Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

THE RYAN WHITE CARE ACT:

EXAMPLES OF LOCAL COORDINATION

JUNE GIBBS BROWN
Inspector General

JUNE 1995
OEI-05-93-00335

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INTRODUCTION

PURPOSE

To describe a variety of experiences of Ryan White grantees in coordinating client services between providers.

Reauthorization Studies

In this current report, we supplement previously acquired data with observations and discussions at the local level. These included our attending planning council and committee meetings; visiting local project sites and providers; holding discussions with grantee administrators, project staff, providers, and persons with HIV/AIDS; and reviewing funding and service plans, and progress reports.

The study complements our report, *Local Implementation Issues*, OEI-05-93-00336. These two studies are part of a series of studies that examine the Ryan White program prior to its first reauthorization, currently pending before Congress. The previous Ryan White CARE Act (the Act) reports are: *Funding Formulas* (OEI-05-93-00330); *FY 1992 Title I and Title II Expenditures* (OEI-05-93-00331); *Consortia Activities* (OEI-05-93-00333); *FY 1992 Special Projects of National Significance - Expenditures by Service* (OEI-05-93-00332); and, *Technical Report of 1992 Expenditures* (OEI-05-93-00334).

BACKGROUND

The Act requires that each community receiving Ryan White Title I funds as an Eligible Metropolitan Area (EMA) form a network to discuss community needs and act together to meet those needs. These new networks consist of State and local governments, health care providers, advocacy groups, and persons with HIV/AIDS.[1] The networks convene a planning council, conduct a community's needs assessment, and determine who will be funded.

The Act is multifaceted, with four titles directing resources to various entities and allowing grantees maximum flexibility in the use of funds, particularly at the local level. Title I provides emergency relief grants to EMAs disproportionately affected by the HIV epidemic. Title II provides grants to States and territories to improve the quality, availability and organization of health care and support services for individuals and families with HIV disease. Title III(b) supports early intervention services on an out-

[1] *Since the Ryan White Act enables grantees to deliver a wide range of services to people diagnosed with either HIV or AIDS, this report uses the term "HIV/AIDS" to refer to either or both groups of Ryan White clients.*

patient basis, including counseling, testing, referrals, clinical and diagnostic services, and other therapeutic services. Title IV aims to improve the system of services for children, youth, women and families infected with or affected by HIV/AIDS.

The Health Resources and Services Administration (HRSA) considers coordination of services to clients and coordination between Ryan White titles and programs to be important. In their application for Ryan White funds, EMAs must describe to HRSA how their network will coordinate to provide services to clients. In December 1994, HRSA convened a working session for some program participants responsible for daily front-line coordination between Ryan White programs. This session stressed best practices in local coordination efforts, approaches to overcoming barriers to effective program coordination, and invited advice on how HRSA could provide better support to grantees on coordination efforts.

SCOPE AND METHODOLOGY

This report describes ways this coordination of services and coordination between agencies occurs in seven EMAs and some of the new or enhanced services they now provide. These EMAs received 43 percent of the 1994 Title I Ryan White funding. We used data from the EMAs' grant applications submitted to HRSA in describing each EMA's characteristics.

The EMAs have evolved in different ways at different speeds. Their approaches are fashioned to meet their community's needs within the political constructs available to them. In each community, the involvement and roles of State, county and city government are different.

We limited our study to seven metropolitan areas where the Ryan White programs have attacked their community's problems in distinct ways, and at different speeds. We used four criteria to select sites. First, we chose sites based on their length of time as an Eligible Metropolitan Area (EMA). Three of our sites, New York, Los Angeles, and Fort Lauderdale, were among the original 16. Three other sites we chose, Seattle, Detroit, and New Orleans, were in the 1993 group of nine cities to become EMAs. We chose Kansas City from the latest of nine cities to become eligible. Second, we considered whether or not the Title II consortium also serves as the Title I planning council. At the time of our field work, this was the case in Los Angeles, Seattle, Detroit, and Kansas City. New Orleans has since combined the Titles I and II planning councils. Third, we looked for cities that represent a variety of approaches to coordinating programs and services. Fourth, we favored communities that would give us a geographically diverse sample. Field work was conducted in summer 1994.

Not all barriers to providing coordinated services have been overcome in these communities. Coordination is still evolving in these EMAs and others across the country. In addition, much coordination takes place between providers on an informal

and frequent basis. Because new ways to coordinate services are still being developed, this report does not represent a comprehensive description of all ways that promote service coordination. Nor does it address all operational and policy related questions which were raised by respondents in discussions of this topic, such as the the awarding of subcontracts, HRSA funding cycles, and conflicting program goals and definitions.

We conducted our review in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

EXAMPLES

Coordination of Ryan White programs is effected by a network of concerned grantees, government agencies, providers, advocates and persons with HIV/AIDS. Together, these networks determine where the affected community's needs lie and decide who is best able to meet these needs.

The networks can be effective at coordinating programs designed to provide services to clients. Those not on planning councils still can participate in informal provider networks or serve on committees dealing with HIV/AIDS issues. The networks bring together people who are concerned, knowledgeable, and influential to discuss and act on these issues. These networks provide a good forum to discuss the nature and extent of HIV/AIDS, how to provide services to those infected, and ideas on ways to slow the spread of the disease.

We saw considerable evidence of the dynamics of these networks during our EMA visits where we attended planning council, executive committee, subcommittee, and other group meetings. Each EMA we visited presents different approaches in coordinating Ryan White programs and services, and overcoming barriers to coordination. For example:

In **Seattle, Washington,** the EMA pools Titles I and II funds. The different titles are invisible to providers and clients.

In **New Orleans, Louisiana,** a merger of the Titles I and Title II planning councils will end turmoil in the EMA relating to responsibilities for delivering services.

In **New York, New York,** the EMA contracts out the Ryan White program to deal with the largest concentration of HIV/AIDS cases in the country. The EMA must also deal with seven consortia serving their clients.

The **Kansas City, Missouri** EMA operates in two States. This EMA also relies heavily on HIV/AIDS clients to provide guidance to their operations.

In **Los Angeles, California,** the EMA is linking 10 large providers in a case management network. This linkage serves to reduce duplicate services and provide a more rational delivery of services to clients.

The **Broward County, Florida** EMA is starting a county-wide case management network, linking all providers of Ryan White services.

The **Detroit, Michigan** EMA considers provider coordination important in determining Ryan White funding. One-fourth of a provider's application score relates to their coordination with other providers of HIV/AIDS-related services.

The Ryan White program also provides increased services to combat HIV/AIDS. Ryan White programs greatly help persons with HIV/AIDS by providing services they otherwise would not receive. Many clients have no medical insurance coverage, including Medicare and Medicaid, and rely on Ryan White services to meet their needs.

