

Using Collaborative Case Management to Create Integrated Services

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Introduction

In October 1996, East Boston Neighborhood Health Center (EBNHC) received a five-year grant from Health Resources and Services Administration (HRSA) to develop and implement the Collaborative Care Management Program (CCMP), a specialized care management/clinical services/primary care integration program for individuals who are living with HIV or AIDS, as well as with coexisting mental health and/or substance abuse disorders.

The goals of the program include: engaging hard-to-serve individuals in treatment through the introduction of a care manager; increasing integration of primary care, mental health and substance abuse treatment; increasing cost effectiveness and improving outcomes through changing patterns of care; developing critical linkages with community mental health and substance abuse agencies; establishing program replicability and program sustainability.

Location

The Collaborative Care Management Program (CCMP) is an HRSA-funded Special Projects of National Significance (SPNS) project located at the East Boston Neighborhood Health Center (EBNHC) in Boston, Massachusetts. Boston, the state capital and largest city, has a population of approximately 600,000, about 10 percent of the total state population.

The East Boston Neighborhood Health Center was established in 1975 as a community-owned and operated health center. It serves the low income and working class communities

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of Chelsea, Revere, East Boston and Winthrop, communities that are geographically isolated from the city of Boston proper by congested tunnels and bridges.

The EBNHC service area includes immigrant communities populated initially by Italians, and since the 1980s by Central Americans, Brazilians and Asians. Many residents are undocumented, and thus uninsured, while others have private health insurance, Medicaid or Medicare.

The health center provides a full complement of primary care services including adult medicine, pediatrics, obstetrics and gynecology; a full spectrum of specialty care; mental health services; a 24-hour urgent care facility; laboratory, radiology, and other services. EBNHC is affiliated with two hospitals: Massachusetts General Hospital and Boston Medical Center and provides more than 300,000 visits annually. It is the largest community health center in New England.

EBNHC has been in the forefront of developing community-based services for both the general population and the special needs populations in its service area. In 1992, the health center decided to extend this experience to develop and implement comprehensive programs for other complex patient populations, including people with HIV and AIDS.

Context of Service Delivery

Ethnicity

The four communities served by the East Boston Neighborhood Health Center range in racial and ethnic diversity. While Winthrop and Revere are more than 90 percent white, Chelsea’s population is only 60 percent white, with 31 percent of Hispanic origin, 4 percent black, and 5 percent Asian. East Boston’s population is more than 70 percent white, 18 percent of Hispanic origin, 4 percent black and 6 percent Asian.

Poverty

The health center’s catchment area is poor compared to the rest of the state, and three of the four communities are substantially poorer as measured by receipt of public assistance and percent of individuals living in poverty. With the exception of Winthrop, each of these



Poverty rates in the communities served by East Boston Neighborhood Health Center

State Poverty Rate	9%
Rever	12%
Chelsea	24%
East Boston	31%
Winthrop	6%

communities has a per capita income below the state average. Thus, a substantial proportion of individuals in the neighborhoods served by EBNHC are living below the poverty level. While the state poverty rate is approximately nine percent, three of the four communities served by the health center have higher

levels of poverty. Revere's poverty rate is 12 percent, Chelsea's poverty rate is more than 24 percent, and East Boston's poverty rate is extremely high at almost 31 percent. Winthrop's poverty rate is less than six percent, reflecting its relative wealth in relation to the other three areas.

As a result of the high poverty rates, a substantial portion of the overall population receives some form of public assistance, from a high of 25 percent in Chelsea to a low of 3.5 percent in Winthrop. More than 15 percent of East Boston residents and 12 percent of Revere residents receive public assistance.

Unemployment is a major concern within most of the communities served by EBNHC. While the state unemployment rate is just over 4 percent, East Boston has an unemployment rate of almost 11 percent, and Chelsea has an unemployment rate of almost 7 percent. Revere's unemployment rate is just over five percent. Each of these numbers also represents a substantial decrease in employment since the early 1990s. Winthrop has a lower unemployment rate than the state average, at just over three percent.

Substance Abuse

Substance abuse is a significant issue in the region served by EBNHC. Among 25 to 44 year olds, drug related mortality was the cause of 30 percent of all deaths in East Boston, compared to the state rate of 17 percent for this age group. In terms of admission to substance abuse treatment, substance abuse rehabilitation or detoxification was the fourth leading cause of inpatient admission for East Boston residents.

