



Data
Decisions
Delivery

Directing Comprehensive TA:
From Systems to Sustainability

ADVANCING HIV PREVENTION THROUGH
HEALTH DEPARTMENTS AND CBOs

**DATA, DELIVERY, AND
DECISIONS AS LEVERS FOR
ENHANCING WHOLE-PERSON
CARE FOR PEOPLE
LIVING WITH HIV**

HIV PREVENTION EDUCATIONAL SERIES



A Case Study of the Ruth M. Rothstein CORE Center

As states continue to focus on integrated care and delivery system reform, meaningful opportunities exist to improve care for people living with HIV (PLWH). In particular, states can use existing centers of care to promote “one-stop shopping” utilization of multi-disciplinary services for PLWH and linkages to Ryan White and Medicaid. Since a large portion of PLWH also qualify for Medicaid coverage, leveraging existing Ryan White-funded delivery systems with providers who have experience with Medicaid can facilitate PLWH access to whole-person care. Additionally, numerous studies have supported that integrated HIV screening and treatment initiatives produce significant returns on investment^{1,2}, both for health system cost savings and for socioeconomic and health benefits among affected individuals.

The Ruth M. Rothstein CORE Center (CORE Center)

has been serving the Greater Chicago and Cook County area since 1998 and utilizes a co-located, “one-stop-shopping” model to deliver primary care, specialty care, and social services to its clients³. The CORE Center operates as a partnership between the Cook County Health and Hospitals System (CCHHS) and the Rush University Medical Center. The CORE Center predominantly serves PLWH and their families, and also focuses its efforts on reaching clients with other sexually transmitted infections (STIs) and communicable conditions, such as tuberculosis. As a safety-net clinic serving a largely low-income population, the CORE Center provides services regardless of an individual’s ability to pay. The CORE Center receives funding support from a mix of sources: the Cook County Health & Hospitals System, with healthcare funding from the county budget appropriations⁴; federal funds such as Ryan White Parts A, B, C, and D⁵; and donations⁶. In addition, healthcare foundations and other entities, including the Chicago Department of Public Health, fund some specific programs and pilot projects at the CORE Center.⁷

In its unique design as a “one-stop shop” for its clients, the CORE Center operates in a structure similar to that of a traditional medical home. Approximately 60 percent of PLWH served by the CORE Center use Medicaid as their primary form of coverage. To this end—since Medicaid is the dominant payer of behavioral health services⁸—having both primary and behavioral health care centered in the same facility (along with social services) allows the CORE Center to develop a comprehensive treatment plan for its clients. Approximately 30-40 percent of the CORE Center’s clients have a behavioral health diagnosis, so the immediate availability of specialized services for this subpopulation is critical.



1. Thirumurthy, et al. “HIV Treatment Produces Economic Returns Through Increased Work And Education, And Warrants Continued US Support”, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3728427/>
2. Hutchinson, et al. “Return on Public Health Investment: CDC’s Expanded HIV Testing Initiative”, [http://www.hivdent.org/_cdc_/2011/Return_on_Public_Health_Investment__CDC_s\(1\).98639.pdf](http://www.hivdent.org/_cdc_/2011/Return_on_Public_Health_Investment__CDC_s(1).98639.pdf)
3. “About Us”, Cook County Health & Hospitals Systems, <http://www.cookcountyhhs.org/locations/ruth-m-rothstein-core-center/about-us/>
4. “Cook County Executive Budget Recommendation”, Cook County Government, <https://www.cookcountyil.gov/Budget>
5. Interview with Rebecca Goldberg and Carmen Sanchez, Ruth M. Rothstein CORE Center. December 5, 2016.



Delivery System

The **CORE Center** emphasizes its focus on simplifying access to multi-specialty care, which encompasses a wide range of disciplines. Three of the most utilized services at the CORE Center include: 1) primary care; 2) behavioral health care; and, 3) dental care.

