DENVER HIV RESOURCES PLANNING COUNCIL
www.dhrpc.org

Medical Case Management Improvement Plan

Fall 2011

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interSector Partners, L3C
What's *your* bottom line?

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Background and Purpose of the Plan

The Denver HIV Resources Planning Council's (DHRPC) mission is to assist in the coordination of high quality, culturally proficient delivery of HIV/AIDS services in the Denver Transitional Grant Area (TGA). The Denver TGA includes the Colorado counties of Adams, Arapahoe, Broomfield, Denver, Douglas and Jefferson.

The Planning Council is comprised of volunteer community members who are appointed by the Mayor of the City and County of Denver. DHRPC members work collaboratively with the HIV/AIDS community to decide on which HIV services receive funding, along with the amount of funding for each service. DHRPC also develops a comprehensive plan to aid the organization in delivery of Ryan White CARE Act designated HIV services, to meet areas of greatest need in the metropolitan area.

One of the major challenges facing the Denver TGA is the positioning of Medical Case Management (MCM) within the system of care to have the greatest impact on quality while increasing efficiency and supporting the direction of the National HIV/AIDS Strategy for the United States. In 2009, DHRPC asked the Denver Office of HIV Resources (DOHR) to conduct an assessment of the current MCM system as a start to a possible larger system change. The next step in utilizing the assessment findings to make system change is the development of a MCM Improvement Plan.

The MCM Improvement Plan, developed in cooperation with the DHRPC Program Manager, Metro Denver AIDS Coalition and Denver TGA providers, outlines input provided during the process, creates an outline for overall system improvements and includes a roll-out plan for implementing the recommendations.

The Planning Process

June & July 2011

- Selected interSector Partners, L3C to serve as MCM Improvement Plan consultants
- Held MCM kick-off meeting: reviewed the case management assessment report, introduced the improvement planning process, gathered initial input on the process
- Convened and hosted first MCM Improvement Plan Workgroup meeting to prioritize topics and interview focus
- Scheduled and developed guidelines for provider and MCM agency in-person interviews

August 2011

- Conducted MCM interviews (14 in-person, one by telephone)
- Drafted preliminary interview feedback
- Hosted MCM Workgroup meeting to review interview feedback and provide additional input and ideas, and share concerns

September 2011

- Combined interview feedback, MCM Workgroup input, Needs Assessment MCM findings and FY 2012 Priorities/Allocations information
- Hosted MCM Workgroup to review input to-date and develop draft implementation plans on top priority items

October 2011

- Drafted MCM Improvement Plan including implementation plan
- Review and input provided by DHRPC staff
- Presented to MCM Workgroup for additional review and input
- Finalized draft for DHRPC staff submittal to Planning Council

November 2011 and beyond

- MCM Workgroup provides ongoing oversight and management of implementation efforts

DHRPC MCM Overview

MCM Background and Current Situation

DHRPC annually prioritizes MCM as service category and allocates funding to MCM services. Funding is distributed through a competitive grants process managed by DOHR. Standards of Care allow DHRPC to ensure that MCM services deliver "timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through an ongoing assessment/reassessment of the client and other key family members' needs and personal support systems." The MCM Standards include five key activity areas:

1. Initial assessment of service needs
2. Development of a comprehensive, individualized care plan
3. Coordination of services required to implement the care plan
4. Continuous client monitoring to assess the efficacy of the care plan
5. Periodic reevaluation and adaptation of the care plan[1]

MCM agencies in the Denver TGA work closely with medical and oral health care providers to meet the above outlined service category description and the detailed Standards of Care provided by DHRPC. The Standards and service delivery are continually adjusted to meet changing needs of People Living with HIV/AIDS (PLWHA), to adapt to a continually evolving system and to respond to changes in the external environment.

Several issues in particular led the Denver TGA to explore how it has traditionally provided services. Outlined in the 2010 Case Management Assessment,[2] these include:

- The change in HIV from a terminal to chronic illness
- The growing number of HIV positive individuals
- Higher acuity of participants' needs expected as the HIV population begins to age
- The possibility of future scarcity of resources

Additional reasons for the Denver TGA to explore MCM improvements at this time include potential implications of the Affordable Care Act and the goals and recommendations of the National HIV/AIDS Strategy for the United States.[3] National HIV/AIDS Strategy goals and recommendations are discussed throughout this document in relation to the Denver TGA MCM Improvement Plan.

[1] *Denver Transitional Grant Area Standards of Care, Unit Costs of Service, Quality Management Indicators,* March 2011.
[2] Denver Office of HIV Resources, *Case Management Assessment, Denver Department of Environmental Health*, January 15, 2010.
[3] The White House Office of National AIDS Policy, *National HIV/AIDS Strategy for the United States*, July 2010.

Denver TGA MCM System Strengths, Weaknesses, Opportunities and Threats

Prior to determining opportunities to improve the MCM system, a look at the system's strengths, weaknesses, opportunities and threats (S.W.O.T.) is critical to fully understand the current situation. The following S.W.O.T. was developed from multiple sources: provider and MCM agency interviews, MCM Workgroup meetings, the 2010 Case Management Assessment, the 2011 Needs Assessment, FY 2012 Priorities and Allocations discussions, and consultant perspective.

Strengths (Areas on which to capitalize)	**Weaknesses (Areas to improve)**
• Working better across agencies than in the past • Committed case managers; do what it takes • Metro Denver AIDS Services Coalition (MDASC) is a great place to learn and get to know people • Standards have improved and provide helpful guidance • Positive perspectives of case managers • Case managers in Denver have a lot of collective experience • Well-established infrastructure • CBOs have a strong community; close, tight knit service provider network • Expertise in certain populations; diversity within the system and funded agencies • Ability to bring our voice to Planning Council and DOHR; they really care what we want • Good system of primary care; patient care • Initial contacts/introductions to the system for clients are good; build trust	• Turnover within the TGA • Language barriers in working with other case managers • Personality-based referrals • Information sharing; hard to know when patients or case managers follow-through • Staffing shortages • Lack of flexibility for case managers to get out, visit others, learn • Still a lot of duplication of service provision • No equity: some case managers are overwhelmed, some are not • Lack of training • Lack of understanding of resources outside our system • System is very rigid; clients shouldn't have to choose where they go based on what's offered • Clinics are not involved with CBOs • Competition between agencies for clients • Some patients struggle to find the right "fit" • Linkage could improve; don't just refer, introduce • Lack of standardization • MDASC could be a place for case managers, mostly agency leadership attends • Inability to do home visits • Lack of patient follow-through
Opportunities (External to DHRPC/The Denver TGA)	**Threats (External to DHRPC/The Denver TGA)**
• Outside funding (i.e. The Colorado Health Foundation's "Health Care Delivery" or "Accelerate the Adoption of Health IT" grants programs) • Capitalize on systems in place at the larger providers (acuity, ROI) and adapt for the TGA • Linking to the Medical Home Model in some way • Potential positive impacts of Affordable Care Act	• PLWHA are shopping state to state for the best services • Complete loss of Ryan White Part A funding • Unanticipated negative impacts of Affordable Care Act

Vision for MCM Services in the Denver TGA

During the improvement planning process, the MCM Workgroup, MCM agencies and providers explored a number of key topics including: acuity, self-management, adherence, coordination of care and services, case coordination and conferencing, resource knowledge, treatment planning, transition planning, Biopsychosocial assessment, access to care and services, quality of care, training, and supervision. Based on in-depth discussions of these topics, the strengths, weaknesses and opportunities of the system and the desires of the case managers and medical providers, the following vision emerged to guide goal-setting, development of objectives and creation of the implementation plans.

