

HARRISHEALTH
SYSTEM

Integrating and Supporting Medical Case Management Into Primary Care
HIV Services Harris Health System
Thomas Street Health Center, Houston Texas

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Thomas Street Health Center

Objectives

- Describe specific components in an integrated system (what are your must haves)
- Describe the roles of the team (how do we work collaboratively)
- Describe barriers to integration (what are some of the pitfalls)
- Describe what integration looks like in a primary care setting

FACT SHEET

COMMUNITY HEALTH PROGRAM

- Sixteen (16) community health centers, including the nation's first freestanding HIV/AIDS treatment center
- One free-standing dental center
- Seven school-based clinics
- Fifteen (15) homeless shelter clinics
- Immunization and medical outreach program with five (5) mobile health units

FACT SHEET

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- Harris Health System's 16 community health centers comprise the largest network of public primary care clinics in Texas.
- Harris Health unites those with seven school-based clinics, a dental center, dialysis center, five mobile health units, and three hospitals.
- Smith Clinic, opened in Fall 2012, provides specialty outpatient services.
- Harris Health System provides for more than one million outpatient clinic visits a year.
- Harris Health also provides teaching facilities for Baylor College of Medicine and The University of Texas Health Science Center at Houston (UT Health).

FACT SHEET OUR LOCATIONS



Thomas Street Health Center



Southern Pacific
Railroad Hospital

History

**1989, first free-standing
HIV clinic in US**

- **2011, serviced 5,483 unduplicated clients**
 - **3,732 Male (68%)**
 - **1,751 Female (32%)**

Services provided on site

- **ENT, Endocrinology, Neurology, Psych, Dermatology, Oncology, Rheumatology, MCM, Non-MCM, OB/Gyn, Anal Dysplasia, Hep C, Pharmacy, Testing & Counseling**

Thomas Street Health Center



Southern Pacific
Railroad Hospital

History

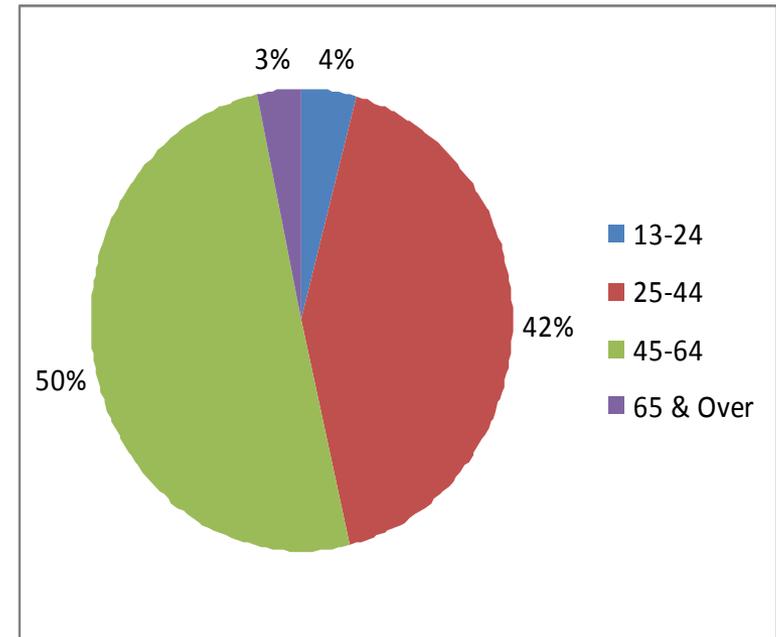
Additional Sites

- **Northwest Health Center (evening hours)**
- **Settegast (once weekly)**
- **Lyndon B. Johnson (OB services for HIV)**