The CORE Center is committed to providing patient-centered care to all individuals who utilize its services. To develop a patient-care plan, all clients receive a comprehensive initial screening by CORE Center providers upon referral (or self-referral, as a walk-in appointment) to primary care at the CORE Center. The purpose of this screening is two-fold. First, it allows the clinicians to accurately diagnose all health conditions a client may have, whether inclusive of or limited to an HIV diagnosis. Second, this screening allows the client to experience the way that clinicians practice at the CORE Center and allows providers an opportunity to demonstrate engagement of the CORE Center's in-house specialty services. Upon completion of the screening process, clinician and client develop a care plan prioritizing client needs, which typically includes the goal of viral load suppression—currently 88 percent of CORE Center's patient population living with HIV are virally suppressed⁹. Primary care providers use the plan to guide the client's interaction with the CORE Center's co-located services, including dental, behavioral health, the onsite pharmacy, specialty medical clinics, social and support services, and clinics serving particular demographics (i.e. the adolescent care clinic). As frequently as possible, providers facilitate direct or "warm hand-offs" to other clinicians and service providers or assist with setting up a future appointment for the individual.

Specialty care is widely administered and embraced at the CORE Center throughout all of its clinics. Behavioral health services are available at the CORE Center for all clients and include mental health services, broad substance use disorder services, and a psychiatric and chemical dependency clinic. In particular, SAMSHA has provided the CORE Center with funding for services targeted towards those who are dually-diagnosed with HIV and substance use disorders. The dental clinic is available to all clients who have an HIV diagnosis and provides a full array of dental services. Approximately one-third of the dental clinic is funded through Parts A and C of the Ryan White HIV Program, with the remainder funded by Cook County.¹⁰

In addition to providing dental services and integrated primary and behavioral health care, the CORE Center also offers access to clinics that are specialized to address comorbid conditions. For example, the facility has seen an increasing population of clients experiencing illnesses related to aging (independent of their HIV diagnosis). As such, many clients require services from the oncology clinic¹¹. The CORE Center also operates a neurology clinic, which addresses neurological conditions such as dementia and memory loss – conditions that prominently appear in older PLWH and that require the attention of specialists¹². The CORE Center's nephrology clinic also plays an important role in delivering care for individuals experiencing issues related to kidney function, which predominantly affect Black and African-American individuals (up to four times more than White individuals¹³). Approximately 70 percent of CORE Center visitors are African-American, and the CORE Center reports that the nephrology clinic is critical to their delivery of patient-centered care that specifically supports their client population.¹⁴

6. "Donations", Cook County Health & Hospitals Systems, <http://www.cookcountyhhs.org/locations/ruth-m-rothstein-core-center/donations/>

7. "Funded Projects & Research", Cook County Health & Hospitals Systems, <http://www.cookcountyhhs.org/locations/ruth-m-rothstein-core-center/funded-projects/>

8. MACPAC, Behavioral Health in the Medicaid Program –People, Use, and Expenditures. June 2015. <https://www.macpac.gov/wp-content/uploads/2015/06/Behavioral-Health-in-the-Medicaid-Program%E2%80%94People-Use-and-Expenditures.pdf>

9. "FY 2017 Executive Budget Recommendation – Healthcare", Cook County Government, https://www.cookcountyil.gov/sites/default/files/healthcare_presrec_update.pdf

10. Interview with Rebecca Goldberg and Carmen Sanchez, Ruth M. Rothstein CORE Center. December 5, 2016.

11. Interview with Rebecca Goldberg and Carmen Sanchez, Ruth M. Rothstein CORE Center. December 5, 2016.



Delivery System

In addition to services that attend to the medical needs of PWLH, the CORE Center provides an array of preventative services aimed at those who are high-risk for contracting HIV. For example, the CORE Center directly serves high-risk individuals through the “Helping Eliminate AIDS through Teamwork with PrEP Clinic” (*HEAT with PrEP Clinic*).¹⁵ PrEP (Pre-Exposure Prophylaxis) is a highly effective preventative treatment for those with high risk factors for contracting HIV. The HEAT with PrEP Clinic provides comprehensive PrEP appointments where other health services are offered. During an appointment, the CORE Center conducts a comprehensive STI test and screens clients for meningitis and viral hepatitis, as these are common comorbid conditions for people living with, and at risk of, HIV infection.¹⁶