While States and local communities have contributed substantial resources to fight this disease, Ryan White programs are responsible for many more, and new services being available to persons with HIV/AIDS. These are services that would not be available in that EMA without Ryan White funds.

SEATTLE, WASHINGTON

Seattle EMA Background

The Seattle EMA includes King, Snohomish, and Island Counties and represents 42 percent of the State's population. King County, which includes the city of Seattle, is geographically large. Its 2,134 square miles make it the 17th largest county in the United States. Snohomish County also is over 2,000 square miles, while Island County is 209 square miles.

The Seattle-King County Department of Public Health is the Title I grantee and is also the lead agency for the Title II consortia. Title I responsibilities include providing services for HIV/AIDS education, prevention, testing, counseling, and client care services. As a consortium, they are responsible for consortium management, which includes planning, coordinating, monitoring, and evaluating program activities. They also maintain a centralized contracting and reporting system, and identify and seek funds for consortium activities.

SEATTLE EMA CHARACTERISTICS

- EMA population is 2 million
- 75% of the AIDS cases in Washington State reside in the EMA
- Estimated HIV/AIDS infection is 11,750
- 94% of the HIV/AIDS population lives in King County
- 85% of the infected population is white, 8% is African-American, 4% is Hispanic, and the remainder is Native American or Asian American
- Gay/bi-sexual males make up 78% of the HIV/AIDS population
- Gay/bisexual men who injected drugs make up 11% of the population, while 5% are heterosexual intravenous drug users
- Women make up 4% of the infected population

The Seattle EMA Planning Council

The HIV/AIDS Planning Council is a 32 member body responsible for all planning and allocation activities for care services and prevention/education. It has two co-chairs, one from the Seattle King County Health Department and one community member. Seattle's model of care is based on a continuum of care covering a range of 28 component services from nutrition to primary care. The planning council uses special workgroups, task forces and committees extensively in helping to decide EMA priorities.

Services to Clients

The planning council describes two levels of HIV/AIDS in determining the needs and service priorities of clients. The stages are: 1) those who are disabled by HIV; 2) those who are HIV positive, but not disabled. The Seattle EMA commits at least 65 percent of its funds for services to clients who are disabled by HIV.

The planning council identified 24 distinct client services as priorities for 1994. In terms of funding commitments, case management, primary care, home health care, housing, and early access are the five areas receiving the most EMA funds.

<u>New Services</u>

The Seattle EMA is unique in its aggressive and coordinated approach to the housing needs of its AIDS clients. Based on housing and residential care plans developed by two AIDS service organizations (ASOs) and the Seattle-King County Department of Health, the EMA developed two AIDS-specific care facilities offering skilled nursing and assisted living.

Other new services available to HIV/AIDS clients include:

- an arbiter's office to assist persons with HIV/AIDS reach agreement with health insurance companies on coverage issues;

- dental care, added to the service components after clients indicated a need for these services; and,

- a network of services exclusively for women with HIV, including primary care, case management and advocacy, day and respite care, information and referral, and emotional support.

Administrative Coordination

The Seattle EMA and Washington State have developed a planned approach to the HIV/AIDS epidemic. The State is divided into six regional AIDS networks for purposes of distributing HIV/AIDS related funding. King County makes up an AIDS network, while the other two counties in the Seattle EMA are part of a separate AIDS network. When Seattle became a Ryan White Title I grantee, they arranged with the State to give Title I monies to a statewide pool of HIV/AIDS-related funds, which also includes Title II funds.

The State distributes these HIV/AIDS funds so that each AIDS network receives an equal dollar amount for each reported living AIDS case. Because the Seattle EMA has an estimated 75 percent of the AIDS cases in the State, the EMA receives 75 percent of the combined Title I and II dollars distributed by the State.

By pooling funds in this way, the State avoids some conflicts that might occur between city and State governments, and between titles, over how to allocate funds. Because there is no distinction within the EMA between Title I and II funds, the Seattle EMA planning council acts as the planning body for both Titles I and II. This arrangement also benefits providers who need to fill out only one application for their funding and meet only one set of reporting requirements for both Titles I and II.

Another form of coordination in Seattle is the Case Management Residential Services Workgroup. This workgroup, which extends beyond the planning council and providers, advocacy representatives, Title IIIb and State representatives, meets monthly to try to resolve case management and other service related issues. The workgroup discusses new services, new procedures, and other issues relevant to direct service delivery or planning for service delivery. In addition, each month, some of the major service providers in the area give updates about their waiting lists and service issues needing resolution.

In 1992, when the Seattle area became eligible for Housing Opportunities for Persons With AIDS (HOPWA) funding, the HOPWA grantee developed a 5 year housing plan which takes into account both the Ryan White funded housing and the complementary HOPWA funds. Although the planning council does not perform the planning function for HOPWA, it must approve the HOPWA grantee's housing plan. Consequently, the HOPWA grantee and the EMA coordinate closely to fill in gaps in housing services.

Seattle's housing plan for people with HIV/AIDS provides a continuum of different types of housing clients need at different stages in their illness including: emergency housing, transitional housing, longer-term housing, assisted living, and skilled nursing/residential hospice housing. The housing plan also addresses an emerging issue in the Seattle area, housing for mentally ill and chemically addicted clients with HIV/AIDS.

Client-level coordination

In Seattle, there are two agencies funded for case management services. These providers are responsible for case managing most of the EMA's disabled AIDS clients. In Seattle, only disabled clients are eligible for Title I and II case management services. Some services for HIV/AIDS clients, like housing, are accessible only through a case manager. This limitation on clients permits case managers to maintain low caseloads and to serve only those clients with the most complex needs.

In spite of only two providers being funded for case management, other Ryan White providers employ case managers or other workers who function like case managers. These case managers are funded through other funding streams. For example, one primary care clinic funded by Title IIIb, hired a case manager to follow up on clients and coordinate with any other case managers for that client.

Despite a somewhat complex arrangement of case managers with vastly different duties, our respondents are not disturbed by the way case management works in Seattle. The caseloads in the Seattle EMA are still relatively small compared with some other cities, and case managers are comfortable having frequent contact with each other about common cases, problems and other case management related issues.

NEW ORLEANS, LOUISIANA

New Orleans EMA Background

Seven parishes (counties) comprise the New Orleans EMA - Orleans (which includes New Orleans,) Jefferson, St. Bernard, Plaquemines, St. Tammany, St. Charles, and St. John the Baptist.

The Office of Health Policy and AIDS Funding, in the Mayor's Division of Human Resources is the Title I grantee. In May 1994, the newly elected mayor moved this function from the Department of Health to the mayor's office in order to address the problems the EMA faces more quickly.