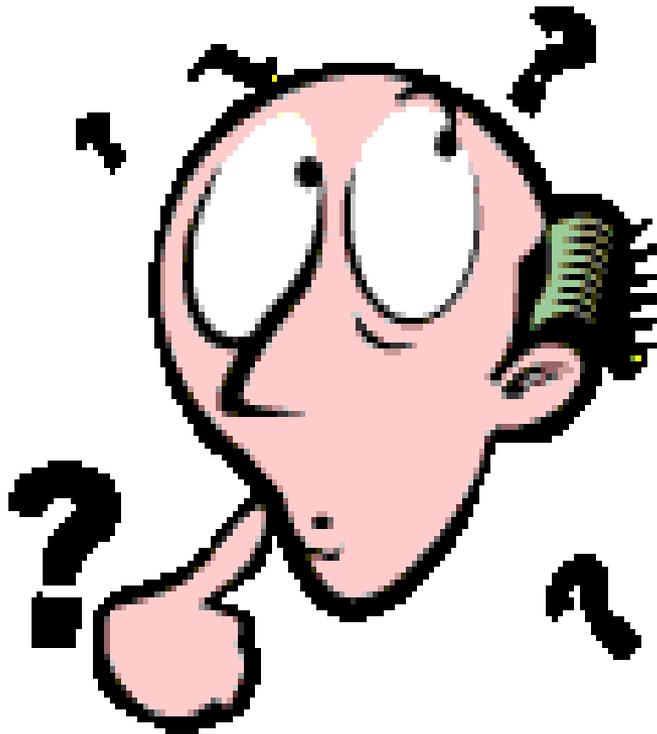
*****NCQA Patient Centered
Medical Home Certified*****

Thomas Street Health Center

Age Categories	Count	%
13-24	225	4%
25-44	2321	42%
45-64	2757	50%
65 & Over	180	3%
	5483	100%



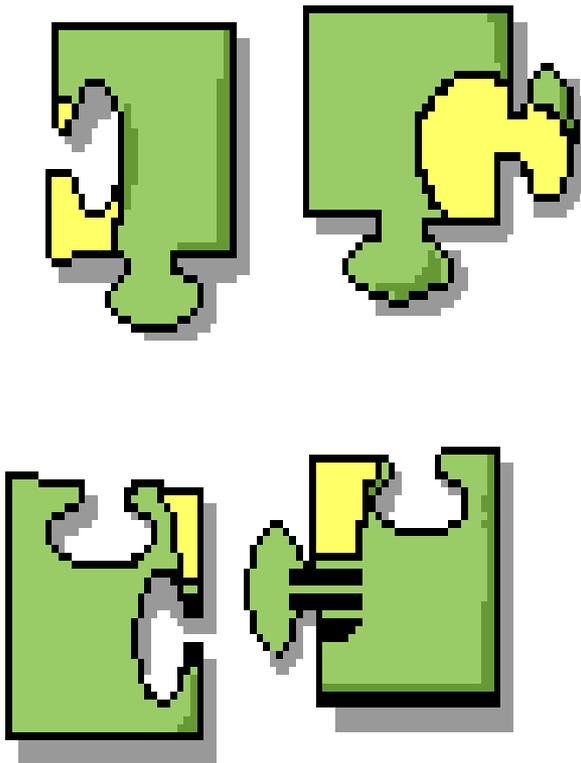
What Does Integration Look Like?



It involves more than:

- Housing Assistance
- Transportation
- Durable Medical Equipment
- Home Health Care

Integration of Support Services



Requires a multidisciplinary team approach

- Client (center)
- Medical Case Management
- Provider
- Nurse
- Other

Medical Case Management Role

- *Medical Case Management is:*
 - a range of client centered services that link clients with health care, psychosocial, and other services
 - the coordination and follow-up of medical treatments (such as medical visits, lab visits, medication access)
 - the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments

What Are The Must Haves???

- Supportive Leadership
- CCC Staff (committed, confidence, courageous)
- Communication skills (agreement to disagree)
- Written processes
- Change agents (Quality Management)
- Knowledge of Standard of Cares

Keys to Integration (Requires Change)

Why are services not integrated?

