Behavioral Health Aspects of Medical Care Coordination

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Coping with Hope
May 22, 2014
Presentation Overview

• Goals of HIV Medical Care Coordination
• Overview of MCC
  – Behavioral Health MCC
  – Service Activities
• MCC Implementation
• Preliminary Evaluation Results
• Experience from the Field
  – LAGLC
  – AltaMed Health Services
• Closing Comments
Background

- LAC and nationally, ~50% of people living with HIV/AIDS do not see a doctor regularly for their HIV medical care
- In 2013, DHSP shifted toward “Medical Care Coordination” model in its HIV clinics
- MCC team consists of nurse, social worker, case worker to address medical and non-medical needs
Goals for Medical Care Coordination

• **Increase Access to Care**
  – Increase the proportion of PLWH engaged in regular HIV medical care
  – Improve access to prevention and care services
  – Identify and treat behavioral health issues

• **Reduce HIV-Related Health Disparities**
  – Improve health outcomes for PLWH
  – Ultimately reduce number of new HIV infections
Overview of MCC

- An integrated approach to addressing social determinants of health
- Delivered by a multidisciplinary team
  - RN, Master’s –level social worker, and Case Worker
- Patients are screened to determine level of care needed to improve health outcomes
- Brief interventions and referrals tailored to patient need to increase patient engagement in HIV care
Rationale for Behavioral Health Integration into MCC Programs

• Mental Health is one of many components of overall health care

• Mental Health conditions in PLWHA are under-diagnosed and undertreated
  – MH and Addiction screening and brief interventions are key strategies to fill this gap

• Depression, cognitive disorders, and addiction disorders affect adherence, clinic attendance and quality of life
Target Population for MCC

- HIV-positive persons who:
  - Not in care (<6 months);
  - Are not on ARTs but meet clinical guidelines;
  - Are on ART and have detectable viral load; or
  - Have significant medical/psychological co-morbidities that impact health status
DHSP MCC Sites

• DHSP funds 20 HIV providers at 41 clinics to deliver HIV care services
  – Also funded to provide co-located MCC services at the 41 clinics
• New Medical Care Coordination contract approved November 2012
  – Integrate medical and non-medical case management services into HIV care services
  – Move towards a medical home model for HIV service delivery
Approach to MCC

• Measure patients’ needs in objective manner
  **MCC assessment**
• Use that data to guide follow-up and the delivery of evidence-based interventions to improve patients’ health outcomes
  **MCC protocol**
• Track whether patients’ outcomes improved after receiving MCC
  **MCC acuity score**
MCC Assessment

• Assessment identifies medical and psychosocial factors that may affect patient’s health
  • Assessment programmed in Casewatch
  • 12 domains (e.g., health status, adherence, mental health)
  • Calculates patient acuity
  • Guides service plan development and use of interventions
    • Management of co-morbidities
    • Referrals
    • Brief interventions

• Intensity of follow-up based on patient acuity
MCC Assessment Domains

**Medical Domains**
- Health Status
- ART Access and Adherence
- Medical Access, Linkage and Retention
- Risk Behaviors*

**Psychosocial Domains**
- Quality of Life
- Housing
- Financial
- Transportation**
- Legal/End of Life Needs
- Support Systems
- Alcohol/Drug Use
- Mental Health
- Risk Behaviors*

*Aspects of Risk Behaviors are both medical and psychosocial
**Transportation need assessed by acuity not calculated
Example: Calculating Health Status Acuity

1. Last CD4 <500 OR HIV nephropathy OR Currently pregnant OR AIDS-defining illness or Chronic Hep B?
   - Yes
   - No

2. Prescribed ART?
   - Yes
   - No

3. Last Viral Load <200 copies?
   - Yes
   - No

4. >=2 comorbidities ever?
   - No
   - Yes

5. >=2 poorly controlled comorbidities?
   - No - MODERATE
   - Yes - HIGH

6. >=1 Active HIV related complication?
   - No
   - Yes - SEVERE

7. Yes
   - SELF MANAGED
   - HIGH

8. No
   - SEVERE
   - SELF MANAGED
Example: Acuity Calculation

<table>
<thead>
<tr>
<th>Client</th>
<th>Case #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient, Test</td>
<td>123456</td>
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</table>