NEW ORLEANS EMA CHARACTERISTICS

- EMA population is 1.2 million
- Estimated HIV/AIDS population is 9,588. Of these:
  - 80% live in Orleans parish
  - 14% live in Jefferson Parish
- Non-hispanic whites make up 60% of the HIV/AIDS population; African-Americans are more than a third of the total, with Latinos and others less than 4% of the HIV/AIDS population
- 90% of the infected are men; more than 2/3 of these are gay or bi-sexual
- One in ten of the HIV/AIDS population are injection drug users

New Orleans is beset with many urban problems, all of which are compounded by widespread poverty. Over 30 percent of all those living in New Orleans live below the poverty level. In New Orleans, 46 percent of all children, and 55 percent of African-American children live in poverty. One in five senior citizens lives in poverty. New Orleans also faces widespread increases in sexually transmitted diseases. Louisiana has the highest gonorrhea rates in the nation; the chlamydia rate is 25 percent higher than the rest of the country, and their syphilis rate leads the nation. New Orleans' syphilis rate is the highest in the State. The lack of safe sexual practices evidenced by these figures suggests that AIDS will become even more widespread among New Orleans' young and poor.

The New Orleans EMA Planning Council

After a year or more of uncertainty, acrimony, considerable overlap of council membership, and duplicative administrative activities, the Title I and Title II planning councils merged in July 1994. The newly combined planning council administers Titles I and II. The single planning council intends to eliminate duplication and fragmentation and to perform coordinated strategic planning, needs assessment, funding prioritization and evaluations. In addition, Titles IIIb and IV play an active role in planning council deliberations and decisionmaking.

Services to Clients

In 1993, the New Orleans EMA received $3.2 million from Title I and $359,000 from Title II. To provide appropriate services to clients, the EMA uses the continuum of care defined by Louisiana with only minor revisions.[2] Primary medical care for hard to reach populations, case management, dental services, substance abuse treatment, emergency assistance, mental health, advocacy, drug reimbursement, housing related services, and buddy/companion services are the EMA's Title I priorities for 1994.

Primary Medical Care

Almost all primary medical care for low income HIV/AIDS clients is furnished at Medical Center of Louisiana at New Orleans (formerly Charity Hospital, and still commonly referred to by that name) and paid for by the State of Louisiana. Many of the other EMA service providers are located near Charity Hospital and the medical complex close by, or near the French Quarter where many of New Orleans' AIDS Service Organizations originated.

Community Services

Using Ryan White funds, three neighborhood-based, community health clinics are now providing services to HIV/AIDS clients. The new emphasis on primary care recognizes that locating services in other neighborhoods may serve to overcome either transportation difficulties in reaching established services and/or the stigma of dealing with providers perceived to be exclusively for gay, white, males. In addition, a city-funded program is providing case management services targeting African-Americans and Hispanics.

New Services

Among the other new services offered to clients since the EMA's inception include:

- case management and transportation services to geographically remote St. Tammany Parish, including delivery of food and medications to those too ill to travel;
- primary medical services to HIV/AIDS clients in St. Charles Parish;
- in concert with HOPWA, housing for families affected by HIV/AIDS;
- subcontracts to provide home health and other services in public housing developments and the surrounding neighborhoods; and,

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[2] *Louisiana defines five levels of care for HIV/AIDS patients beginning with prevention and early detection to ambulatory care for those in the advanced stages of AIDS.*

- neighborhood day care for HIV positive children and other affected family members.

Administrative-Level Coordination

The merging of the planning councils restores full Title II participation in providing the panoply of continuum of care services to clients. The planning council is now united in its goals and can devote their efforts to service delivery and coordinating services to clients.

Prior to New Orleans becoming an EMA in 1993, United Services for AIDS Foundation, the Title II Consortium for New Orleans, distributed monies to a range of providers involved in the continuum of care for HIV/AIDS clients. When New Orleans became an EMA, the former mayor asked the United Services for AIDS Foundation planning council to become the Title I planning council, but he later withdrew the request.

About that same time, the State of Louisiana considerably reduced the Title II funding in New Orleans. As a result, United Services for AIDS Foundation no longer funded social service activities in New Orleans and limited itself to legal advocacy and emergency assistance. Its role in the continuum of care was substantially diminished.

Title I assumed responsibility for services formerly paid by United Services for AIDS Foundation. Despite political events and a lessened Title II presence, the EMA delivered services to clients and made some new client services available.

Client-level Coordination

Currently, little client-level coordination takes place in New Orleans. No common case reporting or intake assessments are required by the EMA. Clients have multiple case managers, and there is no forum to bring case managers from different providers together to discuss cases, services available, or ways to overcome barriers to care. The State of Louisiana provides training, guidelines and licensing for case managers. But no EMA requirements for case managers presently exist. The EMA has consistently supported the State's case management requirements and will issue written guidelines this year consistent with those policies.

In the future, changes may mitigate the current lack of client-level coordination. The EMA is beginning to implement a uniform reporting system that will allow coordination on a client level between case managers and agencies.

New York EMA Background

The New York EMA includes New York City's five boroughs and the Tri-County Region north of the city, comprised of Westchester, Putnam and Rockland Counties. New York City has about 96 percent of the EMA's AIDS cases.

New York City faces myriad problems that compound the fight against HIV/AIDS. The city has large numbers of infected individuals who may be homeless, immigrants, tubercular, injection drug users, poor, mentally ill, non-English speaking, or prisoners.

To address the epidemic in the New York EMA, HRSA awarded over $100,000,000 in Ryan White funds for 1994. In addition, both New York City and New York State provide substantial funding for HIV/AIDS services.

The New York City Department of Health is the Ryan White Title I grantee. The Department of Health has intergovernmental agreements with the three suburban counties to administer Title I funds. They also contract with the Medical and Health Research Association of New York City, Inc (MHRA), a private, non-profit organization, to administer the Title I program in New York City, and with the Westchester County Department of Health to administer the Title I program in the Tri-county region.

