

# A Blueprint for Case Management: A work in progress

AIDS Foundation of Chicago,  
Chicago Department of Public Health, and  
Training Resources Network  
Ryan White Grantee Meeting and 11<sup>th</sup> Clinical Update  
August 26, 2008, 3:30-5:00 pm

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## Welcome and Agenda

- Introductions
- Learning Objectives
- History and Overview of the Cooperative
- Environmental Factors Affective Change
- Description of Key Program Changes
- Q & A

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## Learning Objectives

- To understand the benefits of establishing a coordinated continuum of case management.
- To identify at least three challenges associated with implementing medical case management and determine potential solutions.
- To understand and take away three assessment tools utilized in the Chicago coordinated continuum of case management.

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## Case Management Cooperative

- In 1989, AFC was awarded a HRSA demonstration grant to establish a coordinated system of case management services for people living with HIV
- Case management agencies participated in establishing common expectations, policies and procedures
- Combination of intensive case management (based on need) and standard Ryan White case management
- System now consists of over 160 case managers at 55 agencies
- Funded primarily through the Ryan White Parts A and B and through the Illinois Department of Human Services (IDHS) Division of Rehabilitative Services (DRS)

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## Case Management Cooperative

- Requires ongoing communication and relationships between AFC, CDPH, IDPH, DRS
- Formal relationships:
  - Contractor/subcontractor
  - Standardized workgroups
- Informal relationships:
  - Ongoing unplanned communication
  - Almost the most important key to success
- Consultant/External relationships
  - Facilitates communication

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## Case Management Cooperative

- Philosophy of the Cooperative is to provide comprehensive case management services to empower people living with HIV/AIDS to live healthy and independent lives.
- Case management:
  - assists clients in applying for benefits
  - facilitates access to emergency funds
  - identifies medical and social service needs
  - facilitates appropriate referrals to meet service needs

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## Case Management Cooperative

A coordinated system ensures:

- Seamless and continuous care throughout a client's periods of health and illness
- Non-duplication of services
- Standardized policies and procedures across all sites
- Consistent quality throughout all regions of the EMA through standardized training and technical assistance
- Direct data entry of client-level reporting, allowing for consistent and timely data collection
- Maximized resources available to support case management (CDPH/IDPH/DRS/HUD/etc.)

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## Case Management Cooperative

- Central administration and coordination
- One client - one case manager
- Needs assessment
- Individualized plan of care and approach
- Referrals and follow-up
- Quality service delivery priority
- Quality improvement processes

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## Case Management Cooperative

- Respond to client needs in planning and implementing case management services.
- Take client wishes into account in case management goal development and attainment.
- Foster client empowerment, responsibility, accountability and independence.
- Promote flexibility in approaches and settings to best meet client needs.
- Initiate a broad link with other community services.

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## Optimizing Case Management

- TRN evaluated case management system in 2003. Recommended changes to case management for a variety of reasons:
  - 1,600 new cases of HIV and AIDS are diagnosed in Chicago EMA each year, but resources for case management and other services are not growing.
  - CDC estimates that approximately one-third of all infected people do not know their status, and another third are not engaged in medical care.
  - Case management has been identified by HRSA as a “core service” in facilitating linkages and maintenance of medical and clinical care, “medical case management including treatment adherence”
- AFC, CDPH, and TRN formed a workgroup to “optimize” the system of case management services

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## Optimizing Case Management

- Literature review including chronic care models
- Surveyed case management and clinical sites
- Governance Committee guidance
- Client focus groups
- Case manager focus groups
- Planning Council Steering Committee focus group
- Provider focus groups – physicians and clinic managers
- Reviewed service utilization/medical assessment data

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## Optimizing Case Management

### Health Management Model

- Responded to anticipated changes in the Ryan White CARE Act
- Responded to the levels of client need in the Chicago EMA
- Maintained client access to support services including transportation, emergency financial assistance (EFA), and emergency housing assistance (EHA)
- Emphasized treatment and appointment adherence
- Facilitated active links to primary medical care and other core services
- Monitored health outcomes with the goal of supporting clients as they become partners in their own self care

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## Optimizing Case Management

### 3-Tier System

- **Tier 1** was an intensive case management model that targeted clients with exceedingly high levels of need. Focused on housing and stabilizing clients, facilitated active links to primary medical care and other core services, and emphasized treatment and appointment adherence through increased frequency of client contact.