By the end of FY 2013, case management services in the Denver TGA will be delivered efficiently and effectively utilizing an acuity-based system that will:

- Ensure that participants receive high quality, appropriate and timely services
- Allow for participants to advance on their personal journeys toward self-management
- Provide more fully integrated case management and medical services
- Distribute case load based on the level of participant need
- Support case managers in accessing resources and participating in ongoing educational and networking opportunities
- Lessen the burden of reporting required by case managers and agencies

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MCM Improvement Plan Three-Year Priority Goals

The MCM Improvement Planning process (see outline on page 2), in an effort to address the S.W.O.T. analysis, improve quality, enhance efficiencies, capitalize on practices outlined in the Case Management Assessment, support the National HIV/AIDS Strategy and achieve the MCM vision, resulted in the development of the following ***three-year goals:***

Goal 1: Develop and implement an acuity scale for Part A services

Goal 2: Develop and implement a Denver TGA Universal Release of Information

Goal 3: Explore and pilot co-location opportunities with medical providers and MCM agencies

Goal 4: Enhance electronic data-sharing options to improve information sharing

Goal 5: Develop and provide regular, ongoing MCM education and resource sharing meetings

Each goal is outlined in more detail on the following pages and includes the detailed objectives, MCM Workgroup recommendation, provider and MCM agency input, ties to the Case Management Assessment, alignment with the National HIV/AIDS Strategy and the goal's implementation plan

Goal 1: Develop and implement an acuity scale for Part A Services

Objective 1.1: Create a pilot acuity scale tool by November 30, 2011

Objective 1.2: Pilot the tool with all MCM agencies and providers by January 15, 2012

Objective 1.3: Determine required Standards of Care adjustments to include use of the acuity scale by January 15, 2012

Objective 1.4: By January 31, 2012, train all agencies that will be required to use the acuity scale on the associated changes to the Standards of Care and use of instrument

Objective 1.5: Fully implement the acuity scale for FY 2012 services

The MCM Workgroup identified development and implementation of an acuity scale as a top priority for the MCM Improvement Plan. The 2010 Case Management Assessment outlines a number of ways that acuity scales are utilized across the country to ensure that the program focuses on those most in need of services, including: assigning caseload based on acuity of participants; adjusting services based on the level of assessed need; and regularly reassessing participant acuity to support movement toward self-management.

The MCM Workgroup envisions an acuity scale that both addresses all of these opportunities while being unique and customized to the Denver TGA and its diverse participant populations.

Input and discussion in favor of a Part A acuity scale

All agencies and providers expressed some degree of interest in Ryan White Part A system-wide acuity scale with responses ranging from those who said it "would be helpful" to those who indicated an acuity scale is "critical." The MCM Workgroup determined that this process should be among the first to get underway and that a condensed, focused process will be ideal.

An acuity subgroup of the MCM Workgroup outlined primary requirements of the acuity scale:

1. Match the level of need with the level of service
2. Make sure the Standards of Care reflect a tiered level of service so that the base requirements better match the client and grant reporting requirements
3. Ensure that the tool works for all Part A providers and diversity of clients

"An acuity system is essential to identify people who are at lower acuity levels and for following along with them as they progress."

"The Case Management Assessment has good examples of acuity scales and Part B has done a lot of research to find other examples. We have a lot to go from; let's not reinvent the wheel."

"We can make this relatively easy or complicated. An easy option is to develop an acuity scale in the fall of 2011, pilot it for one month in January, update and revise it and launch it for FY 2012."

Issues/Concerns to address during the Implementation Process

A number of issues were identified for the MCM Workgroup to address during the acuity scale development process. These included:

- Sorting out how to work within the provider's current system (hospital) to develop/refine an existing acuity scale
- Ensuring that all populations are fairly represented in the tool
- Making sure it is truly a standardized tool ("If we let agencies customize the scale, then we end up with what we have now.")
- Ensuring that the score is not tied to a certain course of action; everyone's needs are different

Alignment with National HIV/AIDS Strategy

An acuity scale for Part A in the Denver TGA supports the National HIV/AIDS Strategy related to improving health outcomes for people living with HIV. In particular, an acuity scale will support Recommended Action 3.1: Enhance client assessment tools and measurement of health outcomes.[4]

[4] The White House Office of National AIDS Policy, *National HIV/AIDS Strategy for the United States*, July 2010. Page 29.

Goal 1: Develop and implement an acuity scale for Ryan White Part A services

Objective 1.1 : Create a pilot acuity scale tool by November 30, 2011				
Task/Activity	**Responsible Party**	**Resources**	**Timeline**	**Progress**
Research and compile sample acuity scales/tools from other communities, Denver TGA providers, existing CDPHE research	Maria (CDPHE), Jesse, Bettina (Acuity Team)	CDPHE's existing research, DHRPC research support	10/31/2011	
Narrow down choices and select key components to include	Workgroup; MCM agencies	Meeting space	11/15/2011	
Create one draft tool; test in meeting using case scenarios from each agency	Acuity Team, DHRPC	DHRPC support, meeting space	11/30/2011	
Objective 1.2: Pilot the tool with all MCM agencies and providers by January 15, 2012				
Task/Activity	**Responsible Party**	**Resources**	**Timeline**	**Progress**
Test the pilot acuity scale and provide feedback	Selected agencies/providers	Pilot acuity scale, DHRPC support	12/9/2011	
Revise the tool based on feedback; distribute revised tool for pilot testing round II	Acuity Team, DHRPC	Tool feedback	12/16/2011	
Test the revised pilot acuity scale and provide feedback	Selected agencies/providers	Revised pilot acuity scale	1/6/2012	
Revise the tool based on feedback	Acuity Team, DHRPC	Tool feedback	1/13/2012	

