

CQI and Case Management: The Groundwork for a Developing Model

AIDS Foundation of Chicago,
Chicago Department of Public Health, and
Training Resources Network, Inc.
Ryan White Grantee Meeting and 11th Clinical Update
August 26, 2008, 10:00-11:30 am

Welcome and Agenda

- Introductions
- Learning Objectives
- History and Overview of the Cooperative
- 2003 Evaluation of the Cooperative
- Resulting CQI Efforts
- Q & A

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Learning Objectives

- Understand the basic philosophy and elements of the coordinated system of case management.
- Identify at least three areas of improvement as outlined in the 2003 evaluation.
- Understand the groundwork that the 2003 evaluation and resulting CQI efforts built that enabled the system to optimize case management services.

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Case Management Cooperative

- The Case Management Co-op pre-dates Ryan White funding.
- 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).
- Additional funding provides housing, corrections and perinatal case management.

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Case Management Cooperative

- Requires and facilitates ongoing communication and relationships between AFC, CDPH, IDPH, DRS
- Formal relationships:
 - Contractor/subcontractor
 - Standardized training
- Informal relationships:
 - Ongoing unplanned communication
 - May be the most important key to success
- Consultant/External relationships
 - Facilitates communication
 - Outside perspective

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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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Disclaimer

- Although your community may not have the benefits of a long-standing, coordinated case management system with standardized training and a centralized database, we believe many of the lessons learned will be applicable.

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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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Case Management Cooperative

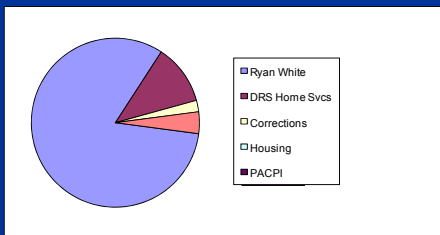
Currently, 55 agencies and approximately 160 case managers (as of 4/2006) throughout the 9-county Chicago area provided case management services to more than 4,900 HIV+ men, women, and children in calendar year 2005.

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Case Management Cooperative

Total clients from 2007 Ryan White Data Report by program served = 6,701

- Ryan White Part A and B clients: 77%
- DRS Home Services Clients: 13%
- Corrections Clients: 4%
- Supportive Housing Clients: 4%
- PACPI Clients: <1%



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Case Management Cooperative

■ 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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Case Management Cooperative

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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Case Management Cooperative

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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Evaluating 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

- AFC, CDPH and TRN formed a workgroup to “optimize” the system of HIV case management services in the Chicago EMA
- Guiding principles:
 - Keep what’s working
 - Maintain the flexibility of the current system
 - Respond to emerging needs

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Evaluating Case Management

- Methods
 - CDPH contracted with TRN to conduct a comprehensive assessment of the Chicago HIV case management system
 - Key informant interviews (AFC, CDPH, MATEC, the Planning Council and consumers)
 - Document reviews
 - Focus groups
 - Case management clients
 - 40 case managers
 - Case management supervisors
 - Program Directors and Executive Directors from Title I-funded case management agencies

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Optimizing Case Management as a CQI Project

- Quality Improvement Principles
 - Involve those closest to the problem, e.g., case managers and case management clients
 - Team effort
 - Engage leadership
 - Look at the system of care rather than focusing on the individual agencies (providers)

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Optimizing Case Management as a CQI Project

- Quality Improvement Principles:
 - Use data and measurable outcomes to determine progress toward relevant, evidenced-based benchmarks (outcome measures)
 - Learn from others/don't reinvent the wheel (literature review)
 - Implement a series of incremental changes (small tests of change, pilot testing)

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Optimizing Case Management as a CQI Project

- Quality Improvement Principles:
 - Communicate clearly and frequently (communication plan)
 - Admit when it's not working (acuity scale)
 - Infrastructure enhances the systematic implementation of improvement activities (AFC staffing, Treatment Coordinators)

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Optimizing Case Management

Recommendation:

- Establish a CDPH/AFC Workgroup comprised of AFC, CDPH and MATEC.

Resulting Quality Activity:

- Established a workgroup that meets at least every other month with a set agenda to discuss ongoing policy, implementation and coordination issues.

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Optimizing Case Management

Recommendation:

- Case management and support standards be reviewed and approved by the Planning Council.

Resulting Quality Activity:

- Involved Planning Council (PC) in advisory capacity to identify and approve the standards in 2005. The standards are currently in the process of being revised and the PC will serve in the same capacity.

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Optimizing Case Management

Recommendation:

- Initiate a competitive bid process for case management services.

Resulting Quality Activity:

- Competitive process held for FY 04-05 and again in 2008.

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Optimizing Case Management

Recommendation:

- AFC and CDPH must address the deficiencies in current data collection and reporting systems.

Resulting CQI Activities:

- AFC/CDPH redirected resources to meet this.
- All case management providers were licensed and trained to do direct entry of client level data.
- Currently in process of updating the database to expand capacity for data collection to do more outcome measurement.

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Optimizing Case Management

Recommendation:

- Develop procedures for monitoring continuous quality improvement through annual site reviews.

Resulting Quality Activity:

- Evaluating site review process.
- Identifying staff training needs.
- Moving away from a three-year certification.
- Incorporating feedback loop and 30-day action plan for deficiencies.

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Optimizing Case Management

Recommendation:

- Work closely with external consultant and MATEC to review and revise the orientation and continuing education program for case managers.

Resulting Quality Activities:

- AFC employs a full-time training and TA manager.
- Implemented a revised competency-based training.
- Enhanced adherence and coordination of care components of orientation.
- AFC provides over 80 trainings a year to case managers.

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Optimizing Case Management

Recommendation:

- Strengthen information communicated to case managers from AFC upon referral and standardized intake period expectations.

Resulting Quality Activities:

- Revised and implemented a new screening tool and referral report to case managers.
- Set expectations regarding the time between referral and expectation based on level of need.

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Optimizing Case Management

Recommendation:

- Examine way to ensure that acuity scores influence levels of need and service plans.

Resulting Quality Activities:

- Revised and implemented a new acuity tool with unfavorable results.
- Currently working to use information from intake to influence a “score” and service plan for clients.

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Optimizing Case Management

Recommendation:

- Foster empowerment through case management to ensure that clients who can achieve independence “graduate” from services.

Resulting Quality Activities:

- Established levels of case management.
- Exploring “self-management” programs for those who graduate.
- Implementation of PeerSpeak.

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Optimizing Case Management

Health Management Pilot Projects

- 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 (population-based) 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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Next Steps

- Piloting Treatment Coordinators.
- Building clinical infrastructure at AFC.
- Incorporating lessons learned from the evaluation and resulting quality activities into new case management program design.
- Ongoing communication with Planning Council, community, Governance Committee, Service Providers Council and funders.
- Redesign AFC site visit process.
- Working to finalize:
 - Acuity scale
 - Self-management programs
 - Access to transportation, EFA, and EHA

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Questions and Discussion?

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