Individuals with hepatitis, and particularly those with hepatitis and HIV co-infection, present specific challenges for the CORE Center, which works to offer truly holistic treatment. Approximately 30 percent of CORE Center clients are coinfected with hepatitis and HIV.¹⁷ For many of these individuals, their HIV is managed and treated as a chronic illness, whereas hepatitis is more symptomatic and may present urgent or acute issues. As many forms of insurance do not adequately cover treatment services for individuals with mild liver disease (at fibrosis Stage 1 and 2), the CORE Center is not always able to provide treatment to those who are co-infected until their liver disease progresses to Stage 3.¹⁸ In order to address this barrier to life-saving treatment, the CORE Center successfully negotiated with the Illinois Public Health Department to use its AIDS Drug Assistance Program (ADAP) funding to care for 100 individuals who are co-infected with HIV, have Stage 1 or 2 liver disease, and are motivated to begin treatment. This allowance does not completely meet the full demand that presents itself at the clinic, and the CORE Center continues to explore other solutions to treat all co-infected clients, regardless of their stage of liver disease.

Continuity of Care Program

The Continuity of Care Program provides transitions from the Cook County Jail System and the Illinois Department of Corrections to the CORE Center. Medical providers from the jail system are able to provide services for the recently released individual at the CORE Center.

The objectives of the program are twofold:

- allow for an individual to continue to visit their trusted provider through a difficult period; and, promote continuous treatment and
- immediate linkage to care while an individual transitions to community life.

Two challenges to the Continuity of Care Program are:

- the high rate of recidivism within the Cook County jail system, and
- the number of recently released participants lacking stable housing and resources, which can hamper their ability to meet the demands of required post-release programs (i.e. anger management training or counseling to address intimate partner violence).

Through the provision of behavioral health and financial assistance services alongside care services, the CORE Center can address many of these challenges and has seen a large number of clients complete the program and return to the community.¹





Delivery System

The CORE Center also operates clinics that address the needs of families comprised of PLWH and people who are HIV-negative. One such clinic is focused specifically on women and children. The CORE Center reports having reached a rate of zero instances of mother-to-child transmission of HIV at birth.²⁰ This clinic serves families by providing pediatric care to HIV-negative children in the same space that parents living with HIV access their care, thereby enhancing access to services for the entire family.

One of the largest and more challenging clinics is the CORE Center's adolescent clinic. In addition to serving adolescents who were infected with HIV at birth, roughly half of all new clients to the center are young men who have sex with men (MSM).²¹ This is a population where individuals, in addition to having medical needs, may be highly affected by HIV-related stigma and/or disenfranchisement related to identification as a lesbian, gay, bisexual, transgender, or queer (LGBTQ) person.²² The adolescent clinic provides an intimate and supportive clinic that works to manage medical needs alongside other whole-person issues.



12. Interview with Rebecca Goldberg and Carmen Sanchez, Ruth M. Rothstein CORE Center. December 5, 2016.

13. Race, Ethnicity, and Kidney Disease" National Institute of Health <https://www.niddk.nih.gov/health-information/health-communication-programs/nkdep/learn/causes-kidney-disease/at-risk/race-ethnicity/Pages/race-ethnicity.aspx>

14. Interview with Rebecca Goldberg and Carmen Sanchez, Ruth M. Rothstein CORE Center. December 5, 2016.

15. "Patient Visitor Services" Cook County Health & Hospitals Systems, <http://www.cookcountyhhs.org/locations/ruth-m-rothstein-core-center/patient-visitor-services/>

16. "Patient Visitor Services" Cook County Health & Hospitals Systems, <http://www.cookcountyhhs.org/locations/ruth-m-rothstein-core-center/patient-visitor-services/>