Objective 1.3: Determine required Standards of Care adjustments to include use of the acuity scale by January 15, 2012				
Task/Activity	**Responsible Party**	**Resources**	**Timeline**	**Progress**
Create a plan for initial administration of the acuity scale and frequency of updates to each client's acuity tool	Acuity Team, DHRPC	Agency input, best practices	12/15/2012	
Adjust the Standards of Care to reflect acuity tool administration and follow-up	DHRPC, DMS		1/15/2012	
Create a mechanism for feedback/input on the tool after the first six and 12 months of use	DHRPC		1/15/2012	
Objective 1.4: By January 31, 2012, train all agencies that will be required to use the acuity scale on the associated changes to the Standards of Care and use of the instrument				
Task/Activity	**Responsible Party**	**Resources**	**Timeline**	**Progress**
Provide two training sessions for agencies and providers that will be required to utilize the tool	DHRPC	Acuity Scale	1/31/2012	
Objective 1.5: Fully implement the acuity scale for FY 2012 services				
Task/Activity	**Responsible Party**	**Resources**	**Timeline**	**Progress**
Make any final adjustments to the tool based on agency/provider input	DHRPC	Agency/provider feedback	2/29/2012	
Final launch of the acuity tool; all agencies and providers required to utilize tool	Providers/agencies, DHRPC		3/1/2012	

Goal 2: Develop and implement a Denver TGA Universal Release of Information

Objective 2.1: Conduct and narrow research into Universal ROIs by March 31, 2012

Objective 2.2: Develop ROI and Standards of Care for use of ROI by May 31, 2012

Objective 2.3: Train providers/agencies in use of the ROI and Standards of Care associated with the ROI; roll out to the Denver TGA by December 1, 2012

The MCM Workgroup indicates that development of a Universal Release of Information (ROI) is one of the most needed, time sensitive components of the MCM Improvement Plan. While there are many moving parts to take into account, an ROI would have a significant impact on service delivery.

Input and discussion in favor of a Universal ROI

This goal addresses the key priority areas of Resource Knowledge, Coordination of Care and Services, Access to Care and Services, and Case Coordination and Conferencing. In addition, this goal supports clients in movement on the path toward another key priority area—Self-Management.

"This would lead to more open information sharing and confidence in knowing that client has given us permission to share."

"I wish we had one release for the whole TGA. Right now we have a different ROI with each agency. With some CBOs, all we get is '19 year old, HIV+.' It's not enough to go on."

"Is there a way to better use the Common Notes section in CareWare to track ROIs?"

"This would be fantastic. One agency would secure the ROI and it would apply to all agencies in the TGA."

Issues/Concerns to address during the Implementation Process

The larger medical providers must consider multiple legal requirements and it may be a challenge to get medical providers to agree on one ROI.

One concern in particular that was discussed in the MCM Workgroup was whether a Universal ROI changes the nature of the client's interaction with the system. For instance, does the patient become a client of the TGA rather than a client of a particular agency or patient of a certain provider?

"Due to HIPPA, not sure that we could ask for permission to share information with ALL Ryan White Part A providers. It may still have to be a ROI between individual organizations."

"I would fight to the death for privacy for our clients. We'd have to figure out how to make sure that we are not opening up the discussion of people's criminal records, other illnesses and family challenges."

Alignment with National HIV/AIDS Strategy

The National HIV/AIDS Strategy seeks to Increase Access to Care and Improve Health Outcomes for People Living with HIV/AIDS. The Strategy's Recommended Actions for this goal include: 1.1 facilitate linkages to care and 1.2 promote collaboration among providers.

A Universal ROI would help to achieve these recommended actions by "supporting linkage coordinators in a range of settings" by giving them easier access to the information and resources they need to understand a client's situation and adequately address it. The ROI would also enhance information sharing among "HIV medical providers and agencies… mental health treatment, substance abuse treatment, housing and supporting services to link people to HIV care.[5]"

[5] The White House Office of National AIDS Policy, *National HIV/AIDS Strategy for the United States*, July 2010. Pages 21-27.

Goal 2: Develop and implement a Denver TGA Universal Release of Information (ROI)

Objective 2.1 : Conduct and narrow research into Universal ROIs by March 31, 2012				
Task/Activity	**Responsible Party**	**Resources**	**Timeline**	**Progress**
Gather / determine data components for Universal ROI	Providers	Components of ROIs	3/31/2012	
Research and gather sample Universal ROIs, HRSA or other federal ROI, Denver TGA provider ROIs	DHRPC / Workgroup?	Samples	3/31/2012	
Determine legal requirements of Denver TGA providers	DHRPC / Workgroup		3/31/2012	
Objective 2.2: Develop ROI and Standards of Care for use of ROI by May 31, 2012				
Task/Activity	**Responsible Party**	**Resources**	**Timeline**	**Progress**
Compile and synthesize research into components of an ROI for the Denver TGA	Workgroup / DHRPC	Research	4/30/2012	
Meet with provider legal departments to review the draft ROI and provide input	DHRPC	Draft ROI	7/31/2012	
Revise ROI based on legal input	DHRPC	Legal input	8/31/2012	
Present the ROI to providers and agencies for review and input	DHRPC / Workgroup	Meeting, draft ROI	9/30/2012	
Finalize ROI and develop Standards of Care for its use	DHRPC	Provider/agency input	10/31/2012	

Objective 2.3: Train providers / agencies in use of the ROI and Standards of Care associated with the ROI, roll-out to the Denver TGA by December 1, 2012				
Task/Activity	**Responsible Party**	**Resources**	**Timeline**	**Progress**
Provide two trainings on use of the ROI and Standards of Care regarding the ROI	DHRPC, DMS	ROI, Revised Standards	11/15/2012	
Launch the ROI for use in the Denver TGA	Providers/agencies	ROI, Revised Standards	12/1/2012	

Goal 3: Explore and pilot co-location opportunities with medical providers and MCM agencies

Objective 3.1: Explore Medical Home, Medical Home levels and implications / opportunities within the Denver TGA by April 30, 2012

Objective 3.2: Assign a sub-group of the MCM Workgroup to work with providers and agencies to determine options for a pilot co-location program by July 31, 2012

Objective 3.3: Develop a way for DOHR to provide seed funding to pilot co-location programs; integrate pilot co-location program into RFP in Fall 2012 for FY 2013

Objective 3.4: Implement pilot co-location programs in FY 2013

Objective 3.5: Recommend ongoing co-location program based on initial evaluation of the pilot programs; integrate in to DOHR FY 2014 RFP by September 30, 2012

While those engaged in the MCM improvement planning process were not certain how a co-location model would ultimately be structured or function, all expressed a degree of interest in exploring how to best co-locate services to support positive client outcomes. In addition to addressing several of the MCM system weaknesses and opportunities (see S.W.O.T. analysis), co-location may also address gaps in and barriers to care identified in the Needs Assessment:

- Better services coordination between providers
- Lack of efficient information dissemination mechanisms
- Lack of client awareness of the role and availability of case management services

Input and discussion in favor of co-located services

Co-located services will support the MCM Workgroup priority area of Coordination of Care and Services/Case Coordination and Conferencing, and Adherence. Such service design is expected to allow for the provision of quality health care along a continuum, decrease fragmentation of care across many settings, enhance the participant's quality of life, and help contain costs.[6]

When implemented, the Affordable Care Act will utilize a Medical Home model to redesign the health care delivery system to provide targeted, accessible, continuous and coordinated care. The Health Resources and Services Administration (HRSA) does not currently require a Medical Home model, yet DHRPC believes that eventually some version of this co-located/coordinated services model will be mandated. At the very least, it is wise for the Denver TGA to explore the Medical Home model to determine how it could benefit Part A service delivery.

