

# Quality Improvement Activities for Medical Case Management: A Ryan White Part A Grantee's Perspective

Philadelphia Department of Public Health  
Philadelphia EMA



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## Presenters

- Marlene Matosky, MPH, RN  
– HIV Care Quality Management Coordinator
- Coleman Terrell  
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- Evelyn Torres, MBA  
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## Agenda

- Overview of the Philadelphia EMA Medical Case Management (MCM) Model
- Quality Initiatives
  - Centralized Services
  - Performance Data, Measurement and Improvement
  - Medical Case Manager Input

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## Philadelphia EMA

- Nine counties across two states
- 70 Part A funded providers – half receiving Parts B, C, and D
- 15,000 consumers receive Part A services
- PDPH, AIDS Activities Coordinating Office (AACO) administers:
  - Part A
  - Local Part B - Pennsylvania
  - CDC Prevention & Surveillance
  - Local HIV funding

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## Philadelphia EMA Service System

- Decentralized system
- 24 Medical agencies
- 28 Medical Case management (MCM) agencies
  - 6600 clients receiving case management services
  - 1800 intakes a year completed through the Client Services Unit

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## Profile of MCM Services in Philadelphia

- Funding: \$7 million (RW A, B, and local)
- Services are provided through:
  - CBOs
  - ASOs
  - Hospital outpatient infectious disease clinics
  - Stand alone HIV clinics

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## MCM Model

- Broker model with goals of:
  - Facilitating access to and retention in medical care
  - Providing treatment adherence counseling
- Standards of care and outcomes established
- Emphasis on the needs of special populations
- Client Services Unit (CSU) is the point of access for requesting case management

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## Centralized Services

- Case management intake
- Waiting list
- Grievance process
- Training

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## Rationale for Centralized Services

- Clients were unsure of where to go for case management services
- Multiple waiting lists
- Services underutilized particularly in smaller agencies
- No EMA-wide grievance process
- Range of competencies of case managers across the system
- Eliminate duplication of service

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## Centralized Client Intake Process

- Gather demographic information and assess needs
- Explain:
  - Case management services
  - Client rights and responsibilities
  - Grievance procedures

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## Intake Process, Continued

- Connect clients to case management services based on:
  - Client needs/preferences
  - Geographic location/program specialization
- Clients not desiring or appropriate for case management are referred to other services

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## Centralized Intake and the MCM System

- Bi-weekly assessment of case management openings at agencies
- Agencies cannot close to referrals without prior approval
- Trends/concerns are shared with pertinent AACO units for follow-up:
  - Chart review
  - New policies requires
  - Technical assistance

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## Centralized Waiting List

Clients are placed on a centralized waiting list when openings are not immediately available

- Typical waiting period is 20 days
- Clients contacted monthly by social work staff and interim services are provided
- Homeless and emergency cases are referred immediately

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## Grievance Process

- Client complaints are documented by CSU
- CSU Manager works with Program Services Unit to get provider response
- Outcome to feedback must be approved through an internal process
- Outcome shared with client and provider
- Providers or clients not satisfied are referred to Program Administrator

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## MCM Training

- Annual training and certification process, coordinated with the local AETC
- Core training: 9 days on 6 specific topics for newly hired case managers and supervisors
- Ongoing training: 20 hours of mandated training of which 6 hours must be medical
- Providers are notified of those employees not completing the annual requirements

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## Data Generated by Centralized Services

- Intake:
  - Client demographics
  - Client needs
  - Other client variables (e.g. client's substance using and treatment, mental health diagnosis and treatment, etc.)
- Waiting list:
  - Length of time on waiting list
  - Agencies generating waiting lists
- Six week & One Year follow-up
  - Retention in case management & HIV medical care
  - Reasons not in case management & HIV medical care
- Grievance Data

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## Intake Data

		CY 2007	Jan-June 2008
Number of intakes		1876	980
Gender	Male	62%	62%
	Female	36%	36%
	Transgendered	1%	1%
Race/ Ethnicity	Black	72%	73%
	White	14%	16%
	Latino(a)	9%	9%
Risk	MSM	18%	20%
	Hetero	43%	44%
	Drug	10%	9%
	Other	13%	15%
	Unknown	13%	12%

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## Intake Data

		CY 2007	Jan-June 2008
Client identified need	Housing	65%	65%
	Medical care	17%	14%
	Medical insurance	21%	17%
	Support	40%	44%
	Substance abuse	11%	10%
	Mental health	33%	26%
	Transportation	25%	30%
	Legal	9%	7%
	Financial	7%	9%
	Dental	3%	3%

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## Intake Data

	CY 2007	Jan-June 2008
No HIV medical in 3 mo at intake	19%	18%
Substance abuse last 3 months	28%	30%
Pre, in or complete treatment	40%	38%
Mental health last 3 months	38%	38%
Pre, in or complete treatment	6%	7%
Both substance abuse and active mental health in last 3 months	7%	9%