17. Interview with Rebecca Goldberg and Carmen Sanchez, Ruth M. Rothstein CORE Center. December 5, 2016.

18. Interview with Rebecca Goldberg and Carmen Sanchez, Ruth M. Rothstein CORE Center. December 5, 2016.



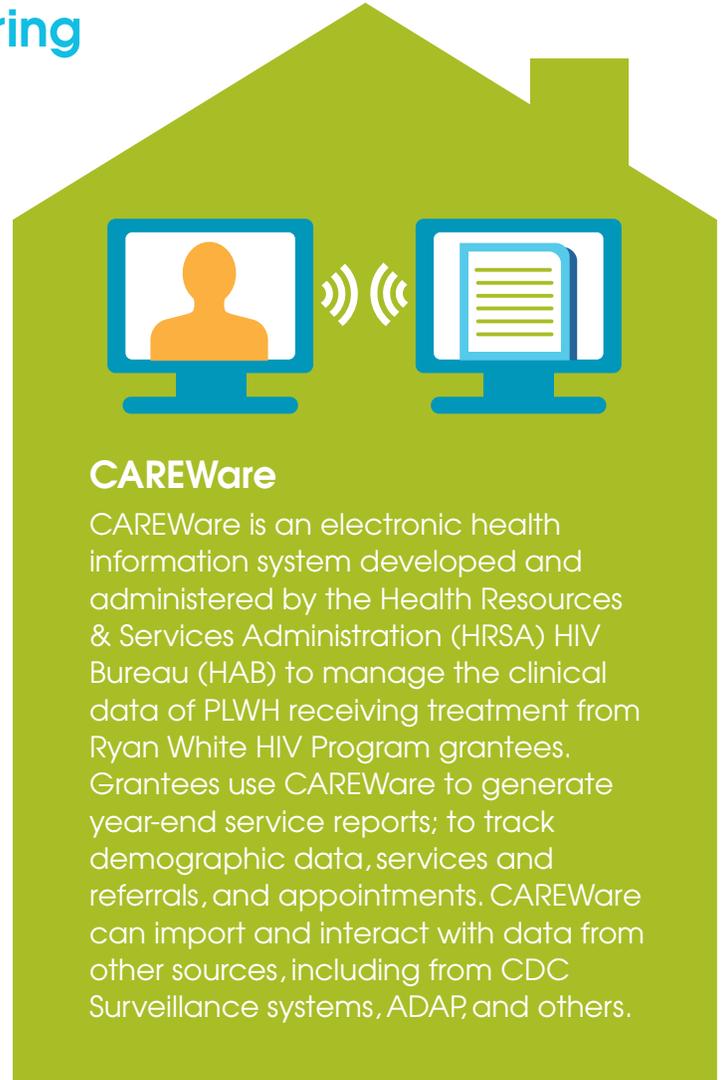
Data Infrastructure and Sharing

A unified data system underpins the CORE Center’s ability to provide its clients with integrated care. All CCHHS entities utilize the same internal data system, Cerner (the Cook County Electronic Health Record), which is connected and aligned with other data collection systems, such as CAREWare.²³

Beginning in 2010, the CORE Center transitioned to using electronic charting for more efficient data input and analysis. By leveraging electronic charting technology and linkages with CareWare, clinicians are able to use data to both support client care and drive quality improvement (QI) initiatives; these electronic charts include fields for providers to manage the process and outcome measures supporting or driving quality improvement.²⁴ For example, the CORE Center’s data system can be used to assess a measurement of how much time has passed between appointments, analyze patient engagement in care, or gauge the administration of tracked process measures (e.g., screenings, patient education services provided).²⁵

More broadly, the City of Chicago shares Ryan White Part A and Part B data with the state of Illinois. At the state level, the Illinois Department of Health uses integrated prevention and surveillance data to ensure individuals with a preliminary HIV diagnosis are linked to care. In addition to supporting connections to care, data sharing through this city-state relationship also has allowed the state to better assess viral load suppression rates as Illinois pursues longer-term strategies at the state level.²⁶

The sharing of data allows for targeted interventions and the deployment of resources critical to achieving primary and secondary prevention of HIV. At both the clinic and state level, data from the CORE Center is being used to map the epidemiological distribution of HIV to inform future work that overcomes geographic barriers to care.²⁷ For example, mapping provider availability within geographic areas may inform policy decisions, such as where to invest resources in provider network development and recruitment that assures timely access to primary and specialty care.



CAREWare

CAREWare is an electronic health information system developed and administered by the Health Resources & Services Administration (HRSA) HIV Bureau (HAB) to manage the clinical data of PLWH receiving treatment from Ryan White HIV Program grantees. Grantees use CAREWare to generate year-end service reports; to track demographic data, services and referrals, and appointments. CAREWare can import and interact with data from other sources, including from CDC Surveillance systems, ADAP, and others.