[6] Denver Office of HIV Resources, *Case Management Assessment, Denver Department of Environmental Health*, January 15, 2010. Pages 29-33.

"If this is going to be a mandate, [we] need to figure out how to do it ahead of the curve; Part A could take a leadership role."

"It's the wave of the future for client-centered care."

"Consider co-location to mean medical providers being located at ASOs (not only the reverse) – even a day or two per month could make a difference."

"Focus needs to remain on client/patient care, not what's easy for providers or agencies; make sure there is equal access across the system for clients."

Ideas for further exploration within co-location included:

- Mobile medical units
- An affiliated model (CBO provides a case manager to two or three medical providers on a set schedule, i.e. two days per week)
- A better focus on information sharing (rather than only physical co-location)
- A central, contracted case management agency to handle all intake and referrals

Issues/Concerns to address during the Implementation Process

Co-location elicited more concern from interviewees and the MCM Workgroup than any other goal. Even with these numerous questions, concerns and cautions, co-location continues to be identified as a top priority for the MCM Improvement Plan.

Items to address during the planning process for co-location include:

- Co-location can negatively impact self-management. A patient's ability to access separate locations and navigate the system are components of self-management.
- Agreement on whether patients are clients of the providers/agencies or clients of the TGA will be needed to fully implement co-location
- Concern about losing clients/patients who prefer to get case management services in the community
- Some providers would be well-equipped to have in-house case managers, some probably not; how does this get balanced?
- Travel can be a huge waste of time; no client care can occur while driving between sites

Alignment with National HIV/AIDS Strategy

As with the first two goals, co-location supports the National HIV/AIDS Strategy in a number of ways:

1. Establishes a seamless system to immediately link people to continuous and coordinated quality care
2. Supports people living with HIV and co-occurring health conditions and those who have trouble meeting their basic needs, such as housing
3. Facilitates support for linkage coordinators in a range of settings where at risk populations receive health and social services
4. Promotes increased collaboration between HIV medical care providers and agencies providing HIV counseling and testing services, mental health treatment, substance abuse treatment, housing and supportive services to link people with HIV to care

Goal 3: Explore and pilot co-location opportunities with medical providers and MCM agencies

Objective 3.1: Explore Medical Home, Medical Home levels and implications/opportunities within the Denver TGA by April 30, 2012				
Task/Activity	**Responsible Party**	**Resources**	**Timeline**	**Progress**
Convene a Co-location team (workgroup?) to research the Medical Home model	DHRPC, DOHR		12/31/2011	
Research the Medical Home model, applications to other systems, advantages/disadvantages	Co-location Team/Workgroup		3/31/2012	
Determine how to relate co-location and Medical Home research to MCM and the provision of seamless service delivery	Co-location Team/Workgroup	Research	4/30/2012	
Objective 3.2: Assign a sub-group of the MCM Workgroup to work with providers and agencies to determine options for a pilot co-location program by July 31, 2012				
Task/Activity	**Responsible Party**	**Resources**	**Timeline**	**Progress**
Convene an inquiry committee/workgroup (or continue team/workgroup from Objective 3.1 above)	DHRPC, DOHR		5/31/2012	
Determine service gaps and co-location opportunities; gather input from providers/agencies on ideas for co-location pilot programs	Co-location team	Needs assessment, MCM Improvement Plan	6/30/2012	
Assess what clients want and need with regard to co-location	Co-location team	Focus groups, survey, interviews	6/30/2012	
Develop co-location pilot options and determine funding needed to implement	Co-location team, DHRPC		7/15/2012	
Present co-location options to DOHR for input				
Present co-location options to providers and agencies for input and to explain the opportunity to pilot a program	Co-location team		7/31/2012	

Objective 3.3: Develop a way for DOHR to provide seed funding to pilot co-location programs; integrate pilot co-location program into RFP in Fall 2012 for FY 2013				
Task/Activity	**Responsible Party**	**Resources**	**Timeline**	**Progress**
Explore options for seed funding the pilot co-location program (directives, allocations, outside funding)	Planning Council, Co-location team/workgroup	DHRPC understanding of funding mechanisms	8/31/2012	
Include pilot co-location programs in FY 2013 RFP	DOHR	Directive, allocation, etc. and pilot recommendations	9/30/2012	
Agencies/providers apply to serve as co-location pilot projects	Agencies, providers, DOHR	RFP	10/31/2012	
DOHR selects co-location pilot programs	DOHR	Proposals	12/31/2012	
Objective 3.4: Implement pilot co-location programs in FY 2013				
Task/Activity	**Responsible Party**	**Resources**	**Timeline**	**Progress**
Launch pilot co-location programs in FY 2013	Selected providers and agencies		3/1/2013	
Evaluate pilot co-location programs at three months and six months	DMS		9/1/2013	

Objective 3.5: Recommend ongoing co-location program based on initial evaluation of the pilot programs; integrate into DOHR FY 2014 RFP by September 30, 2013				
Task/Activity	**Responsible Party**	**Resources**	**Timeline**	**Progress**
Determine recommendations re: future pilot projects and/or a mandate that funded agencies include co-location activities	Planning Council based on recommendations from Co-location Workgroup	Pilot program evaluation data, funding availability	9/15/2013	

Goal 4: Enhance electronic data-sharing options to improve information sharing

Objective 4.1: Determine key functions, components and elements for efficient, effective electronic data-sharing by March 31, 2012; determine capabilities of CareWare or need to purchase software to address these needs

Objective 4.2: Maria – I'm not sure how to handle this section. This will either be "upgrade/modify CareWare" or something along the lines of "research client tracking software options." Is it research first, or funding first or…..what do you recommend for the next couple of objectives?

Objective 4.3:

Objective 4.4:

Enhanced electronic data-sharing options were discussed in every meeting during the implementation planning process. Medical case managers and providers alike feel that there is tremendous opportunity to significantly improve information sharing, case coordination, adherence and quality of care through technology-driven system improvements.

Case managers and providers indicated that having access to the following information available in "real time," with open information sharing at their fingertips, would fundamentally change the nature of service delivery in the Denver TGA. Such information could include:

Last visit	Last lab tests	T-cell strata	Viral load suppression
Residency	Income	Co-infection	Medicine adherence
Service referrals	Services accessed	Referral adherence	Demographics
Family support	ROI	Acuity Scale	Contact information

While CareWare has primarily been utilized as a data tracking tool, exploration is underway as to what opportunities there are to modify or upgrade the system to allow for better tracking and sharing of patient data to allow CareWare to become more useful as a service delivery tool.

