
Integrated Case Management

The goals for ICM Programs are to:

- provide seamless access to medical care and support services to targeted individuals and communities within the Severe Need and Special Population demographics
 - link and maintain individuals within care through the provision of integrated services
 - offer innovative approaches in a culturally competent context
 - provide effective interventions to individuals and communities that have had historical challenges engaging with the traditional medical model of care
-

Integrated Case Management

Integrated Case Management, Early Intervention Programs, and Integrated Service Programs are historical precursors to the Center of Excellence model.

Although there are commonalities between them, each of these three models also have basic underlying differences from the COE model of care.

Integrated Case Management

Services provided within ICMs

- Case Management
 - Peer Advocacy
 - Treatment Advocacy and Treatment Adherence Support
 - Nutrition Counseling
-

Integrated Case Management

There are 4 sites currently funded to provide Integrated Case Management.

Target Demographics

1. Asian and Pacific Islanders
 2. Latino/a
 3. Severe Need and Special Populations with an emphasis on African-Americans and/or Women
 4. Men of Color with an emphasis on African-Americans
-

Integrated Case Management

Site 1

- Case Management – 40 UDC
- Peer Advocacy – 25 UDC
- Treatment Advocacy (Individual) – 15 UDC
- Treatment Advocacy (Group) – 20 UDC

Site 2

- Case Management – 203 UDC
 - Peer Advocacy – 259 UDC
 - Treatment Advocacy – 182 UDC
 - Nutrition Counseling – 132 UDC
-

Integrated Case Management

Site 3

- RN Case Management – 30 UDC
- Peer Advocacy and Care Navigation – 45 UDC
- Treatment Advocacy and Nutrition Counseling Groups

Site 4

- Case Management – 75 UDC
 - Case Management for Seniors – 55 UDC
 - Peer Advocacy – 75 UDC
 - Treatment Advocacy – 75 UDC
 - Nutrition Counseling – 75 UDC
-

Early Intervention Programs

A one-stop model of care

- Funded by the State Office of AIDS
- 36 EIP sites across the state
- 2 EIP sites in San Francisco

San Francisco EIP sites

Combined, these 2 sites provide the following medical and support services to over 500 HIV+ individuals:

- Primary Medical Care
 - Medical Case Management
 - Multidisciplinary Case Conferencing
 - Health Education
 - Medication Adherence
 - Risk Reduction
 - Positive Changes: Prevention With Positives
 - Pathways: Substance Abuse & Mental Health Counseling
 - Bridge Outreach/Case Finders: identify out of care and provide practical support for those at risk of falling out of care
-

Demographic Data

Site #1

- UDC 360
- African American 3%
- Latinos 68%
- Asian 3%
- White 19%
- Men 92%
- Women 5%
- Transgender MTF 3%
- 60% over the age of 40

Site #2

- UDC 170
 - African American 93%
 - Latino/a 4%
 - Native American 2%
 - White 1%
 - Men 73%
 - Women 25%
 - Transgender MTF 2%
 - 60% over the age of 40
-

Severity of Need

Site #1

- 84% under 150%FPL
- 51% substance abuse
- 49% diagnosed with psychiatric illness
- 50% have AIDS diagnosis
- 2 patients died 08/09 FY

Site #2

- 100% under 150%FPL
 - 80% substance abuse
 - 60% diagnosed with psychiatric illness
 - 92% have disabling HIV or AIDS diagnosis
 - Opportunistic Infections at time of entry into EIP is on the rise
 - 6 patients died 08/09 FY
-

Medication Adherence

- Approximately 90% of clients are on medication
 - Most successful component of EIP
 - Assessments of barriers
 - Delivery of medications in medi-sets to the clinic and 1x a week visit with health educator
 - Monthly adherence support visits
 - Medication Adherence Program: assessment prior to starting; 1 & 4 week follow up; on going quantitative assessment of adherence including VL & CD4
-

Gracias!

- Any questions?