- Too many clients
- Not enough staff
- Lack of processes for identifying at risk population
- Lack of follow-up processes

A Look At Us



Diana Parkinson-Windross, LCSW Program Coordinator

- Adolescent Program Coordinator (LCSW)
- Adult (1 LCSW, 3 LMSW)
- Adult Northwest Clinic (vacant LMSW)
- OB/Gyn (vacant LMSW)
- Chemical Dependency Counselor
- Behavioral Therapist (LCSW)
- Non-clinical staff SLW

A Look At Us

Goal of services for the client is self determination

- Current Case load (average 45 – 50 clients) based on acuity level
- The staff to client ratio requires a process for determining level of need

Clinical Support (Weighted Score: 14 – 16)
Open file, but ongoing medical case management not indicated. Able to follow through. Assist PRN.
Limited Health Case Management (Weighted Score: 17 – 28)
Minimal: elimination of initial barriers to care, some assistance necessary for follow through; coping skills evident, information sharing; brief contact, agency referral;
Intermediate Health Case Management (Weighted Score: 29-44)
Moderate: makes most contacts for follow through; child/family unable to complete tasks, limited coping skills; limited family support
Intensive Health Case Management (Weighted Score: 45+)
Severe: child/family resistance hinders process; non-compliance, depressed, no family support Extreme: SW/CM involvement beyond severe; legal CPS intervention

A Look At Us

Responsibilities includes:

- Screening for appropriateness of services
- Comprehensive Assessment
- Service Plan (referrals, monitoring, tracking)
- Reassessment
- Update to Service Plan
- Outreach
- Case Closure

Referral (Sample Document)

REFERRALS FOR MEDICAL CASE MANAGEMENT

PURPOSE: To provide a process for referring patients to Medical Case Management services within the guidelines of Ryan White criteria

- All patients being referred for medical case management are required to meet Ryan White Grant Administration's as per the screening criteria
- Referrals for medical case management may be completed by Service Linkage Worker, Primary Care Physician, Nurse Practitioner, or other clinicians. Referrals are to be made through EPIC in-basket to the Medical Case Management Program Coordinator, or other identified staff. All referrals should provide some information regarding the reason(s) the patient is being referred
- Referrals from a Service Linkage Worker must be accompanied by a brief assessment
- The Case Management Program Coordinator or other identified staff, will review the EPIC Chart of the referred patient to ensure to appropriate assignment
- Patients will be assigned to a Medical Case Manager within 24 business hours of referral. The assigned MCM will begin to outreach the patient, and or representative within 24 hours of the assignment. All contacts/attempts will be documented in an EPIC progress note

Initial Contact (Sample Document)

Initial Case Management Contact (CMALL 2.1)

Purpose: An initial patient contact provides the opportunity for the medical case manager to outreach and engage the patient for into services.

- MCM staff will initiate contact with each patient or their representative **within one** business day of the case being assigned.
- Initial contact/attempted contact may be made by phone, home visit, or face to face during the patient's visit to the clinic
- All contacts/Attempts conducted directly with or on behalf of the patient, **must be documented** in the EPIC Medical Record within 24 hours. All EPIC progress notes must be completed as outlined in the process
- If MCM staff is unable to make contact with patient within one day of the case being assigned, MCM staff must notify the immediate supervisor directly or by EPIC message. Additional attempts to contact the patient/representative must be made, and if they are unsuccessful the issue should be brought to supervision for further discussion as well as to determine disposition of the case.
- Letters may also be sent to patients as a means of contact, and should be completed based on the pre-formatted ones in EPIC. They should be printed on Harris Health System's letterhead, and should not contain any health specific information. Contact information such as the MCM's name and phone number must be included

Screening Criteria (Sample Documents)

Screening Criteria For MCM Services- MCM 2.1

Purpose: The screening process is designed to accurately identify patients who meet the criteria for medical case management services, based on Ryan White Standards of Care.