A number of software options were mentioned for the MCM Workgroup to explore should CareWare upgrades not meet the system needs, including:

- ✓ Provide Enterprise (http://www.grouptech.com/Default.aspx -- Ryan White Part A compliant)
- ✓ ClientTrack (http://www.clienttrack.com/)
- ✓ Penelope Case Management Software (http://www.athenasoftware.net/)

The MCM Workgroup acknowledges that large-scale technology changes can be extremely expensive. In a time of shrinking and uncertain future funding, a wholesale overhaul of the system might not be possible at this time or in the very near future. However, the Workgroup believes that with Affordable Care Act requirements regarding Electronic Medical Records, considerable changes to the current system or a new system will need to be in place within three years.

Input and discussion in favor of enhanced electronic data-sharing

The top reasons for prioritizing this goal included a desire for improved information sharing and the ability to be more proactive in patient care. Case managers and providers indicated that they currently do not know when clients access care and are only aware of the referrals they make themselves. Public health providers also indicated that they need to be aware of whether patients are accessing care from a public health standpoint.

"An 'actual database' (not CareWare) would allow us to see if clients follow up on referrals."

"It would cut down on phone calls between agencies
if we could quickly look up patient information."

"We wouldn't have to rely only on client self-reporting
so our information would be more accurate."

"We need 'CareWare Plus'" –a system that allows us to enter and track individual clients *and* that tracks what's needed for the TGA."

"This is my top item."

"A new database could be a part of co-location."

Issues/Concerns to address during the Implementation Process

As outlined above, the MCM Workgroup tempered its enthusiasm over case management software with realistic expectations about what is possible, what resources are available and the enormity of the change that would have to take place. In looking forward toward research and potential implementation, thoughts included:

"It is critical that clients understand how to opt-in and opt-out; we would need to provide training to providers about how to explain the choices."

"A good first step is for a small group to meet with DOHR to see what's possible."

"This is a multi-year project. We need to first understand the full scope, then we can determine our next steps."

Alignment with National HIV/AIDS Strategy

Progress on this goal has the potential to support several National HIV/AIDS Strategy areas.

Reducing HIV-Related Disparities and Health Inequities: A system-wide electronic data-sharing method has the potential to meet the recommended action of "measuring and utilizing community viral load" by "ensuring that all localities are able to collect data necessary to calculate community viral load." The data-sharing system also has the potential to "promote a more holistic approach to health.[7]

Increasing Access to Care and Improving Health Outcomes for People Living with HIV: As with several goals outlined above, Goal #4 would support "facilitating linkages to care," "promoting collaboration among providers," and maintaining people living with HIV in care.[8]"

[7] The White House Office of National AIDS Policy, *National HIV/AIDS Strategy for the United States*, July 2010. Pages 31-35.
[8] The White House Office of National AIDS Policy, *National HIV/AIDS Strategy for the United States*, July 2010. Pages 21-25.

Goal 4: Enhance electronic data-sharing options to improve information sharing

Objective 4.1 : Determine key functions, components and elements for efficient, effective electronic data-sharing by March 31, 2012; determine capabilities of CareWare or need to purchase software to address these needs				
Task/Activity	**Responsible Party**	**Resources**	**Timeline**	**Progress**
Building on recommendations from the MCM Improvement plan, more fully define desired data-sharing needs	MCM Workgroup	MCM IP key elements, client tracking software samples	2/29/2012	
Determine options for modifications or upgrades to CareWare to meet these needs and / or recommend exploration of client tracking software	DOHR, DMS	List of key elements, desired features	3/31/2012	

Objective 4.2: Maria – I'm not sure how to handle this section. This will either be "upgrade/modify CareWare" or something along the lines of researching client tracking software options. But, all of this would be dependent on funding. So, is it research first, or find funding first or….What do you recommend for these next couple objectives?				
Task/Activity	**Responsible Party**	**Resources**	**Timeline**	**Progress**

Objective 4.3:				
Task/Activity	**Responsible Party**	**Resources**	**Timeline**	**Progress**
Objective 4.4:				
Task/Activity	**Responsible Party**	**Resources**	**Timeline**	**Progress**

Goal 5: Develop and provide regular, ongoing MCM education and resource sharing meetings

Objective 5.1: Create a system for ongoing, regularly scheduled case manager meetings by February 29, 2012

Objective 5.2: Host and evaluate quarterly education and resource meetings in FY 2012

Objective 5.3: Explore opportunities for information sharing through shared subscriptions, library or electronic means by July 31, 2012

Case managers are eager for the opportunity to learn from one another and from others with an end goal of providing more comprehensive, accurate and higher quality service to their clients. Nearly all case managers interviewed mentioned the desire for some type of ongoing education and resource sharing forum and those who didn't mention it on their own responded positively when the idea was shared.

This approach supports the 2011 Need Assessment findings related to training, resources and service coordination as well as the Community Meeting input regarding top service gaps:

- Case management providers should be well-informed of all the services (Focus Groups, English Speaking, Homeless Individuals In-Care, N=11)
- Properly train all case managers to be well-informed on all HIV services available (Focus Groups, English Speaking Individuals In-Care, N=8)
- Better services coordination between providers including awareness of available services (Key Informant Interviews, N=12)
- One of the three most commonly reported organizational capacity development needs: Building on community linkages (Provider Surveys, N=47)
- Service Gap: Efficient information dissemination mechanisms

Case managers also expressed interest in access to online and subscription-based resources that are beyond the funding limitations of individual agencies, but that may be within reach of the DHRPC. In addition, case managers mentioned a DHRPC library or list of all of the resources available within the TGA for sharing purposes.

Input and discussion in favor of regular, ongoing MCM education and resource-sharing meetings

Regular, ongoing MCM education and resource sharing meetings support the key topic areas of Resource Knowledge, Coordination of Care and Services, Quality of Care, and Training. Case managers shared specific ideas about how to make the case manager meetings successful:

- DHRPC coordination (by staff or a contractor) on managing scheduling, finding locations, setting topics/agendas and coordinating presentations from community agencies (Part A or otherwise)
- Regularly scheduled quarterly meetings (i.e. third Thursday in March, June, September and December)
- Mandatory meetings; case managers believe that attendance at these meetings should be a requirement of funding
- Case manager-focused; this is not a meeting that is open to executive leadership or others unless filling in for a case manager or presenting on a specific educational topic
- Rotate between locations so that case managers can visit various agencies and providers
- Provide an opportunity to problem-solve with other case managers on specific client issues

To supplement the quarterly meetings, case managers requested that DHRPC, DOHR or another entity host a Resource Fair (similar to one hosted by DMS several years ago) and also consider an annual or semi-annual case manager full-day to two-day retreat.