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## Waiting List

	CY 2007	Jan-June 2008
% of intakes spending $\geq 7$ days on waiting list	50%	38%
% of intakes waiting for 4 agencies	77%	73%
Average time on waiting list	32 days	24 days

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## Six week and One Year Follow-Up

	CY 2007	Jan-June 2008
Retained in MCM within 6 weeks of intake	88%	71%
Retained in HIV medical care within 6 weeks of intake	84%	77%
Retained in MCM or discharged within one year of intake	79%	89%

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## Grantee Support of Centralized Services

- CSU staffing
- Information technology (IT)
  - Case management intake/follow-up database
  - Information and referral database
- Involvement of other AACO Units
  - Information Services Unit
  - Program Services Unit
  - Senior Management

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## Benefits of Centralized Services

- Leads to better management of the MCM system by:
- Ensuring client choice
  - Fairer distribution of clients to different agencies
  - Guaranteeing that clients on the waiting list receive interim services
  - Supporting the MCM model through training and the facilitation of initial medical appointments
  - Making decisions based on objective data

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## Quality Management Process

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## EMA Quality Management Guiding Principles

- Quality is a shared responsibility between program and data staff
- As much as possible use one data source
- Same standards and performance measures regardless of funding source
- Established process with performance measures and improvement

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## Quality Management Process

1. Performance measures
2. Annual and quarterly data reports
3. Provider developed quality improvement plan
4. MCM quality management meetings

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## Performance Measures

### New client:

- Six-week follow-up form submission
- Retention - clients in case management at 6 weeks following initial enrollment
- Access to Medical Care - clients in ambulatory/ outpatient HIV medical care at 6 weeks following initial enrollment
- Clients retained/discharged at 52 weeks following initial enrollment

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## Performance Measures

All clients:

- Substance abuse & mental health histories & treatment assessed quarterly
- Linkage and retention in medical care
- Treatment adherence
- Clinical supervision
- HRSA performance measure(s)

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## Performance Measure Definition

<b>Measure</b>	Retention in HIV case management
<b>Definition</b>	Percent of clients referred to an HIV case management provider who had a face-to-face case management visit within six weeks of the intake with the Client Services Unit during calendar year 2007
<b>Analysis Inclusion criteria</b>	Clients who were referred to HIV case management during calendar year 2007
<b>Analysis Exclusion criteria</b>	<ul style="list-style-type: none"> <li>• Clients referred to an HIV case management provider during calendar year 2007 for whom a six-week follow-up form was not generated or not returned by agency</li> <li>• Clients who did not have a face-to-face HIV case management appointment due the agency not receiving the intake from the Client Services Unit</li> <li>• Clients who died, relocated or were incarcerated within six-weeks of referral</li> </ul>
<b>Numerator</b>	Number of clients who were referred to HIV case management during calendar year 2007 and had a face-to-face HIV case management visit within six-weeks of intake
<b>Denominator</b>	Number of clients referred to an HIV case management provider during calendar year 2007
<b>Target</b>	90%

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## Sample Data Report

Performance Measure	Data	Aggreg. Jan – Dec 07	Aggreg. Jan – March 08	Provider X Jan - Dec 07	Provider X Jan - March 08
Retained in HIV case management	Numerator	1083	276	247	51
	Denominator	1228	387	366	74
	% of clients retained in CM	88%	71%	67%	69%
	Target	90%			
Retained in HIV medical care	Numerator	860	214	206	40
	Denominator	1021	278	240	51
	% retained in HIV medical care	84%	77%	86%	78%
	Target	100%			

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## Provider Quality Improvement Plan (QIP)

General Information	
Agency Name:	
Program Analyst:	
CQI Contact Person:	
CQI Contact Person's Phone Number:	
CQI Contact Person's Email Address:	
CQI Team Members:	
CQI Project Plan	
Which indicator will the CQI plan target to change?	
What are the causes for the low performance for this indicator?	
What action steps will be implemented to improve performance for this indicator?	
When will each of the action steps be implemented?	
What goal do you want to achieve for this indicator?	

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## QIP Follow-Up

Indicator:	
Goal:	
Action Step	Progress to date

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## Provider QIP: Lessons Learned

- Some providers did not understand data
- Many providers needed to develop policies and procedures as part of QIP
- Emphasize the quality management basics (e.g. flowcharting, root cause analysis, etc.)

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## Quality Management Meetings

- Held every four months
- Attendance is required
- Forum to address issues and present concepts to entire EMA's MCM system
- Small group discussions provide a wealth information
- Prepare for and evaluate each meeting

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## Meeting Evaluation

1. The information presented was easy to understand.
2. The agenda was covered adequately.
3. The meeting room was comfortable.
4. I felt comfortable expressing my thoughts and asking questions.
5. The time allotted for the meeting was just right.
6. For the time I invested in the meeting, I received a good return.
7. I look forward to attending future HIV medical case management quality management meetings.
8. My overall impression of the meeting was positive.
9. What topics would you recommend for future meetings?