- Screening will be completed for each patient who has been referred for medical case management services, in accordance with the criteria below
- Patients with one or more of the following criteria would be considered the most appropriate for medical case management services:
 - a) Newly diagnosed
 - b) New to HAART
 - c) CD4<200
 - d) VL>100,000 or fluctuating viral loads
 - e) Excessive missed appointments
 - f) Excessive missed dosages of medications
 - g) Mental illness that presents a barrier to the patient's ability to access, comply or adhere to medical treatment
 - h) Substance abuse that presents a barrier to the patient's ability to access, comply or adhere to medical treatment
 - i) Opportunistic infections
 - j) Chronic health problems/injury/Pain
 - k) Intimate Partner Violence
 - l) Viral resistance
 - m) Clinician's referral

Screening Criteria (Sample Document)

SCREENING CRITERIA PROGRESS NOTE FOR MCM SERVICES
(CHECK ALL THE AREAS BELOW THAT APPLY)

	Newly diagnosed
	New to HAART
	New to HAART
	CD4<200
	VL>100,000 or fluctuating viral loads
	Excessive missed appointments
	Excessive missed dosages of medications
	Mental illness that presents a barrier to the patient's ability to access, comply or adhere to medical treatment
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	Opportunistic infection
	Chronic health problems/injury/Pain
	Viral resistance
	Clinician's referral

Brief Intervention

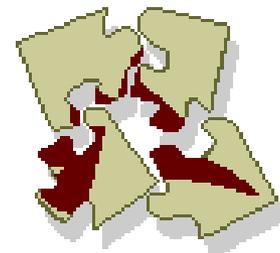
MCM BRIEF INTERVENTION

Patients who are not appropriate for intensive medical case management services may still receive brief medical case management interventions. In lieu of completing the comprehensive patient re-assessment, the medical case manager should complete the brief re-assessment, service plan, and document in the progress notes. Any referrals made should be documented, including their outcomes in the progress notes.

- ☐ Documentation in the progress notes reflects a brief re-assessment and plan (referral)
- ☐ Documentation in patient record on the brief re-assessment form
- ☐ Documentation of referrals and their outcomes in the progress notes
- ☐ Documentation of brief medical case management interventions in the progress notes

Processes for Integration

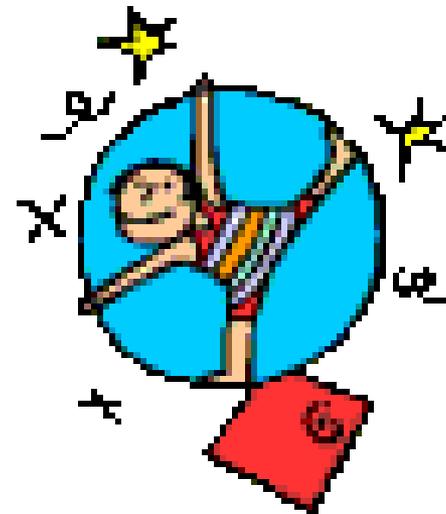
- Weekly Multidisciplinary Team meetings
- Supervisory sessions
- Provider Meetings
- Quality Management/Performance Improvement meetings
- Manager's meetings
- Weekly staff meetings



How Can You Make A Difference

- If your process is not working what are you doing to fix it?
- Are you going round and around?
- Are just doing the same old thing and actually expecting to produce a different outcome?

Breaking News Story You Are
INSANE!!