Issues/Concerns to address during the Implementation Process

In building the process and system to support this goal, case managers asked that the process be simple, yet well-coordinated. Several people expressed that if the sessions are not well-attended, well-managed or on topic that there is the potential for more harm than good. This should be seen as an opportunity for the case managers, not one more thing on their already full plates.

Alignment with National HIV/AIDS Strategy

While well-connected, educated, informed case managers could be said to support all of the focus areas of the National HIV/AIDS Strategy, *promoting collaboration among providers* is the recommended action this DHRPC goal would most clearly support.

Goal 5: Develop and provide regular, ongoing MCM education and resource sharing opportunities

Objective 5.1: Create a system for ongoing, regularly scheduled case manager meetings by February 29, 2012				
Task/Activity	**Responsible Party**	**Resources**	**Timeline**	**Progress**
Determine how the meetings will be coordinated and managed (i.e. rotating leadership, consultant help, DHRPC staff)	DHRPC		12/31/2011	
Create a quarterly meeting schedule for FY 2012 and 2013	DHRPC or coordinator		1/31/2012	
Utilize MCM Improvement Plan input to develop initial agendas	DHRPC or coordinator	MCM IP input	1/31/2012	
Inform agencies and providers of the schedule and expectations re: attendance and participation	DHRPC or coordinator		2/29/2012	
Objective 5.2: Host and evaluate quarterly education and resource meetings in FY 2012				
Task/Activity	**Responsible Party**	**Resources**	**Timeline**	**Progress**
Host four case manager meetings during FY 2012	DHRPC or coordinator		2/29/2013	
Evaluate case manager's experiences and ideas for future meetings and implement on an ongoing basis	DHRPC or coordinator		Ongoing	
Determine whether significant changes should be made for FY 2013 that may require funding or adjustments to the schedule	DHRPC or coordinator		7/30/2012	
Recommend adjustments to allocations or a new directive if needed to support ongoing case manager education programs	DHRPC or coordinator		7/30/2012	

Objective 5.3: Explore opportunities for information sharing through shared subscriptions, library or electronic means by July 31, 2012				
Task/Activity	**Responsible Party**	**Resources**	**Timeline**	**Progress**
Survey case managers (or discuss at a quarterly meeting) about subscriptions, online resources, etc. that they would like access to as resources to inform their work (i.e. MedLine Plus)	DHRPC or coordinator		5/31/2012	
Explore pricing, discounts for multiple users/government pricing, accessibility, licensing and prioritization of recommendations	DHRPC		6/30/2012	
Determine which subscriptions and resources to purchase and how to fund the purchases	DHRPC		7/31/2012	
Objective 5.4:				

Plan Recommendations

The following recommendations are focused on implementation of the MCM Improvement Plan

1. The MCM Workgroup will be responsible for oversight of implementing the MCM Improvement Plan; the Workgroup's focus will shift from developing the plan to implementing the plan

2. The MCM Workgroup will regularly update the implementation plan templates as a way to track progress and provide updates to Leadership. A written report should be provided to Leadership quarterly

3. The Workgroup will complete an annual update to the implementation plan to adjust objectives and action steps/timelines for the coming year

4. Maria – what else?

Appendices

A. MCM Key Discussion Topics and Prioritization
B. MCM In-Person Interviews: Agency and Attendees
C. MCM In-Person Interview Guidelines
D. 2011 Needs Assessment MCM Findings

Appendix A: MCM Key Discussion Topics and Prioritization

The following document was developed by Caryn Capriccioso of interSector Partners, L3C and Bettina Harmon of Diverse Management Solutions. The Key Discussion Topics were gleaned from the January 2010 Case Management Assessment, and presented to and prioritized by the MCM Workgroup during its July 2010 meeting. The prioritized discussion topics served as the basis for developing the in-person MCM interview guidelines.

Document key:

- The number following each topic indicates the number of votes for that item as "important to address in the near term / could make a positive difference in my work"
- Page numbers following each topic refer to the Case Management Assessment Report (http://dhrpc.org/tasks/sites/default/assets/File/PDF%27s/DHRPC_DOHRCaseManagementAssessement_2010.pdf)

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1. **Acuity (10 votes).** Acuity assessment ensures that the program is focusing on individuals who are most in need of case management services. The acuity score is directly related to the type and/or intensity of services case managers provide to participants. Acuity is reassessed over time and the participant's services are adjusted to address the level of assessed need. In some locations, acuity-based caseload systems assign workload based on participant need, rather than the number of participants. (pages 18-26)

2. **Self-Management (5 votes).** Through health literacy and disease management education, individualized goal setting, and self-advocacy support, case managers assist participants to become full and active participants in their own health care. (pages 34-36)

3. **Adherence (5 votes).** Through adherence assessments and screening, coordination of services, psychosocial support, crisis management, and education, case managers assist all providers to communicate a consistent adherence message to the participant and assist the participant to adhere to their medical and service treatment plans. (pages 36-39)

4. **Coordination of Care and Services / Case Coordination and Conferencing (5 votes)** (*Note: the group asked that these two items be combined*)**.** Through facilitation of the organizations providing services and assistance in the sequencing of appropriate health care services in the most cost-effective manner, case managers improve the quality of care in order to promote optimal outcomes for all parties involved. Additionally, they provide quality health care along a continuum, decrease fragmentation of care across many settings, enhance the participant's quality of life, and help contain costs. (page 3, pages 29-33)

   Case Coordination - includes communication, information sharing, and collaboration, and occurs regularly with case management and other staff serving the client within and between agencies in the community. *Case Conferencing* - a formal, planned, and structured event separate from regular contacts. The goal is to provide holistic, coordinated, and integrated services across providers, and reduce duplication. (pages 30-33)

5. **Resource Knowledge (4 votes).** Case managers must be aware of the resources available, both within the system of care and in other social and medical systems. Most participants enter into case management services with a lack of knowledge about the services in the care system or larger community. It is important that the case management system have a way to educate case managers about services within the TGA, but also in other systems of care and services. (pages 39-41)

   (Note: the group asked for specific reference to be made to information sharing and a release of information for further exploration under this item.)

6. **Treatment Plan (2 votes).** The case management plan (i.e. service plan, treatment plan, service linkage plan) sets the foundation for strong service delivery. Well-developed plans lower the risks of failing to complete treatment tasks and the delivery of inappropriate care. Case reviews are central to the treatment planning process. Case managers need to be skilled in: conceptualizing the participant's needs, counseling skills to turn the biopsychosocial assessment into an action plan, and the ability to engage the participant to buy into the planning process.

7. **Transition Planning (1 vote).** Through regular assessment and psychosocial support, case managers ensure that the participant is functioning in society at the most appropriate level, they assist in returning the participant to work (or other meaningful activities, depending on their condition), and they also determine when services, including case management, are no longer needed. (page 3)

8. **Biopsychosocial Assessment.** Through the utilization of early biopsychosocial assessment tools, case managers ensure that services are generated in a timely and cost-effective manner. (pages 15-18)

   (Note: The group identified this item as one that's working well and where some general improvements could yield immediate and important results.)