19. Interview with Rebecca Goldberg and Carmen Sanchez, Ruth M. Rothstein CORE Center. December 5, 2016.

20. Interview with Rebecca Goldberg and Carmen Sanchez, Ruth M. Rothstein CORE Center. December 5, 2016.

21. Interview with Rebecca Goldberg and Carmen Sanchez, Ruth M. Rothstein CORE Center. December 5, 2016.

22. Interview with Rebecca Goldberg and Carmen Sanchez, Ruth M. Rothstein CORE Center. December 5, 2016.

23. Interview with Rebecca Goldberg and Carmen Sanchez, Ruth M. Rothstein CORE Center. December 5, 2016.

24. "Quality and Patient Safety Committee Minutes", Cook County Health & Hospitals Systems, May 17, 2011. <http://www.cookcountyhhs.org/wp-content/uploads/2012/01/05-17-11-QPS-scan-minutes.pdf>

25. "Quality and Patient Safety Committee Minutes", Cook County Health & Hospitals Systems, May 17, 2011. <http://www.cookcountyhhs.org/wp-content/uploads/2012/01/05-17-11-QPS-scan-minutes.pdf>



Decisions: Care Management and Care Coordination

At the CORE Center, programmatic decisions enhance the care that clients receive through the integrated service delivery and data systems. As an additional reinforcement of the warm hand-offs and connected services that the delivery system inherently provides, care coordination activities are embedded throughout the CORE Center's operations.

Peer Educator Program

Peer support is instrumental to the CORE Center's mission of providing holistic care for PLWH and has been a component of the facility since it opened in 1998.²⁶ As part of the New Patient Orientations (NPO) Guide program, peer educators are trained by CORE Center staff to escort and assist all new clients as they navigate the CORE Center's many services and clinics. NPO Guides provide introductions to health care clinicians, case managers, and social service staff, offer a physical tour of the CORE Center, and share their personal stories as clients of the CORE Center.²⁹ For new clients, the NPO program reinforces a sense of cohesion between different services at the CORE Center. Peer educators support new clients as they manage their treatment plans, promote adherence to and retention in care, and provide a firsthand model for building "life, work, and coping skills." The NPO program and other peer educator positions offer current clients with paid, stable employment opportunities.³⁰ NPO Guides receive a stipend from Part A, B, C, and D federal Ryan White HIV Program funds.³¹

With funding from the Chicago Department of Public Health (CDPH), peer educators also conduct HIV/STI prevention outreach within and outside of the CORE Center. Peer Educators on Prevention for Positives, for example, work with new clients of the CORE Center's primary care services to provide education about preventing HIV transmission to HIV-negative partners (as well as preventing the transmission of other STIs). Additionally, medical providers within the CORE Center can refer individual, existing clients to Peer Educators on Prevention for Positives.

Peer educators also work within the CORE Center's Resource Center. The Resource Center houses a library with current literature about HIV and other health issues, as well as computers with free internet access. Peer educators at the Resource Center assist clients as they learn basic computer skills.³²

At the CORE Center, providers describe the peer educators as the "glue which keeps the whole place together," affirming that the program "helps new clients dramatically."³³ The decision to implement and grow peer educator programs bolsters the provision of integrated care delivery at the CORE Center, threading together multiple health and social services and offering stability and opportunity to those who wish to participate.



26. Interview with Eduardo Alvarado, Illinois Department of Public Health. November 16, 2016.

27. "Quality and Patient Safety Committee Minutes", Cook County Health & Hospitals Systems May 17, 2011. <http://www.cookcountyhhs.org/wp-content/uploads/2012/01/05-17-11-QPS-scan-minutes.pdf>

28. Personal communication from Wendy Rebolledo, Ruth M. Rothstein CORE Center, December 12, 2016.

29. <http://www.cookcountyhhs.org/locations/ruth-m-rothstein-core-center/education-research/>

30. Personal communication from Wendy Rebolledo, Ruth M. Rothstein CORE Center, December 12, 2016

31. Personal communication from Wendy Rebolledo, Ruth M. Rothstein CORE Center, December 12, 2016

32. "Education Research" Cook County Health & Hospitals Systems, <http://www.cookcountyhhs.org/locations/ruth-m-rothstein-core-center/education-research/>