Of the other three communities served by EBNHC, two had higher rates of admission to substance abuse treatment than the state rate, while one was about equivalent: Substance abuse is a particularly serious problem in Revere, with admission rates to treatment more than double that of the state as a whole. Of the four communities served by EBNHC, Revere has the highest rate of admission to treatment at 3.9 percent. Additionally, injection drug use accounts for the majority of substance abuse in this community. Deaths induced by substance abuse are double the state average in Revere.

In Chelsea, injection drug user admissions to substance abuse treatment programs were 327 percent higher than the rate within Massachusetts as a whole. The rate of substance abuse related deaths in Chelsea is 26 percent of all deaths, compared to the state rate of 15 percent.

HIV/AIDS

The most recent HIV/AIDS surveillance data from the CDC report indicates a total of 13,809 AIDS cases or 924 cases per 100,000 population in 1998, up from 850 cases per thousand population in 1997 in Massachusetts. In East Boston, AIDS is among the ten leading causes of death, but does not equal the rate for the city of Boston or the state as a

Substance abuse is significant... among 25 to 44 year olds, drug related mortality was the cause of 30 percent of all deaths.

whole. On the other hand, in Chelsea, the rate of newly diagnosed AIDS cases annually is 22 percent, nearly doubling the state rate of 13 percent. In addition, 138 persons per 100,000 were living with AIDS in Chelsea, while the state rate is 82 persons per 100,000. In Revere, the rate of newly diagnosed AIDS cases annually is almost 17 percent, slightly higher than the state rate. HIV and AIDS do not have the same impact in Winthrop as in the other communities served by EBNHC. The rate of newly diagnosed AIDS cases in Winthrop is available, but the number of persons living with AIDS is slightly lower than the state average, although AIDS-related deaths were significantly higher than the state average.

Context for the Collaborative Care Management Program

CCMP operates in the context of the demographics of the area served by EBNHC as well as in the context of a city that is home of numerous major teaching hospitals and centers of HIV and AIDS care. It also operates in the context of a previous SPNS project at EBNHC. In 1994 the East Boston Neighborhood Health Center received a grant from HRSA under the SPNS program to develop an integrated model of care for individuals with HIV/AIDS. Project SHINE (Support, Healthcare, Intervention and Education) was designed as a community-based program that uses a multidisciplinary team approach to caring for people with HIV/AIDS. CCMP was developed to complement Project SHINE, with a goal of extensive integration and coordination between the two programs. Project SHINE was also expected to serve as CCMP's primary referral source of HIV-positive individuals who also have severe mental health and/or substance abuse problems.

Lessons Learned

Lesson #1: Taking a program from theory into reality is difficult.

Developing a program from theory into one with an active case load, active referral sources and a common understanding among program and referring staff as to the basic tenants purposes and referral procedures is extremely difficult. One by one, each obstacle to implementation was confronted and favorably or reasonably resolved before proceeding.

These barriers included the scarcity of building space, model revisions within collaborating agency and contract negotiations snags with linking organizations.

The investigators learned that the time required to complete the linkage development process from initial contact to an executed letter of agreement (LOA) has often been lengthy. It became apparent that existing linkages are ineffective without actual patient referrals to test the strength and viability of the system. They now know that an executed LOA, in the absence of a solid connection with service delivery staff of an agency, means very little at the time of admission and discharge of referred patients.

Referral numbers have lagged well behind expectations. The original target patient load was 100, but as of early 2000, had reached only 40. It is believed that patient numbers are small as the result of collaborating agency's patient load remaining consistent, which in turn can be traced to

the growing number of new, hospital-based HIV service programs. That is, patient load has not increased because of the slower-than-expected growth of HIV primary care at the health

The use of formal agreements for linkage has been seriously questioned....

center. Most importantly, low patient load will have a significant impact on the project's ability to secure third party reimbursements and managed-care contracts, and develop viable linkages. It is difficult to form strong alliances if the relationships are not used and tested. More patients in the program would have afforded a greater opportunity to interact with and strengthen collaborations with linkage partners.

Lesson #2: It is the staff that implements linkage.

