



AIDS: *Critical Matters*

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THE IMPLICATIONS OF CHANGES IN AIDS TREATMENT FUNDING AND SUGGESTIONS FOR AN ALTERNATE MODEL

by: Arthur Y. Webb, Emma DeVito, Allison Silvers and Jan Zimmerman⁺

AIDS: *Critical Matters* is a series of articles presented from the perspective of practitioners of care. In this forum, you will find a discussion of significant issues that impact individuals living with HIV/AIDS in our society, as well as a dialog on making sense of public policies and translating them into practice. We invite others to submit outside commentaries for inclusion after a review by Village Care of New York. To inquire about submitting a paper for publication, please send an email to policyforum@vcny.org.

New York is at a critical juncture in the history of AIDS: on the one hand, good medical management opens opportunities for long-term productive survival, but on the other, those opportunities dwindle when AIDS is intertwined with the psycho-social disadvantages that our most vulnerable citizens face. In truth, AIDS exists on a spectrum from “controllable chronic illness” to “complex social disease,” and these varying needs must be accommodated in AIDS care and funding.

The complexity and impact of AIDS in disadvantaged populations is quite striking. For example, black female New Yorkers are five times as likely to be infected as their white counterparts, and AIDS is the third leading cause of death in Brooklyn, but does not rank in the top ten in the whole of New York State. AIDS often co-occurs with chronic mental illness, addictions, poor health literacy, high-risk behavior, and a distrust of the health care system, all of which create barriers to good medical management. These complex cases require holistic and flexible responses.

For many years, the State Department of Health’s AIDS Institute encouraged a combination of medical and non-medical services as an opportunity to engage clients in treatment. HIV infection was recognized not just

Village Care of New York
154 Christopher Street
New York, New York 10014
(212) 337-5600
www.vcny.org

⁺ Arthur Y. Webb is President & CEO of Village Care of New York, Emma DeVito is Executive Vice President and Chief Operating Officer at Village Care of New York, Allison Silvers is Director of Strategic Grants and Contracts for Village Care of New York and Jan Zimmerman is Director of the AIDS Day Treatment programs at Village Care of New York..

as a medical disease, but also an ailment confounded by stigma, poverty, racism, ignorance and homophobia. AIDS Day Treatment Programs (ADTPs)—which Village Care was the first to pioneer in 1988—served as “safe havens” providing a range of medical, psychological, socialization and harm-reduction supports.

To complement the center-based approach, Village Care and other AIDS service providers offer home-based intensive case management programs (ICMs). These social intervention programs help clients to understand their needs and work with them to get those needs met, so they are then in a position to participate in treatment.

The ADTPs and ICMs work well for the “AIDS complex social disease.” However, recent AIDS Institute guideline clarifications, stipulating acceptable billable activities and restrictions on combination ADTP-ICM usage, seem to move AIDS towards the “controllable chronic disease” end of the spectrum. Some examples:

- Clients must complete all requirements of their treatment plan over the course of a week, and partial completion is not reimbursed.
- Complementary therapy is not a sufficient reason for a day center visit.
- ICM clients who are also clients of ADTP must be discharged.

We do not argue that regulation is unnecessary. Medicaid dollars are public funds and assurances must be in place so that these funds are spent wisely. However, it must be understood that these policy changes have significant consequences. They are pushing providers into strict medical management of AIDS, leaving those people who cannot maintain the behavior required to participate to “fall through the cracks.”

Village Care has nearly doubled its discharges due to clients not being able to meet the new requirements, from 40 in 2004 to 75 in 2006. We know that other programs have done the same—discharged clients and left them to their own devices. We do not know whether these people are adhering to their medication regimens, but it is unlikely, and therefore, may be spreading the virus.

Moreover, the de-valuing or restricting of complementary services is driving away others who atypically connect to the service system for the relief of pain, fatigue, stress, anxiety, depression and addictions. We do not know how many of those with HIV infection are

now avoiding service providers altogether because of the additional “hoops” to jump through to access the complementary services. But we do know that the new program requirements are turning away the marginally-engaged members of our society.

Perhaps worse, those who do not have the appropriate life skills or living situation to take advantage of medication therapies and ADTP benefits are losing access to care when specialized ICM field services cannot be used to support them. To highlight this point, we explored the needs of our clients who utilize both ICM and ADTP services. From our review, it is clear that the time that case management staff spend on “overlapping ICM clients” goes towards those services which cannot be met by ADTP social services and yet are required to maintain optimal health, including:

- Accompanying the client to medical appointments and helping him or her understand and incorporate the physician’s instructions.
- Working with the client to develop a more healthful “harm reduction” approach to his or her lifestyle, which enabled adherence to their HIV medications.
- Assisting the client’s children with obtaining special education and mental health services, so that the client can spend time in ADTP receiving mental health care.
- Working with the client to remain in housing that is safe and conducive to stabilizing health, avoiding a return to a drug-abusing household.

As programs have become restricted by funding changes, the unfortunate and undesired impact is that we ignore a person’s social-emotional development, without which we cannot enable medical management and prevent the spread of the disease. In this context, one can argue that case management and psycho-social supports are indeed “medically necessary” in that they are: 1) necessary to meet basic health needs; and 2) consistent with the diagnosis or condition and rendered in a cost-effective manner (if the condition is the interplay of HIV infection and psycho-social disadvantages).

To maximize medical management in all types of AIDS patients while remaining fiscally responsible, Village Care recommends that New York AIDS funding vary across the spectrum from social disease to manageable chronic illness. As a first step, these are

the highlights of a recommended two-tier approach to day treatment:

- Tier One would involve a less-onerous care plan, simply requiring a minimum of two days per week of attendance and participation in early HIV mental health, social and recreational activities. This tier would be equivalent to the “social adult day care” model of in New York’s aging services network.
- Tier Two would become the current ADTP regulations, reflecting the March 2007 clarifications.
- Tier One reimbursement would be based on a set percentage of the Tier Two daily rate. Therefore, Medicaid would not be paying for a full clinical regimen for those who cannot participate.
- Only Tier One clients would have access to “overlapping” ICM services. The ICM care plan must coordinate with the ADTP care plan (which Village Care currently does successfully) with the goal of creating sufficient structure and engagement in the client’s life to enable movement to Tier Two within nine months.
- All funding sources could be consolidated – that is, DOH, OASIS, DOMH, and HIV prevention funding – all of which have vested interest in stabilizing the triply-diagnosed client (HIV, mental illness and addiction).

Such a multiple-access-point approach to AIDS care appropriately reflects the range of emotional readiness among those today with HIV infection, and can open additional opportunities for necessary provider interactions.

This is one alternative we believe holds promise to achieve multiple goals. We would welcome additional thoughts and comments, as we strive to address the myriad problems of AIDS in the 21st Century.

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