33. Interview with Rebecca Goldberg and Carmen Sanchez, Ruth M. Rothstein CORE Center. December 5, 2016.



Three D HIV Prevention Educational Series: Advancing HIV Prevention Through Health Departments

Case Management and Connections to Social Services

Formal case management and individualized assessment processes are also integral to a holistic client experience and are central to the CORE Center’s operations. Early Interventions Services (EIS) staff directly call new clients who have been externally referred to the CORE Center, but are not yet engaged in care. The EIS staff person works with the individual to complete a “barriers assessment”,³⁴ which the EIS staff then relays to the CORE Center providers who will constitute the client’s care team.³⁵ The purpose of this is to ensure that all of the providers who will interact with the client are aware of what external factors may be impacting the individual’s ability to access services and become engaged in care at the CORE Center.

When any client first meets with a provider at the CORE Center, a case management assessment is completed. For those who are eligible, Comprehensive Medical Case Management fosters a cooperative relationship between the client and the case manager as they work together to design and maintain a plan of care for the client.³⁶ AIDS Foundation of Chicago uses Ryan White HIV/AIDS Program funding to deploy 20 case managers, each of whom typically have an average caseload of 40-60 individuals, throughout the CORE Centers’ clinics.³⁷ Behavioral health case managers also are available onsite to provide specialized support to clients with substance use disorders or psychiatric health needs.³⁸

The CORE Center also collaborates with other agencies and entities – braiding funding, resources, and capacity together – in order to facilitate connections between clients and social services within each of their clinics. Several local universities with social work programs have partnerships with the CORE Center and provide their students with the opportunity to work directly with clients as interns (who sometimes become hired staff).³⁹ Additionally, the Illinois Department of Child and Family Services (DCFS) provides funding for the CORE Center to specifically work with, and support, high-risk children and families.⁴⁰ For clients with other social service needs that impact their ability to access to care, the CORE Center provides tailored forms of assistance. For example, social service staff are able to assist justice-involved individuals with acquiring identification cards and other important documents.⁴¹



34. Interview with Rebecca Goldberg and Carmen Sanchez, Ruth M. Rothstein CORE Center. December 5, 2016.

35. The composition of the care team varies from client to client, based on their needs, but typically includes their primary care provider and any specialty providers.

36. “Patient and Visitor Services” Cook County Health and Hospitals System, <http://www.cookcountyhhs.org/locations/ruth-m-rothstein-core-center/patient-visitor-services/>

37. Interview with Rebecca Goldberg and Carmen Sanchez, Ruth M. Rothstein CORE Center. December 5, 2016.

38. Interview with Rebecca Goldberg and Carmen Sanchez, Ruth M. Rothstein CORE Center. December 5, 2016.

39. Interview with Rebecca Goldberg and Carmen Sanchez, Ruth M. Rothstein CORE Center. December 5, 2016.

40. Interview with Rebecca Goldberg and Carmen Sanchez, Ruth M. Rothstein CORE Center. December 5, 2016.

41. Interview with Rebecca Goldberg and Carmen Sanchez, Ruth M. Rothstein CORE Center. December 5, 2016.



Assistance with Coverage and Payment

While many of the clients visiting the CORE Center are uninsured or underinsured at the time of their first visit (prior to Medicaid expansion, 70 percent of clients were completely uninsured), several different sources of health coverage and funding streams are available to support individuals in accessing and paying for services. The Benefits Department at the CORE Center works with every new client (including those who visit the CORE Center for a walk-in appointment) to assess the individual's eligibility for public insurance options or to assist privately insured individuals as they navigate their benefits. After assessing eligibility for Medicaid and/or Medicare, ADAP⁴², Medication Assistance Programs (MAP), and CareLink (CCHHS's sliding fee scale program), Benefits Department staff can work one-on-one with clients to complete applications for these programs. As all of these programs, including CareLink, operate with annual review and redetermination periods, the Benefits Department provides clients with reminders about renewals and can assist the client in maintaining continuity of coverage.

Furthermore, Benefits Department staff assist clients as they manage bills and routinely connect with both clients and their provider teams to check in about their care. They also may work with a client's providers and care team to ensure that the CORE Center will be able to connect the client with coverage - for example, identifying workarounds in cases where fluctuating housing/residential status may present challenges as the staff attempts to reach the client for reminders and assistance.