In April 1998 when the first CCMP patient was admitted to a local collaborating hospital, staff realized the linkage agreement with the hospital was not working as originally intended. As a result they decided to involve direct service staff when negotiating affiliations. This represented a shift in focus from the administrative/ executive level to the service delivery level as the first and most effective level at which to implement linkages. What became important was how the process of linkage development was implemented and who was included. While agency management

needs to be involved in the contractual process, there also must be involvement of the direct care staff. They are the ones who actually make referrals and provide services and coordination if linkages are to be effective. Service providers from both agencies should be included early in the process in order to create and maintain an ongoing relationship. The use of formal agreements for linkage was seriously questioned. Staff were concerned about the effectiveness of contracts that did not filter down to the people who are doing the work.

In September of 1998 program staff again reviewed the linkage process. At that time, they shifted from an exclusive focus on formal linkages (using letters of agreement) to examination of the importance of informal and operational approaches.

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Lesson #3: Cultural competence requires continual reassessment.

In June 1998 a decision was made to pull cultural competence out of the formal evaluation plan. This decision was later reconsidered on the basis of need and commitment in particular to Spanish-speaking populations. A cultural competence coordinator was appointed in recognition of the need to consolidate this vital program component. In October of 1998 a cultural competence evaluation plan was completed. The decision was made to discontinue cultural competence training for the mental health staff in favor of redirecting energy toward determining why so few referrals of Latino patients had been received by the program. Prior to this time, three training sessions had been held for East Boston Neighborhood Health Clinic mental health and social service staff.

By April of 1999, program staff recognized the need for overlap between addressing cultural competence concerns and linkage development in order to achieve the goal of increasing Latino referrals. This led to a shift from a theoretical approach to a more operational look at providing culturally competent care.

Hiring an additional care manager increased patient assignment options. It became possible to accommodate language, cultural, gender preferences and diagnostic considerations when making care manager assignments for new participants.

However, when the trilingual care manager resigned, the program found itself without the ability to immediately serve non-English-speaking clients. But due to the low numbers of such referrals, the program was able to still consistently serve its patient population. The program referred the few Spanish-speaking patients to a fluent HIV case manager from a collaborating agency. The project also renewed a contract with a private outpatient mental health practice in East Boston with Spanish-speaking service capacity. This agency was successful in adding several new bilingual staff members and has welcomed new referrals from the health center. Unfortunately the number of Latino referrals has not increased despite cultural competence training, the existence of a senior-level, trilingual, bicultural care manager and a HIV- patient population that is 27 percent Latino.

Despite cultural competence training, Latino referrals have not increased.

Lesson #4: Care managers can provide unique services.

By developing a theoretical framework from individual relationships between provider/client to provider to patient in his/her environment, program staff defined the role of care manager and differentiated this role from the role of case managers and strictly traditional individual psychotherapists. Theoretical concepts such as the holding environment and parallel process, as well as systems theory, further enriched and deepened the process of supervision as well as differentiated the role of care manager and case manager.

The care manager, as the role was originally conceptualized, was a person with a masters degree with demonstrated expertise in triple diagnosis. This model has the potential to prove both clinically effective and cost effective, as the care manager coordinates all care from client's entry into the system, and follows the client wherever he or she is. Care managers work closely with all other individuals involved with the client's care, including physicians, other mental health and substance abuse providers, and support service providers. The care manager may also serve as the primary mental health provider if appropriate.

Significant progress has been made in the development and field testing of the specialized care manager role. It has been especially challenging to construct and implement customized service plans and continuously adjust the care manager role for each participant. Thus considerable time and energy have been expended during clinical supervision, peer advisory meetings, and weekly clinical team meetings examining, from theoretical and pragmatic perspectives, the evolving iterations/reiterations of this care manager role, which is the cornerstone of the project.

In April of 1999, project staff discussed the overlap of services with collaborating agencies. This was necessary in order to create a truly interdisciplinary treatment team and reduce role confusion between HIV case managers and the care managers. It was hoped that communication, cooperation and camaraderie would improve. Project staff recognized the inherent risk of inadvertently creating parallel program models targeting the very same

patient population, and assessed the additional risk of inadvertently creating the very fragmentation they had set out to address and reduce. The result of these concerns was a plan to create a diagnostic evaluation clinic in an effort to engage clients immediately in the treatment process and to speed up the access to critical services. By creating this newly constituted multidisciplinary team, for the first time, the entire range of providers who serve the relevant patient population were working together at the health center.