Through New York's contract with MHRA, the EMA is able to bypass some of the bureaucratic obstacles in allocating grant funds quickly, and to avoid the

NEW YORK EMA CHARACTERISTICS

- EMA population is 8.5 million
- New York City has 56,581 cumulative AIDS cases, 17% of the national total
- The New York EMA has 26% of the cumulative AIDS cases reported for the nation's 34 EMAs
- There are 17,000 people living with AIDS in New York City
- Estimated New York City HIV/AIDS infection is 165,000; 1 person in 50 living in New York City is HIV-infected
- Between 30% and 40% of the city's 200,000 injection drug users are HIV-infected
- 52% of New York City's AIDS cases are associated with injection drug use; 43% with homosexual activity
- 18% of New York City's AIDS cases are females; 86% of these are either African-American or Latina
- AIDS is the third leading cause of death in New York City; in New York City, AIDS is the leading cause of death for those between the ages of 25 and 44
- One of four of the nation's pediatric AIDS cases is in New York City
- Nearly 11,000 New York City children have been orphaned by AIDS
- There are 7 Ryan White Title II consortia serving New York City
- The Tri-county area of the EMA has 11% of the State's population outside of New York City, but has 21% of the State's reported AIDS cases outside of New York City

pressures for downsizing that government agencies often face. Also, because MHRA awards the funds, the EMA avoids some of the conflict of interest issues raised in other communities. In other EMAs, planning councils are open to criticism when their memberships are comprised of service providers making direct funding decisions.

The New York EMA Planning Council

The New York EMA's 45 member planning council serves at the invitation of the Mayor, and is chaired by the Mayor's Coordinator of AIDS Policy. Members serve 2 year terms. All boroughs and counties are represented on the planning council. Representatives from Ryan White Titles II and III(b) also sit on the planning council.

At least 25 percent of the planning council are persons living with HIV/AIDS. In addition, the planning council established an advisory group of persons with HIV/AIDS to give advice to the planning council on issues before it. This 40 person group is composed of both council members and non-members.

Besides this advisory group, three committees and five work groups assist the planning council in its work. The committees are the executive committee, which serves as the planning council's steering committee, the nominations committee, and the planning and evaluation committee. The work groups deal with issues relating to health, substance abuse, mental health, housing, social services, and infrastructure, which includes activities not directly related to client services.

Services to Clients

New York State is unique in encouraging providers to treat HIV/AIDS patients by paying considerably higher Medicaid reimbursement for AIDS related services. The enhanced rates cover HIV/AIDS testing, primary care, chronic care, case management, long-term nursing home care, mental health services, home care and rehabilitation, and respite care. In addition, hospitals meeting certain criteria can become Designated AIDS Centers to receive the highest AIDS-related reimbursement rates in New York.

New York State's enhanced reimbursement program allows New York to recruit more providers of HIV/AIDS related services and overcome the difficulties faced by other States in attracting more providers to treat HIV/AIDS patients. Each of the EMAs counties contributes to the State's Medicaid fund which provides one-fourth of the funds available to the State for the enhanced provider payments.

In their 1994 Supplemental Grant Application, the New York EMA identified five areas for service initiatives. These priorities are in primary health care, substance abuse, mental health, housing and social services. In addition, the application identified a number of infrastructure development activities. These included personnel recruitment and retention in HIV/AIDS service agencies, support for mental health licensure, and establishing financial technical assistance to serve Title I contractors.

New Services

Despite the volume and complexity of New York's AIDS epidemic, the New York EMA has taken advantage of Ryan White in an effort to address many of the unique needs of New York City. The EMA has stitched Ryan White funding into the existing complex patchwork of AIDS service that dwarfs those in other cities. The New York EMA is involved in funding of more than 300 programs. Many of these programs are jointly funded with other Federal, State, and New York City programs.

Among new programs in the New York EMA made possible by Ryan White funds are:

- orphan support services for children of people who have died of, or are dying of AIDS;

- primary medical care and case management for those of Haitian descent who suffer from HIV/AIDS;

- the "Air Bridge" between Puerto Rico and New York City. This program coordinates medical services and case management for HIV/AIDS patients who travel to New York City primarily to receive medical treatment. Puerto Rico's Medicaid program has a limitation on spending and very limited funding for HIV/AIDS care and drug treatments.

Programs for Special Populations

Title I funds have allowed many programs treating special needs to be funded as well. As one city official described, Ryan White funds afforded the opportunity to develop programs targeting the many special needs of AIDS clients in New York that would have no other funding source. In particular, many community-based organizations treating injection drug users at varying stages of their recovery benefit greatly from Ryan White Title I monies.

New York City is in various stages of planning and implementing special programs to target populations with special needs. Many of these programs involve collaboration between various Ryan White Titles. These programs include:

- providing case management services and primary medical care to immigrants with HIV/AIDS;

- a housing program providing housing, directly observed therapy, and individual supportive services for hospital patients identified with both tuberculosis and HIV/AIDS;

- serving clients triply diagnosed with mental illness, chemical addiction, and HIV/AIDS;

- transitional residences providing temporary housing and comprehensive programs for homeless substance abusers with HIV/AIDS to help them make the transition from structured living situations to more independent living;

- providing recovery readiness to HIV/AIDS clients who do not see drug recovery as their first priority. These clients often have much more immediate health needs, or other priorities like food and shelter. Recovery readiness programs recognize this, meet some of the other basic client needs, and work on behavior change strategies and other intervention with clients;

- harm reduction programs targeting HIV/AIDS clients who are injection drug users who cannot or will not use conventional drug treatment. Community-based organizations are funded for outreach, education, counseling, and referral for other drug treatment and medical services;

- relapse prevention programs furnishing ongoing help to HIV positive clients who are former drug users. These programs can involve case management, outreach, support groups, recreational activities, and other means to keep clients involved in a consistent routine, and to keep contact with them so that they do not relapse into drug use.

Administrative Coordination

The vast array of programs available to HIV/AIDS clients, the sizable contributions of other funding agencies, and the types and scale of problems facing the New York EMA, makes their coordination with other agencies imperative. To this end, the New York EMA has direct and frequent interaction with New York City programs and also through its contractor, MHRA. The MHRA also contracts with New York City as the representative agency for its "Healthy Start/NYC" project, as well as other maternal and child health, infectious disease control service, research and demonstration projects.

Coordination and collaboration with Ryan White Title II occurs in several ways. The AIDS Institute in New York State's Department of Health is the Title II grantee and oversees the Title II consortia. Meetings between the managers of Title I and Title II-funded programs take place weekly at both the city and State levels. An AIDS Institute representative is a voting member of the planning council and also serves on the executive committee. Coordinators from many of the EMA's consortia are represented on the planning council's work groups.

The Title I and Title II grantees jointly sponsor several programs that provide services to uninsured and underinsured clients with HIV who are not yet eligible for Medicaid. These programs include:

- the AIDS Drug Assistance Program (ADAP), providing free drugs for the treatment of HIV and infections that may occur;
- ADAP Plus, providing free primary medical care at enrolled clinics, hospitals and drug treatment centers; and,
- the Home Care program delivering services to HIV clients in need of home care.

In addition to joint sponsorship of programs, Title I funds have also been awarded to the AIDS Institute to administer eight contracts for delivery of primary care in substance abuse treatment settings.