### Acuity

<table>
<thead>
<tr>
<th>Section</th>
<th>Moderate</th>
<th>Severe</th>
<th>Self-Managed</th>
<th>Moderate</th>
<th>Severe</th>
<th>Severe</th>
<th>Moderate</th>
<th>High</th>
<th>Self-Managed</th>
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<td>Health Status</td>
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<td>Antiretroviral Access and Adherence</td>
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<td>Risk Behaviors</td>
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<td>Mental Health</td>
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### Overall Acuity Score

42

### Overall Acuity Level

Moderate
### Patient Follow-Up

<table>
<thead>
<tr>
<th>Acuity Level</th>
<th>Screening</th>
<th>F/U Assess. &amp; Serv. Plan</th>
<th>Brief Interventions</th>
<th>Ongoing F/U</th>
<th>Case Conference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe</td>
<td>N/A</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Weekly</td>
<td>Weekly</td>
</tr>
<tr>
<td>High</td>
<td>N/A</td>
<td>Quarterly</td>
<td>Bi-monthly</td>
<td>Bi-monthly</td>
<td>Bi-monthly</td>
</tr>
<tr>
<td>Moderate</td>
<td>N/A</td>
<td>Every 6 mos</td>
<td>Monthly</td>
<td>Monthly</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Low (Self-managed)</td>
<td>Bi-Annually</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

- Evaluation of the effectiveness and relevance of the integrated care plan
- Measurement of client progress toward stated goals and activities, determine the need for revisions
Brief MCC Interventions

- **Non-Medical Interventions**
  - Coping with long term chronic illness
  - Addressing Mental Health and Substance Use issues
  - Partner Services/Disclosure Assistance

- **Medical Interventions**
  - Adherence to ART/Motivational Interviewing
  - Engagement in Care
  - Risk Reduction

- **Other Interventions**
  - Linkages to Other Services
**MCC Service Flow**

**IDENTIFY PATIENTS NEEDING ACTIVE MCC SERVICES**

1) Screen patients every 6 months:
   - Newly diagnosed <6m
   - Out of care >7m
   - Not on ART but meets guidelines
   - On ART w/o viral suppression
   - STI in the past 6m, OR
   2) Medical Provider Referral

**ALL CLINIC PATIENTS**

**YES –NEEDS ACTIVE MCC**

- Does not want Active MCC
- Wants Active MCC

**ADMINISTER INITIAL ASSESSMENT**
(MCM and PCM)
- Determine service need

**DEVELOP, AND IMPLEMENT ICP**
(MCM and PCM)
- Deliver brief interventions
- Refer and link to support services
- Update as needed

**ADMINISTER RE-ASSESSMENT**
(MCM and PCM)
- Acuity reduced to low/self-managed?

**NO –DOES NOT NEED ACTIVE MCC**

**PATIENT IS SELF-MANAGED**
- Screen for Active MCC every 6 months

**YES**

**NO**

**Does not want Active MCC**

**Wants Active MCC**
Implementation Progress – MCC Service

- Service Guidelines
  - Evidence-based and best practices
- Screening
- Assessment
  - Determines patient acuity
- Monthly reports
- Monitoring/TA
- Training
  - 4-day programmatic training
# MCC Performance Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Retention in HIV Care</td>
<td>90%</td>
</tr>
<tr>
<td>1.2 Viral Load Suppression on ART</td>
<td>85%</td>
</tr>
<tr>
<td>2.1 Provision of ART Adherence Intervention</td>
<td>85%</td>
</tr>
<tr>
<td>2.2 Linkage to Mental Health Program</td>
<td>85%</td>
</tr>
<tr>
<td>2.3 Linkage to Substance Abuse Program</td>
<td>85%</td>
</tr>
<tr>
<td>2.4 Linkage to Housing Program</td>
<td>70%</td>
</tr>
<tr>
<td>2.5 Linkage to Partner Services</td>
<td>100%</td>
</tr>
<tr>
<td>2.6 Provision of Risk Reduction Intervention</td>
<td>100%</td>
</tr>
</tbody>
</table>
Self-Managed vs. Active MCC Patients by Gender (N=7,446)