As many clients receive health services and medications from the CORE Center that are covered by various funding levers (for example, ADAP or Ryan White may be used to cover pharmacological or medical services as the "payer of last resort" when Medicaid coverage alone is not sufficient), Benefits Department staff and others at the CORE Center ensure that these coverage options operate smoothly in tandem. At the state level, Illinois' Medicaid program and the Illinois Department of Health work collaboratively with the CORE Center to facilitate dual enrollment for the Medicaid and ADAP-eligible client population.⁴³ Medicaid and IDPH maintain an administrative partnership to ensure that Medicaid-eligible clients can easily dual-enroll in ADAP and other Ryan White Part B services.⁴⁴ Thus far, this relationship has been informal, but the two agencies are currently working together through the HIV Health Improvement Affinity Group, an initiative supported by several federal agencies.⁴⁵ Moving forward in their Affinity Group work, the two agencies plan to increase collaborative efforts, including enhanced data sharing and billing analysis.

Approximately twenty to twenty-five percent of all patients are eligible for CareLink. Of those individuals who qualify for CareLink, ninety-eight percent meet the eligibility criterion for 100% discount. As such, the CORE Center's ability to offer and sustain multiple avenues of financial assistance for clients is critical to its vision of providing integrated and whole-person care.



CareLink

CareLink is the Cook County Health & Hospitals System's sliding fee scale program for low-income clients. Financial counselors throughout CCHHS assist clients with assessing eligibility for other coverage options first, and then if appropriate, enroll them in CCHHS so that they can access services at CCHHS on a sliding scale or free of cost. CCHHS counselors, through interpretation services and bilingual staff, can provide services in 170 different languages to clients. CareLink enrollees receive an identification card that allows them to access services at CCHHS clinics and pharmacies.

42. The Health Resources and Services Administration (HRSA) supports the AIDS Drug Assistance Program (ADAP), which states and local grantees administer through Part B of the Ryan White HIV Program. ADAP provides low-income, underinsured, and uninsured individuals living with HIV with access to medications. Additionally, ADAP funds are used to support the purchase of health insurance for eligible individuals, and to pay for health services that improve the individual's ability to adhere to medication regimens. For more information: <https://hab.hrsa.gov/about-ryan-white-hiv-aids-program/part-b-aids-drug-assistance-program>

43. Interview with Eduardo Alvarado, Illinois Department of Public Health. November 16, 2016.

44. Interview with Eduardo Alvarado, Illinois Department of Public Health. November 16, 2016.

45. The HIV Health Improvement Affinity Group is the HIV Health Improvement Affinity Group is an initiative supported by the Centers for Medicare & Medicaid Services (CMS), the Health Resources and Services Administration (HRSA), and the Centers for Disease Control and Prevention (CDC), in collaboration with the HHS Office of HIV and Infectious Disease Policy (OHAIDP), and in partnership with the National Academy for State Health Policy (NASHP).



Conclusion and Recommendations



As other states and localities undertake efforts to provide PLWH – along with other chronic and complex populations – with integrated, whole-person care, the Ruth M. Rothstein CORE Center acts as a valuable model. As evidenced by its work, a number of key elements must be present and interconnected at the clinical level:

- **The delivery system** must center the client’s needs and render care across disciplines and specialties – attending not only to medical needs, but also to key factors that impact access to care (such as financial need, family composition, involvement with the justice system, gender and sexual orientation, and so on);
- **Data systems** should cut across the entire organization’s array of services to support continuity and coordination of care across disciplines; and,
- **Programmatic decisions** should bolster the delivery and data system to directly support the client as they navigate the integrated care system, engaging the individual in their plan of care and in its execution.

As states seek to replicate the CORE Center’s work or pursue their own innovations to provide integrated care, they can explore various state levers. Similar to the state of Illinois, states may:

- **Pursue** structured partnerships between the state Department of Health and state Medicaid program;
- **Strengthen** data and other administrative or strategic connections between the state and the city- or county-level health entities; and,
- **Bring** care providers to the table to understand how best to implement policies that can immediately and most meaningfully support integration efforts at the clinical level.

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