The care managers provide the primary brokerage for the implementation of a more integrated model of care. They provide weekly clinical supervision to the case managers, informal peer case review to the case managers and HIV nurse, trainings on a relevant clinical issues, and steady service and leadership for the diagnostic evaluation unit, a progressive model of immediate engagement of newly diagnosed HIV infected individuals. Care managers also, take the lead in facilitating internal care coordination meetings, attend treatment and discharge conferences, and work with patients to negotiate the legal system or access needed services. Referring agency staff now confer with a care manager whenever making a new referral, thereby removing the guess work relative to program criteria and ensuring the development of an engagement plan. All of these coordinated efforts promote the project's goal of reducing fragmentation and improving access while simultaneously decreasing role confusion and duplication of effort.

East Boston Neighborhood Health Center Project Chronology

October 1996

- Grant award received. Begin a search for a qualified evaluator with whom to execute a consultant contract.
- Team developed for program implementation.

November 1996

- Negotiate with local mental health association to cosponsor and comanage the Collaborative Care Management Program.

December 1996

- First care manager hired. Program development continues.

February 1997

- Implementation team members plan to initiate meetings with other agencies to discuss affiliations and linkages in conjunction with the grant objectives.

January 1997

- Negotiation with Medicaid Working Group (MWG) of Boston University to serve as project evaluator begins.

February 1997

- Negotiate contract with a small managed care organization serving individuals with disabilities, HIV and AIDS, to manage the care of a segment of EBNHC primary care patients.

March 1997

- Tools and procedures for initial program implementation are finalized, including referral forms and referral process.
- Achieve same day access for all EBNHC patients to local treatment center.

April 1997

- HRSA/SPNS site visit.

May 1997

- First of a series of three training sessions in cultural competence presented to the staff of the Mental Health/Social Services Department.

June 1997

- Preliminary data collection tools researched and recommendations made: 1) screening, outcome, quality of life and satisfaction measures; 2) develop service linkages in the community for mental health and substance abuse treatment.

July 1997

- Complete Department of Mental Health (DMH) IRB process in conjunction with goal of admitting DMH eligible patients, thereby beginning to address the need to contract with payer sources to sustain the program beyond the grant funded period.

September 1997

- IRB approval by DMH Central Office Research Review Committee received.

October 1997

- Second care manager hired. Care managers become increasingly involved in program development and the data collection process.
- Care managers begin to attend CCMP planning meetings.
- CCMP goes live and officially starts accepting referrals.
- Begin weekly evaluation meetings to discuss progress of data collection, the amount of data to be collected and resulting client burden. Decision made to eliminate several local evaluation tools from data set in an effort to decrease client burden.

November 1997

- CCMP begins reviewing referrals in accordance with preliminary admission requirements.
- First linkage survey administered. Staff at EBNHC interviewed and concerns about referral process and access to CCMP emerged.

December 1997

- Develop criteria and process for discharge and inactive status.
- Care managers finalize intake forms. CCMP data binder is created.
- Finalize project data codebook, data collection and data submission procedures.
- First client enrolled in the program.

March 1998

- Linkage process moving slowly. Start weekly linkage meeting to review the progress of affiliations and assign tasks for the week. Results in drafting of guidelines for the linkage development process.

April 1998

- First CCMP patient admitted to collaborating hospital. Realize that linkage agreement not working as originally intended. As a result decide to involve direct service staff when negotiating affiliations. This represents a shift in focus in the linkage development process and procedures from the administrative/executive level to the service delivery level as the first and most effective level at which to initiate and operationalize linkages.

May 1998

- First data submission, including linkage data, submitted to ETAC. Data is clean.
- Substance abuse consultant hired to provide expertise in addictions to team. This consultant is an important addition as a balance to the more psychodynamic approaches of the care managers.

June 1998

- Decision made to pull cultural competence out of formal evaluation plan. This decision was later reconsidered on the basis of need and commitment to population.
- Implement participant incentives to facilitate the completion of data collection. Although some staff have initial reservations about this policy, it increases the amount of data collected. These reservations are about the complications associated with mixing financial incentives with clinical work, especially with a multiply challenged patient population. The policy also helped clarify the historical tension between clinical work and data collection. Staff decides upon using food vouchers over cash incentives.
- Re-examination of team roles reveals the need for an administrative assistant
- Move to new building.

July 1998

- Site visit by ETAC. As a result, a procedure for performing process evaluation added to evaluation and dissemination plans.

July 1998

- Develop HIV risk criteria, which results in our requesting and gaining HRSA approval to admit the “not yet positive” category of patients to the CCMP. This will potentially strengthen our evaluation with higher referral numbers and a greater likelihood of developing a comparison group.
- Refer first patient to collaborating treatment facility after negotiating same day access. Linkage with agency is actualized.