*Does not include 4 patients without current Casewatch registration data

**Source:** DHSP, Casewatch, Years 22-24, as of February 2014
Self-Managed vs. Active MCC Patients by Race (N=7,446)

*Does not include 4 patients without current Casewatch registration data
**Active MCC significantly more likely to be African American (p<0.001)
***Active MCC significantly less likely to be Other Race (p<0.001)

Source: DHSP, Casewatch, Years 22-24, as of February 2014
Self-Managed vs. Active MCC Patients by Age (N=7,446)

*Does not include 4 patients without current Casewatch registration data

**Significantly more likely to be in Active MCC than Self-Managed compared to age 45-54 (p<0.001)

***Significantly less likely to be in Active MCC than in Self-Managed compared to age 45-54 (p<0.01)

**Source:** DHSP, Casewatch, Years 22-24, as of February 2014
Self-Managed vs. Active MCC Patients by Viral Suppression at Baseline (N=7,446)

*Does not include 4 patients without current Casewatch registration data

**Significantly less likely to have suppressed VL compared to Self-Managed (p<0.001)

*Source: DHSP, Casewatch, Years 22-24, as of April 2014*
Self-Managed vs. Active MCC Patients by Income (N=7,446)

- **At or Below Federal Poverty Level**
  - Self-Managed (n=6,078): 69%
  - Active MCC (n=1,368): 79%

- **Above Federal Poverty Level**
  - Self-Managed (n=6,078): 31%
  - Active MCC (n=1,368): 21%

*Does not include 4 patients without current Casewatch registration data

**Significantly more likely to be in Active MCC compared to Above Poverty Level (p<0.001)

*Source: DHSP, Casewatch, Years 22-24, as of April 2014*
Patient Acuity Level and Service Delivery Hours

**Patients by Acuity Level (n=1,372)**
- Low (n=257): 18.7%
- Moderate (n=704): 51.3%
- High (n=406): 29.6%
- Severe (n=5): 0.4%

**Hours of Service per Patient by Acuity Level (n=1,342**)**
- Low (n=252): 34.1
- Moderate (n=688): 11.7
- High (n=397): 13.8
- Severe (n=5): 8

*Excludes 3 patients with incomplete data to determine acuity level
**Service data not available for 30 patients due to data reporting delays

Data source: DHSP, Casewatch, Years 22-24 and MCC Assessment, Jan 2013-Feb 2014
Health Status Need by Overall Acuity at Baseline (N=1,372)

Source: DHSP, Casewatch, Medical Care Coordination Assessment, Jan 2013-Feb 2014
Housing Need at Baseline by Overall Acuity (N=1,372)

- **Low (n=257):**
  - 98%
- **Moderate (n=704):**
  - 91%
  - 5%
  - 0%
  - 4%
- **High (n=406):**
  - 54%
  - 9%
  - 0%
- **Severe (n=5):**
  - 100%

**Source:** DHSP, Casewatch, Medical Care Coordination Assessment, Jan 2013-Feb 2014
Substance Use Need at Baseline by Overall Acuity (N=1,372)

Source: DHSP, Casewatch, Medical Care Coordination Assessment, Jan 2013-Feb 2014
Mental Health Need at Baseline by Overall Acuity (N=1,372)

Source: DHSP, Casewatch, Medical Care Coordination Assessment, Jan 2013-Feb 2014
Patients in Active MCC by Acuity, Jan 2013-Feb 2014 (N=1,372)