9. **Access to Care and Services.** By facilitating and coordinating timely and appropriate health services, case managers assist the participant in achieving an optimal level of wellness and functioning. (pages 26-34)

10. **Quality of Care**. Through continual assessment of the participant's situation and care, case managers ensure they are connected to and adhere to the proper treatment needed, and that the treatment is implemented in an efficient way and avoids duplication of other services the participant is already receiving (Powell & Tahan, 2008).

11. **Training.** Case management training is necessary to establish a solid knowledge base for all case managers. Training may include: Biopsychosocial Assessment; Acuity Assessment; Treatment planning; System and Resource Knowledge; Utilization management & Case Conference/Collaboration; Health Literacy/Self-Management assessment; psychosocial support and understanding of mental health and substance abuse issues. (pages 41-45)

12. **Supervision.** In addition to certification, some HIV programs have recognized that the work of case management requires a clinical aspect of supervision and requires that the supervisor have, at minimum, a master's degree in social work or a related discipline. In addition, some sites have also required documentation that the supervisor and case manager discuss every participant involved in the agency program, either annually or every six months. (pages 45-49)

Additional ideas, issues and thoughts that were raised during the July 19, 2011, MCM Workgroup meeting include:

- The importance of terminology (what is self-managed, what are provider's definitions vs. what participants understand, etc.)
- Whether the ultimate goal of case management is to help clients achieve self-management?
- Developing a mechanism for providers to share issues and problems with the system so that they can be addressed

Appendix B: MCM In-Person Interviews: Agency and Attendees

The following providers and agencies participated in interviews to inform the MCM Improvement Planning Process. All interviews were conducted in-person, on site with one exception as noted below.

July 22, 2011

Denver Community Health Services Primary Care Clinic: Eastside Family Health Center
Peter Bradley

July 25, 2011

Children's Hospital HIV Program
Jennifer Dunn, Jessica Forsyth, Kerry Hartel, Mindy Paddock

Empowerment Program – Women's AIDS Project
Allyson Drayton, Carol Lease, Kate Leos

Kaiser Foundation Health Plan
Debi Bridge

July 26, 2011

Sisters of Color United for Education
Sylvia Hernandez-Granillo

Rocky Mountain Cares
Adrian Pilarski, Robert Riester, Shannon Southall

Colorado AIDS Project
Robert George, Ruth Pederson, Jesse Yedinak

July 28, 2011

Children's Hospital HIV Program
Dr. Betsy McFarland (interviewed by telephone)

Servicios de la Raza
Fabian Ortega, Jalene Salazar

University of Colorado Hospital—Infectious Disease Control Group Practice
Clarie Means

August 2, 2011

It Takes a Village
Khalil Halim, Jeff Lewis, Veronica Ledezma

August 3, 2011

Howard Dental Center
Ernie Duff, Hazel Harris

Clinicia Tepeyac
Oswaldo Lozano, Marlene Valadez

August 9, 2011

Denver Health
Ed Gardner, Julia Weiss

August 18, 2011

Metro Community Providers Network
Jose Castilla-Mancilla (attended for a brief time), Stuart Thomas

Appendix C: MCM In-Person Interview Guidelines

The following questions were developed by interSector Partners, L3C and DHRPC and were designed to both emphasize the top priorities identified by the MCM Workgroup (see Appendix A) and to explore additional findings of the 2011 DHRPC Needs Assessment.

Interview Guidelines for Outpatient Ambulatory and Oral Health Care Providers

Intro: Thanks for making the time to meet with me today. As you are aware, one of the major challenges facing the Denver TGA is the positioning of Medical Case Management (MCM) within the system of care to have the greatest impact on quality while simultaneously increasing efficiency. We've talked at the MCM Kick-off meeting and at the MCM Workgroup about the assessment conducted by the Denver Office of HIV Resources in 2009—today's meeting is the next step in the process to develop a plan for creating a healthy and successful system for the Denver TGA.

This interview should last just about an hour. Your responses—along with those of other primary care providers, oral health providers and case management agencies—will help to shape the implementation plan in the coming months.

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1. Please tell me about the role that case managers play in your care for people living with HIV/AIDS.

2. Please share your thoughts on the strengths of the case management system in the Denver TGA.

3. What do you see as the weaknesses of the system?

4. How do you ensure that people who are most in need of services receive those services? Which assessment instruments do you use?

5. Acuity was identified by the MCM Workgroup as a top priority for the improvement planning process. How do you see a standardized acuity system fitting into the Denver TGA?

   (If needed: Acuity assessment ensures that the program is focusing on individuals who are most in need of case management services. The acuity score is directly related to the type and/or intensity of services the case manager provides to the participant. Acuity is reassessed over time and the participant's services are adjusted to address the level of assessed need. In some locations, Acuity-based caseload systems assign workload based on participant need, rather than the number of participants.) (pages 18-26)

6. The MCM Workgroup also identified self-management as a top priority to address in the improvement planning process. What elements of self-management do you feel are most important for your clients? *(prompt: exploring personal meaning of their chronic illness, adaptive coping skills, support groups, etc.)*

7. How do you coordinate care and services with case managers? Which case management agencies do you work most closely with?

8. What are your thoughts on co-location of medical case management within the primary care system? What do you see as potential barriers and / or opportunities?

9. Do you hold case conferences? If so, who what does that look like? *(prompts: are these internal meetings? If not, who is involved, are case managers involved, how often are they held, where are they held, etc.)*

   (*If needed: A case conference is a formal, planned structured event separate from regular contacts. The goal of case conferencing is to provide holistic, coordinated, integrated services across providers and to reduce duplication.")*

10. What are your thoughts on how to improve information sharing within the system?

11. Would a standardized release of information be helpful to your ability to deliver services? What barriers or opportunities do you see?

12. What overall thoughts would you like to share about case management services or the system?

Interview Guidelines for MCM Agencies

Intro: Thanks for making the time to meet with me today. As you are aware, one of the major challenges facing the Denver TGA is the positioning of Medical Case Management (MCM) within the system of care to have the greatest impact on quality while simultaneously increasing efficiency. We've talked at the MCM Kick-off meeting and at the MCM Workgroup about the assessment conducted by the Denver Office of HIV Resources in 2009—today's meeting is the next step in the process to develop a plan for creating a healthy and successful system for the Denver TGA.

This interview should last just about an hour. Your responses—along with those of other providers—will help to shape the implementation plan in the coming months.

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1. Please tell me about your agency's case management services *(prompt: number of case managers, services provided, caseload, etc.)*

2. Please share your thoughts on the strengths of the case management system in the Denver TGA.

3. What do you see as the weaknesses of the system?

4. How do you ensure that people who are most in need of services receive those services? Which assessment instruments do you use?