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## Optimizing Case Management

- **Tier 2** focused on facilitating active links to primary medical care and other core services with an added emphasis on treatment and appointment adherence.
- **Tier 3** served clients with low need. Tier 3 services consist of various client support services that maintain client access to transportation, EFA, EHA.
- By having a coordinated system of case management, clients were able to seamlessly move through the three tiers without disruption in services as the need arises as measured through acuity scores.

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## Optimizing Case Management

- **Lessons learned from the pilot project:**
  - Clients comfortable with CMs doing adherence assessment and education
  - Treatment/medication adherence assessment tools burdensome and unreliable (self-report)
  - Appointment verification difficult to confirm
  - Most formidable challenge is coordinating services between case managers and core clinical providers
  - Treatment coordination cannot be achieved without active, ongoing communication
  - Social stability not necessarily an indicator for adherence
  - Low need clients unwilling to stop CM services
  - Must reassess staffing capacity at the systems level (AFC)

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## Key Program Changes

- Congress enacted the Ryan White HIV/AIDS Treatment Modernization Act in October 2006
- After Congress passed Act, HRSA changed its allowable service definitions in May 2007
- The new definitions were effective immediately
- The new definition with the largest impact on us is the definition for case management
  - medical case management (CORE)
  - supportive case management (NON-CORE)

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## Key Program Changes

### Ryan White Program Services Definitions:

*(REID=new language, not previously included in definition)*  
*Medical Case management services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence: counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments.*

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## Key Program Changes

### Ryan White Program Services Definitions:

*(Supportive Services) Case Management (non-Medical) includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.*

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## Key Program Changes

Biggest challenge still? Treatment Coordination

- HRSA requirements to track clinical indicators
- Current challenges with Medical Assessment
- Coordination and follow up of care
- Treatment Adherence and readiness counseling

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## Key Program Changes

- Literature review including chronic care models
- Analyzed Pilot Project findings
- Surveyed case management and clinical sites
- Convened Clinical Advisory Workgroup
- Governance Committee guidance
- Interviewed providers doing treatment coordination
- Client focus groups
- Case manager focus groups
- Planning Council Steering Committee focus group
- Provider focus groups – physicians and clinic managers
- Reviewed service utilization and medical assessment data

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## Implementation of New Model

In order to bring the Northeastern Illinois Case Management Cooperative in line with the HRSA service definition for *medical case management including treatment adherence*, Chicago underwent a 90-day implementation plan with four distinct areas of change:

- Integration of Treatment Coordination
- Tool Implementation
- Case Manager Training and Capacity Building
- Communications Plan and Consumer Education

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## Implementation of New Model

AFC reviewed treatment coordination methods (including, but not limited to case conferencing, telephone coordination, and patient care liaisons) that providers currently utilize in the case management system. AFC evaluated the current methods and determine which ones are the most effective and most easily replicated throughout the system.

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## Implementation of New Model

### Medical Case Management Model

New model of case management for the Cooperative. Combines social services, public health, and medical (chronic care) models, incorporating best practices of each.

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## Implementation of New Model

- **Intensive case management** model that targets clients with exceedingly high levels of need.
- **Medical case management** focuses on facilitating active links to primary medical care and other core services with an added emphasis on treatment and appointment adherence.
- **Supportive services case management** will serve clients with low need and who are medically stable.

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## Implementation of New Model

- Treatment Coordinators
  - Based at health care clinics
  - No direct contact with clients
  - Review medical records and influence case management service plans
  - Track HRSA clinical performance indicators in client-level database
  - Serve as liaison between clinical providers and case managers

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## Implementation of New Model

AFC is implementing assessment and tracking tools that were developed with the input from the Clinical Advisory Group and tested in the OCM pilot projects. The forms are as follows:

- Revised AFC Screening Tool
- Revised Intake and Reassessment
- Revised Acuity Scale
- Revised Medical Assessment

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## Implementation of New Model