<table>
<thead>
<tr>
<th>SELECTED KEY RESPONSES*</th>
<th>Low n=257</th>
<th>Mod n=704</th>
<th>High n=406</th>
<th>Severe n=5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline viral load &lt;200 copies/mL</td>
<td>69%</td>
<td>51%</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>In stable housing</td>
<td>87%</td>
<td>83%</td>
<td>59%</td>
<td>20%</td>
</tr>
<tr>
<td>Homeless in the past 6m</td>
<td>11%</td>
<td>16%</td>
<td>43%</td>
<td>80%</td>
</tr>
<tr>
<td>Ever incarcerated</td>
<td>25%</td>
<td>38%</td>
<td>53%</td>
<td>80%</td>
</tr>
<tr>
<td>Incarcerated in the past 6 months</td>
<td>8%</td>
<td>44%</td>
<td>47%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Diagnosed with an STD in the past 6m</td>
<td>14%</td>
<td>22%</td>
<td>34%</td>
<td>20%</td>
</tr>
</tbody>
</table>

*Chi-square trend test, p<0.001 for each key response across acuity levels (high and severe acuity combined)

**Data source:** DHSP, Casewatch, MCC Assessment, Jan 2013-Feb 2014
Patients in Active MCC by Acuity, Jan 2013-Feb 2014 (N=1,372)

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<tr>
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<th>Mod n=704</th>
<th>High n=406</th>
<th>Severe n=5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever diagnosed with a MH issue</td>
<td>34%</td>
<td>44%</td>
<td>64%</td>
<td>80%</td>
</tr>
<tr>
<td>Possible depressive disorder (PHQ9 ≥ 9)</td>
<td>22%</td>
<td>33%</td>
<td>66%</td>
<td>100%</td>
</tr>
<tr>
<td>Possible anxiety disorder (GAD8 ≥ 10)</td>
<td>14%</td>
<td>24%</td>
<td>49%</td>
<td>80%</td>
</tr>
<tr>
<td>Ever used drugs/alcohol</td>
<td>80%</td>
<td>85%</td>
<td>97%</td>
<td>100%</td>
</tr>
<tr>
<td>Drug/alcohol use in the past 6m</td>
<td>62%</td>
<td>69%</td>
<td>87%</td>
<td>100%</td>
</tr>
<tr>
<td>TCU Screener for possible SA issue</td>
<td>2%</td>
<td>13%</td>
<td>57%</td>
<td>100%</td>
</tr>
</tbody>
</table>

PHQ-9=Patient Health Questionnaire; GAD=Generalized Anxiety Disorder Scale; TCU Screener=Substance Use Screener

**Chi-square trend test, p<0.001 for each key response across acuity levels (high and severe acuity combined)

Data source: DHSP, Casewatch, MCC Assessment, Jan 2013-Feb 2014
MCC Service Delivery

Median Hours of MCC per Patient by MCC Provider
(n=1,342)

*Includes services delivered during face-to-face and telephone contacts

Source: DHSP, Casewatch, Years 22-24, Jan 2013-Feb 2014
Median Hours of Brief Intervention per Patient (n=1,342)

*Includes services delivered during face-to-face and telephone contacts

**Source:** DHSP, Casewatch, Years 22-24, Jan 2013-Feb 2014
Patients were significantly more likely to have suppressed viral load after 6 months in active MCC (Adjusted OR=3.2; 95%CI=1.9, 5.2)

Source: DHSP, Casewatch, Years 22 and 23, Jan-Dec 2013
**Key Issues**

- **MCC as a foundation for HIV Medical Homes**
  - Tension between MCC and traditional nursing roles in the clinic
  - Care coordination model as basis for practice changes

- **MCC as an anchor for linkage to care activities**
  - Strengthening relationships between testing and HIV care services
Implementation: Experience from the Field

AltaMed Health Services
Los Angeles Gay and Lesbian Center
Closing Comments

• Implementing MCC successfully at 41 clinics in LAC
• Identified patient need (acuity) guides intensity of services
• Addressing both medical and psychosocial issues is critical to successful delivery of MCC
• Preliminary data suggest that MCC services can improve health outcomes
• Continue to strengthen behavioral health component of MCC
• Questions?
Acknowledgements

• All recipients of MCC services

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  – Alonso Bautista, MFTI (AltaMed)
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