Titles I and II coordinate strategic planning of service delivery through their support of the Health Systems Agency of New York City (HSA). The HSA provides analyses to the EMA and State which facilitate their strategic planning for HIV-related services.

Client-level coordination

Despite New York's overwhelming numbers, mechanisms like the Title II AIDS networks contribute to New York's ability to administer some HIV/AIDS services on a scale similar to those in smaller cities. There are 7 AIDS networks, or Title II consortia, covering the different boroughs and many of their neighborhoods. The networks fill the role of organizing the smaller communities in a borough. Each network meets at least quarterly, and its committees often meet monthly.

Each network is required to have a case management committee which allows providers and case managers to discuss new services, service needs, and other case management issues. This also allows case managers to network with each other, and to facilitate coordination between case managers who share clients.

Kansas City EMA Background

The Kansas City EMA is comprised of Jackson County, which includes the city of Kansas City, Missouri, and Clay, Platte, Cass, Clinton, Lafayette Counties in Missouri, and the Kansas counties of Johnson, Wyandotte, Miami and Leavenworth.

Kansas City became eligible for Title I funding as an EMA in 1993. The Kansas City Health Department is the Title I grantee and also dispenses HOPWA funds. The Kansas City Health Department also serves as the lead agency for Missouri Title II.

A case management contract with the State of Kansas formalizes EMA participation by the four Kansas counties.

The EMA includes urban, suburban and rural communities, and they vary markedly. For example, the median household income for Wyandotte County is $23,780, barely half that of adjacent Johnson County at $42,741. Five of the eleven EMA counties have at least 10 percent of households below the poverty level. Very few, about ten percent, of the Missouri persons with HIV/AIDS have private insurance. More than 46 percent have no insurance, while the balance are Medicaid eligible.

KANSAS CITY EMA CHARACTERISTICS

- EMA population is 1.6 million
- Estimated HIV/AIDS infection is 8,400
- Most live in the Kansas City metropolitan area
- 72% of the infected population is white, 22% is African-American, 3% is Hispanic, and the remainder is Native American, Asian American or no data is available on heritage
- Gay/bi-sexual males make up 69% of the HIV/AIDS population
- 6% are intravenous drug users, with another 8% are combining male to male sexual activity with injecting drug usage
- Heterosexual transmission represents 4% of the HIV/AIDS cases
- Women make up 7% of the EMA's infected population and face the highest risk of infection through heterosexual transmission

The changing nature of the HIV/AIDS pandemic is reflected in the growing number of African-Americans being infected with HIV. African-Americans are 18 percent of the population in the EMA, but are more than a third of those with HIV. In addition, African-American women are 29 percent of the EMA's female population, but are 56 percent of the HIV positive women in the EMA.

The Kansas City EMA Planning Council

The steering committee for the Missouri Title II Ryan White Care Consortium, is also the Title I planning council. The planning council is comprised of 20 voting members, 9 of whom are persons with HIV/AIDS. Planning council by-laws require all planning council decisions be taken to the full Consortium for consensus. Only if consensus cannot be reached from the full Consortium, and after consideration at two Consortium meetings, a steering committee vote will be taken to resolve the issue. This has occurred only one time.

The full Consortium has over 80 members including persons with HIV/AIDS, providers, Title IIIb and both State agencies. Besides its Ryan White responsibilities, the Consortium also sets priorities for HOPWA spending.

Sub-committees have a significant role in the EMA's activities. Sixteen sub-committees have been formed to identify barriers to service, review utilization of existing services, and to recommend changes to the steering committee.[3] Membership on the sub-committees is open to all.

Services to Clients

In 1993, the Kansas City EMA received $2.6 million from Title I, and $330,000 from HOPWA. Primary care, case management, and medications are the EMA's Title I priorities for 1994. The priorities are determined by the annual needs assessment. The needs assessment priority setting is based on a 60/40 split between the consortium/steering committee and full Consortium recommendations. Sixty percent of the priorities are decided by the consortium/steering committee, and the balance by the full Consortium. Based on the needs assessment, Title I subcontractors provide home health services, emergency assistance, food, transportation, mental health, substance abuse counseling, advocacy, early intervention pre-case referrals, information and referrals, buddy/companion/child care/adoption/foster care, and hearing impaired services.

<u>New Services</u>

New services funded by the EMA include case managers in Kansas, the addition of rural primary care sites, dental services, and respite summer camps for children of HIV/AIDS affected parents.

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[3] *The sub-committees are: (1) primary medical care, (2) case management, (3) housing, (4) transportation, food, and emergency assistance, (5) substance abuse/mental health, (6) barriers to care/criminal justice system, (7) minority issues, (8) hospice, (9) foster care/adoption, (10) buddy system, (11) advocacy (12) information and referral, (13) dental care, (14) early intervention/pre case referral, (15) home health, and (16) volunteer.*

States' Contributions

The States of Missouri and Kansas allocate Title II funds for services to clients in the Kansas City EMA. Missouri provided $210,000 in client services in the EMA for fiscal year 1993. These funds were primarily used for case management and home health services. In addition, Missouri also paid $480,000 Statewide for medications for HIV/AIDS affected patients.

The Kansas state-wide consortium uses its funds for medications, home health services and insurance continuation. Cooperation between the States has allowed Kansas clients in the EMA to be case managed and tracked by the same system used by Missouri clients.

Administrative-Level Coordination

Coordination between the Ryan White Titles and providers is intrinsic to the administration of the program. Kansas City had several advantages in becoming an EMA. Preceding the EMA were the State general fund dollars, their Title II experience, and widespread community acceptance. Several ASOs had arisen to fill service voids - a volunteer program, food bank and the free health clinic to serve as an anonymous testing site. With Title I imminent, grass-roots community organizations made a concerted effort to identify the numbers of clients required for funding. The EMA made the level of coordination attained in reaching Title I status an integral part of the way they operate. Since the planning council must reach decisions by consensus, cooperation and coordination are important to fund activities or determine priorities.

The Role of Case Management

In addition, the case management process mandates cooperation between all agencies involved. Consequently, contact is frequent between the case managers, service providers, the grantee, and the State. Coordination with the State of Missouri is facilitated by the case management computer system. Titles II and IIIb case managers also use the same case management system as Title I providers.

The Role of Persons with HIV/AIDS

The persons with HIV/AIDS are vital to the EMA's decisionmaking process. As one person with HIV/AIDS said, "they (the EMA) use us to make policy, ... (we are) not mere window dressing." One immediate result of including persons with HIV/AIDS in the sub-committee process was the EMA's funding of dental services. Prior to this input, the consortium/steering committee process had not considered dental services to be a priority. By relying on persons with HIV/AIDS for substantial input and activity in the administrative process, the HIV/AIDS community has a reason to buy into the program. As a result, some potential turf issues are defused.