5. Acuity was identified by the MCM Workgroup as a top priority for the improvement planning process. How do you see a standardized acuity system fitting into the Denver TGA?

   (If needed: Acuity assessment ensures that the program is focusing on individuals who are most in need of case management services. The acuity score is directly related to the type and/or intensity of services the case manager provides to the participant. Acuity is reassessed over time and the participant's services are adjusted to address the level of assessed need. In some locations, Acuity-based caseload systems assign workload based on participant need, rather than the number of participants.) (pages 18-26)

6. Do you currently assign caseload based on severity of need? If not, what do you think of that idea?

   (If needed: Acuity-based caseload systems assign workload to case managers based on participant need rather than the number of participants.)

7. The MCM Workgroup also identified self-management as a top priority to address in the improvement planning process. What ideas do you have for how the system could better support participants in moving toward self-management of their care? *(prompt: exploring personal meaning of their chronic illness, adaptive coping skills, support groups, etc.)*

8. How do you coordinate care and services with other agencies/providers? Which medical providers do you work most closely with?

9. What are your thoughts on co-location of medical case management within the primary care system? What do you see as potential barriers and / or opportunities?

10. Do you hold case conferences? If so, who what does that look like? *(prompts: who is involved, how often are they held, where are they held, etc.)*

(*If needed: A case conference is a formal, planned structured event separate from regular contacts. The goal of case conferencing is to provide holistic, coordinated, integrated services across providers and to reduce duplication."*)

11. What are your thoughts on how to improve information sharing within the system?

12. Would a standardized release of information be helpful to your ability to deliver services? What barriers or opportunities do you see?

13. What overall thoughts would you like to share about case management services or the system?

Appendix D: 2011 Needs Assessment MCM Findings

The 2011 Needs Assessment was not specifically aimed towards evaluating the case management system; however, a variety of questions that relate to this topic were included in the assessment. The following data may serve as preliminary information to guide the MCM Implementation Plan. This data was collected through: Provider Surveys, Key Informant Interviews, Client Surveys, Client Focus Groups and Client Interviews.

Secondary Data Analysis:

CareWare Data

- The proportion of individuals ages 2 to 12 and 13 to 24 accessing MCM significantly decreased from 2008 to 2010; from 53.6% (15) to 14.6% (6) and 58% (91) to 37.2% (61) respectively. However, the proportion of individuals 25 to 44 accessing MCM significantly increased from 48% (822) in 2008 to 53.4% (947) in 2010.
- The proportion of females accessing MCM increased considerably from 39.6% (249) in 2008 to 47.2% (326) in 2010.
- The proportion of HIV-positive individuals with an unknown AIDS status utilizing this service more than doubled, from 12.5% (3) in 2008 to 30.8% (12) in 2010.
- The proportion of non-permanently housed individuals accessing MCM significantly increased from 64.2% (183) in 2008 to 80.4% (344) in 2010. The proportion of institutionalized individuals accessing MSM increased substantially from 13.3% (2) in 2008 to 63.6% (7) in 2010.
- The proportion of individuals below 100% of the Federal Poverty Level (FPL) accessing MCM significantly increased from 49.7% (1,280) in 2008 to 53.6% (1,461) in 2010. However, the proportion of individuals in all other income brackets above 100% the FPL accessing MCM decreased in the same time period.
- The proportion of individuals with no insurance accessing MCM significantly decreased from 42% (697) to 31.6% (413) in 2010. In contrast, the proportion of individuals with "other public" insurance accessing MCM significantly increased from 64.4% (273) to 85% (779) in the same time period.
- The proportion of individuals with no risk identified accessing MCM significantly increased from 22.5% (93) in 2008 to 35.7% (131) in 2010. The proportion of individuals categorized as contracting HIV through perinatal transmission accessing MCM significantly decreased from 92.3% (24) in 2008 to 11.5% (6) in 2010.

Primary Data Analysis:

Common Themes Across all Primary Data Collection:

- Service Gaps – Efficient information dissemination mechanisms.

Service Needs/Priorities:

- 37.3% received case management services vs. 10.1% who did not receive case management services. *(Client Surveys, N=496)*

- Case managers that are compassionate, responsive and effective, this includes service delivery through good customer service and cultural competency. *(Client Focus Groups, Monolingual Spanish Speaking Women, N=3)*

Gaps in Care:

- Lack of client awareness of the role and availability of case management services. *(Focus Groups, Monolingual Spanish Speaking MSM, N=13)*

- Provide case management through Spanish speaking provider. *(Focus Groups, Monolingual Spanish Speaking MSM, N=13)*

- Case management providers should be well informed of all the services available and should be comprehensive with their information when they go over it with their clients, this may include a longer initial client visit. *(Focus Groups, English Speaking, Homeless Individuals In-Care, N=11)*

- Properly train all case managers to be well informed on all HIV services available and to provide compassionate care to their clients. *(Focus Groups, English Speaking Individuals In-Care, N=8)*

- Better services coordination between providers, including awareness of available services provided by other agencies to effectively refer client/patients for appropriate care. *(Key Informant Interviews, N=12)*

Barriers to Care:

- Switching client's case manager too many times can be frustrating and lead to individuals dropping out of care. *(Focus Groups, English Speaking, Homeless Individuals In- Care, N=11)*

- Providers agree that, in many cases, individuals are misinformed of the services available to them or are unaware of the process for accessing such services. *(Key Informant Interviews, N=12)*

Linkage to Care:

- One specific provider reported increased efforts to reach out to incarcerated individuals through testing expansion to jails and care transitional case management for those about to leave Denver County Jail. Outreach efforts to incarcerated persons were also reported within a couple other agencies, including an HIV/AIDS and STI prevention course targeting young men and women involved with Denver Juvenile Probation for over two years.
    - Common Successes: Improved access to care and "markedly improved connections to care following release from correctional settings."
    - Common Challenges: Funding and ensuring access to medications while incarcerated.

  (Provider Surveys, N=47)

Capacity Development Needs:

- The three most commonly reported organizational capacity development needs included:
    - Building community linkages (41%)
    - Training on risk reduction counseling (41%)
    - Working with diverse populations (28%)

  (Provider Surveys, N=47)

- A lack of coordination of funding and priorities between Ryan White Parts A and B leading to duplication of efforts and a lack of seamless systems of care. *(Provider Surveys, N=47)*

Revised Monitoring Standards:

- The majority of providers (77%) reported familiarity with the revised HIV/AIDS Bureau Monitoring Standards for Parts A and B grantees. The most commonly reported challenge to implementing such Standards involved increased paperwork and time constraints. Such constraints were often put in the context of not receiving additional funding to allow time for administrative staff to collect and organize such additional information.
    - This seemed a particularly acute challenge for an organization which experiences already high caseloads and requires large amounts of medical information from various providers in order to comply with such standards and practices.

  (Provider Surveys, N=47)