Common Pitfalls

- Staff does not understand their role
- Lack of direction
- No discrete processes
- Ineffective communication
- No drive to change
- Workplace Dynamics
- Lack of ongoing training
- Lack of passion for the role
- You just want a job

Quality Management Is A Must Have

You Must:

- Know your processes
- Measure your processes
- Evaluate your processes
- Change your processes as findings indicate
- Stabilize/Sustain processes
- Engage process owners

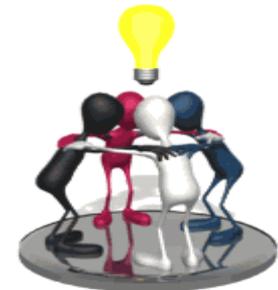
Plan-Do-Study-Act



Contrary to popular belief QM
is not busy work

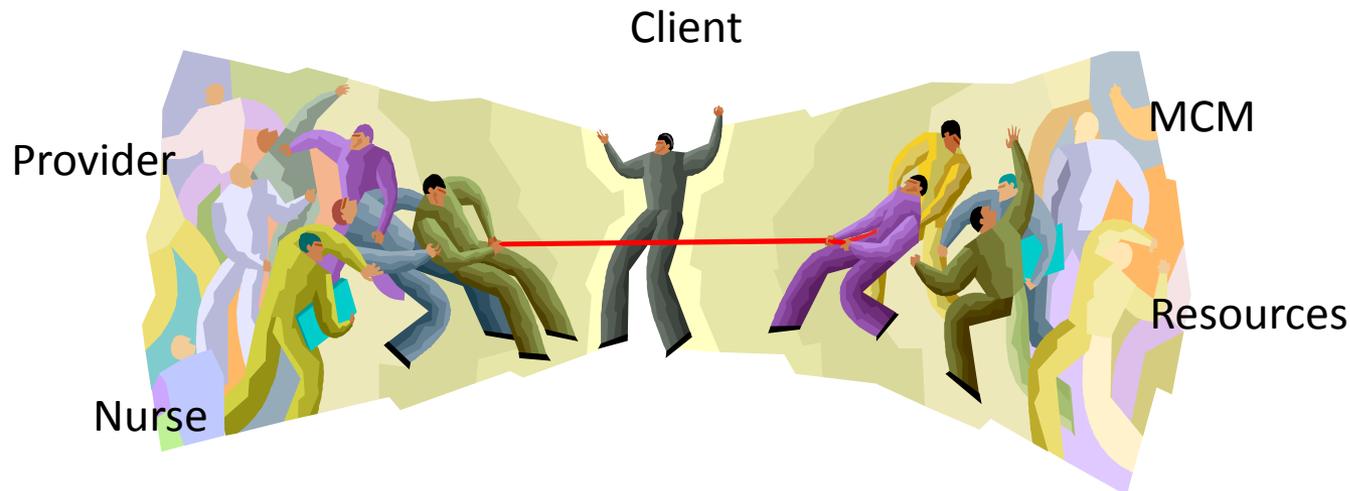
Summary: I Can Do More Because of Us!!!

- The team must work together
- The team communicates
- The team huddles to decide on the best strategy to improve the overall health of the client
- The team works toward assisting the client in self determination



Summary: I Can Do More Because of Us!!!

Our abilities to integrate services will prevent a tug of war with our clients caught in the middle.

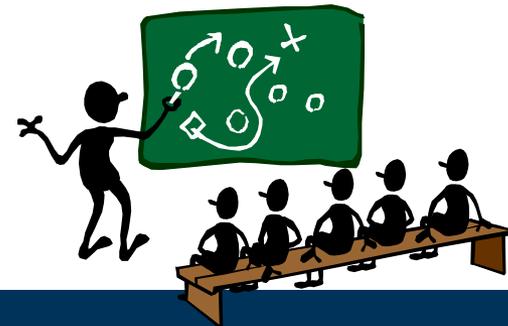


Remember “Client Centered Approach”

Pick battles big enough to matter, small enough to win”. ~Jonathan Kozel

“Do what you can, with what you have, where you are”. ~Theodore Roosevelt

“Improve your client’s overall health outcomes”.



Resources

- Texas HIV Case Management Standards (Dec. 2011)
- 2012 – 2013 Houston EMA: Ryan White Care Act Part A/B Standards of Care for HIV Services

Thanks

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Questions

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