The EMA also recognized the need for and developed a mentor program for persons with HIV/AIDS. Cross-educating across the program, developing a base line of knowledge, and breaking down barriers are goals of this activity. In the future, this program will develop surveys, hold focus groups, and participate in quality assurance procedures.

Client-level Coordination

Case management is integral to ensuring a continuum of care and delivering services to clients in Kansas City. A client has just one case manager, and is free to change case managers at any time. Service decisions are made based on both the client's economic needs and their HIV status. Case managers use an acuity scale to determine the appropriate extent and type of intervention needed. No services are provided unless they are in line with the client's needs assessment.

The EMA considers case managers to be the gatekeepers to all Ryan White and HOPWA services in the EMA. The case managers, who are located at primary care sites, are responsible for verifying HIV status, determining income eligibility, and authorizing services. Regardless of provider, case managers use identical intake, assessment, and service authorization forms. Data from the forms is then entered into the Missouri Department of Health case management computer system. The system also includes EMA clients residing in Kansas. The system helps prevent duplicating counts of clients or duplicate services, and allows for oversight of case manager activities.

All case managers attend meetings every Thursday, so all Ryan White case managers are present at the same time. Case managers are encouraged to develop informal networks to discuss cases, treatment plans, and alternatives to high cost services. Case managers also can work with the State AIDS representative to get Title II homemaker and home health services for clients. These sessions train case managers so they can authorize primary care, counseling, and other services. The weekly meetings are also used to instruct case managers on the State forms and procedures.

Los Angeles EMA Background

Los Angeles County is one of the largest and most racially, ethnically and culturally diverse local jurisdictions in the United States. The 1990 census data shows 41 percent Caucasian, 37 percent Latino, 11 percent African-American, 11 percent Asian/Pacific Islander, 1 percent American and Alaskan Native. One of six people in the EMA lives below the Federal poverty level. One of seven receives some form of public assistance; 1 of 6 is entitled to Medicaid; 1 of 3 under the age of 65 has no health insurance.

In FY 1993, Los Angeles received over $19 million in Title I funds, and $1.375 million in Title II monies. There are also five grantees in Los Angeles county who receive $1.5 million in Title III-B funds. Aside from Ryan White money, Los Angeles received over $80 million in other Federal funds, the majority of which came from AIDS research grants. In addition, Los Angeles received more than $26 million from the State and over $52 million from local funds.

Los Angeles County is governed by a five-member Board of Supervisors. The Board designated the Los Angeles County Department of Health Services as the entity responsible for administering Ryan White Title I Formula and Supplemental Grants.

LOS ANGELES EMA CHARACTERISTICS

- EMA population is 9 million
- EMA is over 4,000 square miles, and includes 88 cities
- There are over 27,000 confirmed AIDS cases in Los Angeles County, the 2nd largest local caseload in the United States
- Estimated HIV/AIDS infection is 40,000 to 51,000
- 49% of the infected population is white, 28% Latino, 20% African-American, 2% Asian/Pacific-Islander, and 1% American and Alaskan Native. In 1986, the rates were 70% white, 15% Latino, 14% African-American, 1% Asian/Pacific-Islander, and an unknown number of American and Alaskan native
- Gay/bi-sexual males comprise 72% of the HIV/AIDS population
- 8% are injection drug users, with another 6% combining male to male sexual activity with injecting drug usage
- Heterosexual transmission represents 3% of the HIV/AIDS cases
- Method of transmission is unknown for 8% of the HIV/AIDS population
- As of November, 1994, there are 9,433 living reported adult/adolescent AIDS cases and 373 living reported pediatric AIDS cases

The AIDS Program Office in the Department of Health Services provides staff support to the Los Angeles County HIV Health Services Planning Council. The AIDS Program Office also serves as the applicant and grant recipient for Title I funds and most other governmental, non-research HIV/AIDS funding.

The Los Angeles EMA Planning Council

The Los Angeles County HIV Health Services Planning Council is a 42 member body established by ordinance of the Board of Supervisors. This ordinance grants the planning council the authority to review all HIV/AIDS programs operated by the County and to make recommendations to the Board regarding the distribution of funds and unmet HIV/AIDS community needs.

Services to Clients

Ryan White program funds have greatly enhanced the variety, quantity, and accessibility of services to HIV/AIDS clients. New services provided by Ryan White funding include:

- Additional community-based outpatient sites are providing services to clients.
- Transportation for Ryan White clients is one of the most important new services provided, given the geographic spread of Los Angeles County and the lack of a public transportation network.
- Translators assist a variety of monolingual clients with providers. These translators travel to program sites as needed to assist non-English speaking clients.
- Vision rehabilitation is now provided to the partially sighted.
- Self-help programs have been instituted using HIV-infected persons to provide peer support.
- Family support programs allow families with one or more HIV parent to remain intact, or promote reunification of the families.
- Household support services are available for clients.

Administrative-level Coordination

The sheer size of Los Angeles County presents issues about the coordination of services between agencies. The Los Angeles County Department of Health Services identifies six distinct regions, each differing in needs, service availability, and demographics. The lack of public transportation also is a constant factor to be considered in attempting to coordinate agencies or services to clients.

Despite these drawbacks, Los Angeles EMA grantees and providers frequently come together formally and informally to resolve common problems. Coordination between the Ryan White Titles I and II is simplified since the planning council serves as the Title II consortium for Los Angeles County. The Title II staff person attends all

council meetings as an advisor and reports on any new developments. His office is located at the Title I coordination site. In addition, with only one exception, the organizations receiving Title II funds also receive Title I funds. Titles I and II have recently developed common data elements for reporting purposes.

Agency members know what services are available from other providers and often do cooperate in joint endeavors. One such endeavor is the case management computer system that is on-line at 10 of the largest agencies in the County. Other examples of administrative coordination include negotiating agreements with local Social Security offices, area food pantries working cooperatively with other providers, health facilities being willing to work with bilingual translators, and case managers from different agencies convening monthly.

There are a variety of task forces operating in the HIV/AIDS community. In addition to planning council task forces, individual agencies have task forces as does the AIDS Regional Board. The networking that results from these task forces has beneficial aspects. For example, people not on the planning council who had been involved in task forces contribute to the work of the planning council. Also, the case management task force is seen as a benefit by several of the case managers with whom we spoke.

While coordination between Titles I and II is stressed, there is not the same priority to coordinate Titles IIIb and IV. Title IIIb is funded directly by HRSA to local organizations and is not discussed at the planning council, although IIIb agencies are represented on the planning council. One of the planning council co-chairs is the director of the network of agencies serving the HIV-infected pediatric population and their families. Most respondents see Title IV as a separate service delivery system and consequently, there is not as much coordination with the pediatric population.

