusers, recent releasees and unstably housed. Most common program goals were: access to/maintenance in medical care, stabilization of client’s situation, empowerment/self-sufficiency/ independence/higher functioning, and treatment adherence.

Intervention models included: AIDS Institute guidelines, health belief model, medical, COBRA-style and others. Referrals were mostly verified by paper or escorts.

What we know is that: agencies are multi-service; providers are attending to standards, guidance (steps, timeframes); client-centered services are addressing barriers and/or strengths; some programs are interdisciplinary, others COBRA-like or peer-based; and some designs are based in behavior theory. We do not know: how exactly do case managers coordinate with other providers (internal or external to agency); what client-directed services are delivered to ensure engagement in primary medical care; how would program goals/objectives translate to outcome indicators; what is program logic model, and how does it shape program activities; what guidance (other than AI standards) do case managers have for how to perform their jobs.

Questions and discussion raised by IOC members included: what is “stabilization” and how is it measured; further analysis is needed to compare CM with other service categories (e.g., outpatient medical care); more qualitative data is needed on client satisfaction; the differences between CM provided by CBOs and large medical institutions; clarifying different definitions (e.g., “holistic”); the difficulty of attributing an improved outcome to a specific service. Dr. Laraque pointed out that this is why we need guidelines that address the range of integrated models.

III. Other Business

The minutes of the November meeting were approved with no changes.

The next meeting date will be on March 18th.

There being no further business, the meeting was adjourned.