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## Medical Case Manager Input

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## MCM Request for Proposals (RFP)

- RFP emphasis:
  - Treatment Adherence
  - Retention in medical care
  - Supervision
  - Case closure
- Mandates policies and procedures for each of above – system-wide improvement plan

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## Effective Improvement Plans Need Input From Stakeholders

- Consumers
- HRSA
- Local government
- Planning council
- Outpatient/ambulatory medical providers
- Grantee program staff
- Medical case managers

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## Input from MCMs

- Quarterly QM meetings
- Facilitated focus group of clinic-based CM
- Web based anonymous survey of all case managers

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## Focus Group

- Six agencies funded for both ambulatory/outpatient medical care and medical case management
- Facilitated by non-AACO staff
- Goal: Describe client population/ need, activities, challenges & success
  - Is there a difference between case management delivered in a clinic setting and that provided through CBOs?

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## Findings

- No major differences between clinic-based and community-based medical case managers
  - Do not need two sets of standards
- Challenge: sharing of clients between clinic and CBO

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## Case Management Survey

Anonymous web-based survey  
– Sent to 138 MCMs with a 84% response rate

Four domains:

1. Knowledge and experience with medical providers
2. Perception of clients' management of their HIV disease
3. Role in clients' medical care
4. Role in clients' health literacy

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## Knowledge and Experience of Medical Providers

How would you rate your clients' HIV medical providers on...

- Being cooperative when you request information?
- Being knowledgeable about HIV medical care?
- Being aware of your clients' psychosocial issues?
- Being energetic in their interactions with your clients?
- Accepting you as part of the health care team?

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## Perception of Clients

How would you rate most of your clients on being able to...

- Understand their role in HIV case management?
- Manage their lives independently?
- Self-manage their HIV disease?
- Independently take their HIV medications as prescribed?
- Follow the directions they receive from medical providers?

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## MCM Role in Medical Care

To what extent do you agree with the following statements?

- I assess my clients' barriers to attending medical appointments.
- I inform the medical providers of client information that may impact my clients' medical care.
- I motivate my clients to attend medical appointments.
- I attend medical appointments with my clients.
- I coach my clients on discussing their treatment with their medical providers.
- I use pictures of the HIV medications for my clients to indicate which they are prescribed when I discuss HIV medications.

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## MCM Role in Health Literacy

### Thinking about the health literacy of your clients...

- I think it is important to assess my clients' health literacy.
- I assess all of my clients' health literacy.
- I use a standardized questionnaire to assess my clients' health literacy.
- I can "just tell" when one of my clients has low health literacy.
- I ask my clients how far they got in school to judge their health literacy.
- I have never heard of health literacy

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## Survey Analysis – Perceptual Mapping

### Perceptual mapping

- Visual display of the perceptions of case managers
- Products are three dimensional maps
  - Distance between categories and the MCM self show how closely MCMs identify with categories and relate different categories
- Mapping done by Temple University School of Public Health

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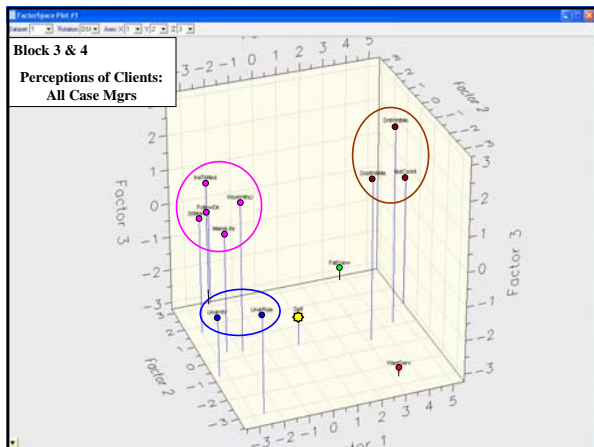
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## Findings

- High regard for both medical providers & clients
- Again, there is little difference between clinic & CBO case managers
- Do not associate counseling with practical actions
- Place the self close to counseling & farther from practical actions

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## Using the Findings

- Incorporate into:
  - Standards
  - Role & responsibilities
  - Policies & procedures
  - Training

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## AACO Medical Case Management Committee

Priority areas: Treatment adherence, clinical supervision, & linkage/retention in medical care

Tasks:

1. Identify responsibilities & roles of providers
2. Identify key implementation activities for CSU, ISU, & PSU
3. Develop standards
4. Draft minimum components of policies & procedures

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## Lessons Learned

- Involve front line workers in developing program models, policies, and standards
- Use multiple strategies to get input
- Ensure there is a feedback process to use the input

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## Acknowledgements

- Philadelphia EMA consumers
- Philadelphia EMA providers
- PDPH staff
- HRSA Project Officer

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