Client-level Coordination

There are many examples of client level coordination taking place in Los Angeles. Most of these seemed to be initiated either by an individual agency or by one of the task forces that operate on different levels in the County. The various task forces that are ongoing on different topics provide a ready network for communicating on any recent developments.

One example is the work initiated by the case management task force. In order to eliminate the duplication of case managers for clients and the potential for duplication of efforts, a computer system was created to insure that only one case manager is working with a client. The task force has defined case management as "joining with the client to access services." The task force meets monthly to talk about better ways to serve their clients through referrals to other agencies or just to learn about different ways they can be of more help. The task force is also working to establish standards for case managers. Titles I and II have recently developed common data elements for reporting purposes.

Broward County EMA Background

Ryan White Title I funds provide over $6,800,000 to the Broward County, Florida EMA. The Office of HIV/AIDS Support Services in Broward County's Human Services Department administers Ryan White Title I as well as (HOPWA) grants from the Department of Housing and Urban Development.

Broward County provides all the health and social service programs for Ryan White clients except those funded by the State. Consequently, no intergovernmental agreements between the EMA and the municipalities are required.

There are 29 municipalities in the Broward County EMA, the largest being the city of Fort Lauderdale. Over 10 percent of Broward County's population falls under the Federal poverty level. There are several large concentrations of Haitian-Americans in Broward County.

BROWARD COUNTY EMA CHARACTERISTICS

- EMA population is 1.3 million
- Estimated HIV/AIDS infection is 17,226
- 44% are between the ages of 30-39, 23% are age 40-49, and 12% are older than 49
- African-Americans now make up 37% of the HIV/AIDS population, compared to 30% in 1990, but comprise only 15% of Broward County's population. White Anglos represent 57% of the HIV/AIDS population, and Hispanics 6%
- Women comprise 17% of the HIV/AIDS population. Nearly 3/4 are African-American
- Gay or bi-sexual males are more than half the HIV/AIDS population
- 18% of the HIV/AIDS population are injection drug users, with another 6% combining male to male sexual activity with injecting drug usage
- Heterosexual transmission represents 6% of the HIV/AIDS cases
- Method of transmission is unknown for 2% of the HIV/AIDS population
- There are 5,107 living reported adult/adolescent AIDS cases and 107 living reported pediatric AIDS cases

The Broward County EMA Planning Council

Broward County's Board of County Commissioners appoints the 30 member Broward County HIV Health Services Planning Council to serve indefinite terms. Although only these members vote on planning council issues, numerous community representatives attend planning council meetings and participate fully in sub-committee decisions. The planning council also solicits community participation through efforts like conducting focus groups on specific HIV/AIDS issues, and sponsoring an Ecumenical Conference on HIV/AIDS aimed at bringing African-American religious leaders and clergy into the planning process.

Five sub-committees assist the planning council. A priorities sub-committee works on the community needs assessment and recommends funding priorities and allocations to the planning council. A nomination sub-committee finds and recommends new planning council members to the county commissioners when replacements are needed. A multi-cultural sub-committee develops strategies and implements ways to increase minority participation in Ryan White activities. A case management study committee developed an improved system that will provide a centralized case management agency for all Ryan White funded case managers. A by-laws sub-committee ensures that planning council procedures are adhered to in making decisions.

Services to Clients

In their 1994 application for supplemental Ryan White funds, Broward County identified 12 priority services for their community. In order of intended outlays, their priorities are: medical/dental treatment and diagnosis, pharmaceuticals, case management, housing, respite child care, home health care, transportation, nutritionist services, mental health therapy/counseling, health insurance continuation, food bank, and holistic therapies.

New Services

Ryan White funds have allowed the EMA to fund medical professionals at several sites and also to provide many new services to clients. These new services include:

- an urgent care outpatient clinic, currently providing primary medical care to approximately 360 patients monthly, and diverting 20 to 30 patients monthly from using costly emergency room services;
- a children's day care center;
- homemaker/companion services; and,
- van transportation services to 250 unduplicated clients, and bus passes to 30 clients.

Administrative Coordination

Considerable coordination occurs between Titles I and II. There is some overlap in Title I planning council membership and in the Title II consortium, the South Florida AIDS Network of Broward County, which is made up of 88 member agencies. The local State director and the EMA's grant administrator meet periodically to share program planning information. The titles share data from needs assessment studies, provider and consumer surveys, focus group meetings and other program data. Where both titles fund the same service, like transportation, they collaborate on standardizing program and data reporting requirements. As a result, providers applying for funding are not faced with different criteria for each Ryan White title.

Coordination with other Ryan White titles also takes place in Broward County. Title I funds have been used to supplement the Title III(b) and Title IV providers in Broward County, helping to ensure a continuum of care for clients served at those sites. In addition, the Title IV director is a planning council member, active on two sub-committees.

Another form of administrative coordination between titles takes place at a statewide level through Florida's annual inter-title meetings. The first inter-title meeting was held in 1993 and included representatives from every Florida Title I EMA grantee and the Title II representatives from those EMAs. The 1994 meeting included representatives from all four Ryan White titles.

Client-level coordination

Client-level coordination has been a major EMA concern. A major barrier to this coordination occurs when clients have multiple case managers. No exchange of client information takes place between agencies, making coordination of services difficult and inefficient.

The planning council convened a special Case Management System Study Sub-committee who studied the issue for 7 months. The sub-committee recommended that a centralized case management agency with a case management client database be established. Broward County EMA is in the process of choosing an agency to administer a centralized case management services program.

This new case management agency will employ all the Ryan White Title I and HOPWA funded case managers and implement and maintain a centralized client data base system. The case management system will work in the following way:

An existing Broward County agency will employ and train all case managers who are funded by Ryan White Title I and HOPWA grants. Although employed and trained by the centralized case management agency, case managers may be physically located outside that site. Each client will do an intake interview with a case manager only once. The case manager will enter all intake information onto a centralized case management database that will be accessible to agencies in the area. For example, if a client enters the system at a community-based medical provider, a case manager will collect intake information and enter that information onto the client database. If that client later goes to a food bank, the client can show the food bank proof of his or her HIV status and the food bank can enter the client's name into the computer and get information. The food bank would have access only to the relevant part of that client's file, not all medical information. The centralized case management database will allow a case manager to see where the client has been and prevent duplication of services.

Detroit EMA Background

The Detroit EMA is comprised of Wayne County, which includes the city of Detroit, and Oakland, Macomb, Lapeer, Monroe, and St. Clair Counties.