### Tool Implementation

- Screening Tool
  - Phone screening conducted by AFC staff (not CMs) at point of referral into the case management system
  - Gathers limited information regarding demographics, diagnosis, health, housing, substance use, and mental health needs to help influence referral and level of care
  - AFC able to provide case manager with brief overview of client upon referral

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## Implementation of New Model

### Tool Implementation

- Intake/Reassessment
  - In October 2007, implemented revised Intake/Reassessment tools
  - Gathers significant amounts of data regarding access to care, adherence to medications, and SA/MH histories
  - Conducted on clients every six months or when there is a significant change in the client's life
  - Currently being looked at to assess levels of need

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## Implementation of New Model

### Tool Implementation

- Acuity Scale
  - Many iterations over the past ten years, mostly focused on social determinants of health
  - In 2006-2007, piloted a more clinically-focused tool
  - Made significant changes and implemented a system-wide revised acuity tool
  - Data and case manager feedback determined:
    - Burdensome to implement (intake was close to two hours)
    - Data gathered did not accurately portray client need

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## Implementation of New Model

### Tool Implementation

- Medical Assessment
  - One page assessment that is to be completed by staff at the client's primary care site every six months
  - Includes information regarding OIs, CD4/VL, vaccinations, and other health concerns that case managers need to be aware of
  - Currently captures HRSA performance indicators

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## Implementation of New Model

### Tool Implementation

- Medication/Treatment Adherence Assessment
  - Still in development
  - Piloted assessments that were burdensome and unreliable
  - Need to determine what is the minimum level of information and how to use it
  - Need to determine the role of case managers versus the role of clinicians and treatment adherence counselors

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## Implementation of New Model

- In 2007, 6,701 HIV positive men, women, and children were served in the Cooperative.

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## Implementation of New Model

- Outcomes for Client-level Data

*Target Indicator:* 90% of active clients in Case Management will be linked into primary care.

*Result 2006:* 91% (3,632/3,980) of active clients in Case Management were linked into primary care.

*Result 2007:* 92% (4,130/4,472) of active clients in Case Management were linked into primary care.

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## Implementation of New Model

*Target Indicator:* 75% of all case management clients linked into primary care services will have improved or stable CD4 counts.

*Result 2006:* 71% (108/152) of case management clients receiving primary care services (and reported at least two data points) had improved or stable CD4 counts.

*Result 2007:* 72% (517/717) of case management clients receiving primary care services (and reporting at least two data points) had improved or stable CD4 counts.

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## Implementation of New Model

*Target Indicator:* 85% of newly referred case management clients will be comprehensively assessed for mental health and substance abuse services.

*Result 2006:* 66% (228/344) of newly referred case management clients were comprehensively assessed for mental health and substance abuse services.

*Result 2007:* Of 305 clients referred between 1/07 and 9/07 who then met with a CM 212 (70%) were assessed for Mental Health, 191 (63%) were assessed for Substance Use

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## Implementation of New Model

### Case Management Training and Capacity Building

- Case Management Competencies Curriculum
  - Required 20-Module Curriculum for all CMs
  - Mix of presenters
  - Testing Component
  - Scenario Component
  - Scoring to be certified as a medical case manager
- Treatment Adherence Counseling
- Ongoing continuing education requirements

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## Implementation of New Model

### Client Education

- Drafted a letter that went to all current clients (via their case managers) informing them of the changes
- Conducted 10 Consumer Education Forums
- Developed an on-line Client Orientation to be used by case managers with all new clients
- Continues to provide updates to all case managers, supervisors, contract administrators, medical providers, clinic staff, and the broader service community.

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## Implementation of New Model

- PEERSpeak
  - Peer Empowerment Education Referral Station
  - Goal to improve the ability of people living with HIV/AIDS, including newly diagnosed, to access quality HIV information and service referrals in metropolitan Chicago.
  - On-line education modules that address “Getting into Care”, “Treating HIV”, “Mental Wellness and Self-Care”, “Navigating the System”, and “Staying Healthy”
  - Audio and written text
  - Development involved people living with HIV at all levels

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## PEERSpeak Demo

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## Next Steps

- New model roll out
- Treatment Coordinator Pilot
- Incorporation of SA/MH assessments
- Refining tools
- Incorporation of self-management

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## Questions and Discussion?

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## Further Information

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