August 1998

- Develop local evaluation activities. Local evaluation activities will take place in five domains: overall process evaluation, cost effectiveness, cultural competence, role of the care manager, replicability in the current health care environment.

July/August 1998

- Collaborating mental health association declares intention to terminate contract to jointly fund and manage the CCMP as a result of significant changes in DMH funding.

September 1998

- Clinical supervision re-examined.
- Neighborhood Health Plan (NHP) Intensive Case Management contract awarded.
- Review program linkages again.
- Creation of a monthly integration meeting to better coordinate clinical and evaluation components of program.

October 1998

- Administrative assistant hired.
- Draft of cultural competence evaluation plan complete. Discontinue cultural competence training for the mental health staff.
- Second round of linkage survey given to EBNHC staff.
- Second data submission submitted to ETAC. Data clean.
- Administrative assistant resigns. Administrative tasks become increasingly burdensome for the care managers and project directors.

January 1999

- Implementation of policy and procedures in the assessment and management of risk factors in patient care and development of corresponding risk management/special clinical review form.
- Draft cost effectiveness evaluation plan and complete first cost-effectiveness data run.
- Collaborating agency again implements revisions to the program model. This changes the way in which CCMP interacts with agency.
- East Boston Neighborhood Health Center files for Chapter 11 Bankruptcy protection potentially imperiling the program. Neither the CCMP staff in particular nor the mental health/social services staff are directly affected by the planned reduction in force and subsequent health center reorganization.

February 1999

- Collaborating agencies develop a system for coordinating the collection of data common to both projects. Represents an improvement in the collaboration on data collection between the two projects, thereby reducing patient burden in the process.

March 1999

- Re-initiate collaborative meetings with the Community Medical Alliance Program of NHP to redefine roles, clarify misperceptions and discuss patient care.
- Graduate intern agrees to assist with data entry in preparation for third data submission to ETAC while program seeks to hire an administrative assistant.

April 1999

- Decide to redesign the linkage survey. Previous survey did not reflect the impact on staff perceptions of new affiliations with mental health and substance abuse agencies and does not survey outside agencies' satisfaction with linkage development process.
- Cultural competence and cost effectiveness concept paper drafts are distributed to the integration team.
- Discuss need for overlap between cultural competence, linkage development and the goal of increasing Latino referrals.

April 1999

- Discuss need for overlap meeting between collaborating agencies. This process precipitates a needed mid-life review of the program, including lessons learned in several key areas for the project.

May 1999

- Third care manager hired.
- Full day meeting in Boston with ETAC to discuss evaluation process and procedures.
- Care managers begin to formally outline and develop the conceptual model of the role of the care manager.
- Third round of data and second round of linkage data submitted to ETAC. Data clean.

June 1999

- Team decides to look at referral process and base in attempt to increase program numbers. This results in a broad re-examination of systems issues at the Health Center including those between the SPNS I and II projects and a redefining of our audiences and potential sources of increased referrals.
- After carefully considering issues such as patient burden, reliability and duplication of effort, decision made to apply to HRSA for an exemption of the requirement to administer the PPQ to our project participants. Decision made to rescind the request once the implications for modification to the database, data collection tools and data submission process were fully assessed and understood. HRSA project officer offers the possibility of additional funds to assist with this data collection effort. Consider increasing the incentives budget to ease patient burden, and continue to explore and address our concerns about instrument validity and the use of clinical judgment as to the timing of the PPQ administration to avert, whenever possible, adverse reactions.

July 1999

- First meeting collaborating agency staff held to identify areas of progress, as well as significant barriers to progress at the midpoint in the project. Barriers to effective communication, role confusion and access to services are cited as the most critical issues. Case examples illustrating the efficacy as well as limitations of the model were provided.
- Key outcomes of the meeting are the deciding factors to construct a new multidisciplinary team created by combining collaborating agency staff and to plan and implement a diagnostic evaluation clinic to be staffed by the HIV nurse, the CCMP care

managers and the HIV case manager. These two measures are intended to improve patient care by decreasing fragmentation, increasing communication and distributing patient care-related tasks among team members, thereby reducing duplication and role confusion. This is viewed as a major accomplishment.

Further Information and Technical Assistance

Should you wish to obtain additional information about the service delivery model developed by East Boston Neighborhood Health Center, you are welcome to contact the project director and request technical assistance:

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