The City of Detroit Health Department (DHD) is the Title I grantee and is also the HOPWA grantee. The DHD has provided primary medical care services to a largely indigent population for more than 50 years. Their client population is 90 percent minority. Over half of these have no health insurance; about 40 percent are Medicaid eligible.

Widespread poverty and chronic unemployment in the Detroit area compound the EMA's responsibilities of providing primary medical care and psychosocial services to meet the needs of clients living with HIV/AIDS. In March of 1993, Detroit's unemployment was 12.6 percent, nearly double the State jobless rate.

Henry Ford Hospital and the Detroit Medical Center provide primary medical care to about 30 percent of the persons with HIV/AIDS. Community providers, private physicians and the Veterans Administration Hospitals treat another 15 percent. An estimated 6,000 people, 55 percent, do not receive any HIV primary care.

DETROIT EMA CHARACTERISTICS

- EMA population is 4.4 million
- Estimated HIV/AIDS population is 10,600. Of these:
  - 63% live in Detroit
  - 15% live in Oakland County
  - 14% live in Wayne County, outside of Detroit
  - 6% live in Macomb County
  - 2% live in Lapeer, Monroe or St. Clair Counties
- About 2/3 of HIV/AIDS population is African-American, about 1/3 white, about 3% are of Latino, Arab-Caldean, Native American or Asian heritage
- Gay, bi-sexual males are almost half the HIV/AIDS population
- A third or more of the HIV/AIDS population are drug users
- Women comprise more than a fifth of the HIV/AIDS population; the majority are African-American

The Detroit EMA Planning Council

The Southeastern Michigan HIV/AIDS Council (SEMHAC) is the Ryan White planning council for both Titles I and II, as well as HOPWA. The SEMHAC has been the Title II planning council since 1989. In 1992, when Detroit became eligible for Title I funding, SEMHAC accepted that same responsibility for Title I. The planning council has 45 members representing the persons with HIV/AIDS, the EMA

counties, and 26 agencies. Titles IIIb and IV are also represented on the planning council.

The planning council has undergone a metamorphosis. The new mayor in Detroit brings a change of focus to the planning council. This new administration is conducive to coordinating with the State, counties and other entities. As a result, the planning council is looking ahead at proposals for advocacy, mental health, primary care and emergency assistance. The planning council is also trying to solicit more input from the people with HIV/AIDS in the community.

Services to Clients

In 1993, the Detroit EMA received $2.8 million from Title I, $1.5 million in Title II funds, $700,000 from HOPWA, and supplemental monies from Michigan Health Initiative funds. Case management[4], primary care/complementary therapies, substance abuse treatment, emergency assistance, mental health, advocacy, drug reimbursement, housing related services, and buddy/companion services are the EMA's Title I priorities for 1994. The priorities are determined by the annual needs assessment, an important component in the continuum of care.

New Services

The Title I and HOPWA subcontractors offer a diversity of services. The planning council opted to reach out to the community providers to make sure ethnic, geographic and service needs were met. New services include housing to women with children, addressing a need identified as a priority by Title II, and advocacy services, responding to needs expressed by persons with HIV/AIDS. Other new programs funded by Title I include an approach that focuses on African-American persons who are gay and HIV positive, and another where both persons with HIV/AIDS and caregivers participate in support groups together.

New Primary Care Network

Two respondents cited the formation of a primary care network by three hospitals to apply jointly for funding as a major contribution to providing medical care to clients. This coalition should mitigate the competition between these providers, result in more coordination between the hospitals, and improve clients' accessibility to services.

[4] *The EMA defines case management as: "Client-centered service that links clients with health care and psychosocial services to insure timely, coordinated access to medically appropriate levels of health care and support services and continuity of care. Key activities include: 1) assessment of the client's needs and personal support systems; 2) development of a comprehensive, individualized service plan; 3) coordination of services required to implement the plan; client monitoring to assess the efficacy of the plan; and 4) periodic re-evaluation and adaptation of the plan as necessary."*

Case Management

The State of Michigan sees case management as the key that ensures that a comprehensive continuum of care is available to persons with HIV/AIDS. The Detroit EMA committed $1 million in Title II funds for case management. (The other $150,000 in Title II funds went for home and community services.) Since 1989, about 5,000 persons in the Detroit EMA have received case management services.

The two major case management agencies in Detroit receive Titles I and II funding for case management. These agencies recently began subcontracting some case management activities to several other providers. All case managers are required to coordinate all Ryan White services delivered and to record all services clients receive on the Uniform Reporting System (URS). All subcontractors must report continuity of care services via the URS.

Administrative-Level Coordination

Coordination among Ryan White grantees and providers occurs in several ways. First, the planning council maintains several standing committees. Each committee is responsible in some way with the coordination necessary to ensure that the continuum of care is delivered. Also, coordination is also facilitated by the subcontractors required quarterly reporting and their mandated use of the URS. The planning council can evaluate the extent of client level and administrative coordination by reviewing these submissions. In addition, the planning council is awaiting the results of a 240 client survey utilized by 15 persons with HIV/AIDS as interviewers. Final results will be available in May 1995 and should provide insight into whether coordination needs to be enhanced.

Provider Coordination

Beginning in 1994, the grantee advised providers applying for Title I funding that coordination was a very important responsibility for Ryan White provider. Applicants were told to describe how they would coordinate, and that coordination now would account for one-fourth of the scoring of their application. Providers are required to demonstrate this in part, by securing signed agreements of coordination with other service providers. These agreements can lead to a referral network between providers and their staffs.

In addition to this formal coordination, providers interact informally as well. Providers call each other frequently or meet monthly through a community network committee made up of 60 providers.

State Coordination Efforts

The State of Michigan also coordinates Ryan White activities in several ways. They interact with the planning council on many activities. They fund case management, participate in the needs assessment, and are active in resource development. The State requires quarterly reporting from their subcontractors - the Detroit case management agencies, and performs site visits, in part to ensure that appropriate coordination is taking place. In May 1994, Michigan hosted their first Statewide continuum of care conference, attended by the spectrum of Ryan White providers and administrators. In October 1994, Michigan held a 2 day consortia training, attended by all consortia regions.

Client-level Coordination

In the Detroit EMA, coordination begins with case management. Every 2 weeks, case managers meet to discuss cases, exchange information on providers and services offered, and ensure that services are being coordinated. This network increases resources and access for clients. At the same time it lessens opportunities for clients to abuse the system.

Both of the large case management agencies, AIDS Care Connection and AIDS Consortium of Southeast Michigan (ACSEM), hold weekly in-house case conferences. At these sessions, questions are answered and expertise is shared among staff. At least monthly, ACSEM includes a service provider participate in their meetings.