



CASE MANAGEMENT SERVICES

Ryan White Title I Office Clinical Quality Management Program (CQM)

The Baltimore City Health Department (BCHD) Clinical Quality Management Program (CQM) began in 2001 to ensure that people living with HIV/AIDS in the Greater Baltimore Eligible Metropolitan Area (EMA) have access to quality medical care and services consistent with USPH Guidelines and best-practices. The FY 2004 CQM initiatives focused on primary care, case management, food bank and home delivered meals, and nutritional counseling.

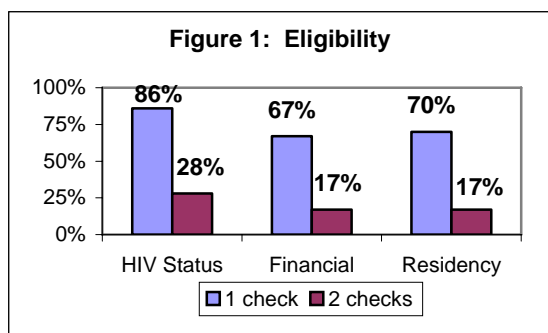
This fact-sheet summarizes the EMA-wide findings for case management, which is defined as “a range of client-centered services that links clients with health-care, psychosocial, and other services. Case management ensures timely and coordinated access to medically appropriate levels of health and support services and enhances continuity of care through on-going assessment of the client’s and other key family member’s needs and personal support systems. It also includes inpatient case-management services that prevent unnecessary hospitalization and that expedite discharge from an inpatient facility.”^{1, 2}

In 2004, 15 agencies provided adult case management services and 2 agencies provided pediatric services to a total of 1,577 clients within the EMA. This fact-sheet presents findings from a review of 478 (34% of total) client charts from the 15 adult agencies.

Adult Demographics

Overview: Over a third of clients (35%) were female, 62% were male, and 2 clients (0.4%) were transgender. Clients’ mean age was 43.3 years, with the largest proportion (42%) falling between the ages of 40-49. The majority of clients were African American (78%), with White clients (13%) being the second largest group. Heterosexual contact (32%) was the most commonly documented risk factor for HIV infection, followed by Injection Drug Use (IDU) at 20% and Men Having Sex with Men (MSM) at 19%. Sixteen percent of charts did not document risk factor.

The majority of clients had an HIV-positive, not AIDS diagnosis (59% of total) and 25% had a CDC-defined AIDS diagnosis. Disease status was not documented in 15% of charts. The largest proportion of clients were uninsured (41%), followed by Medicaid, Medicare, MADAP and private insurance. Slightly less than half of the clients resided in Baltimore City (47%) and 43% were from the surrounding counties.

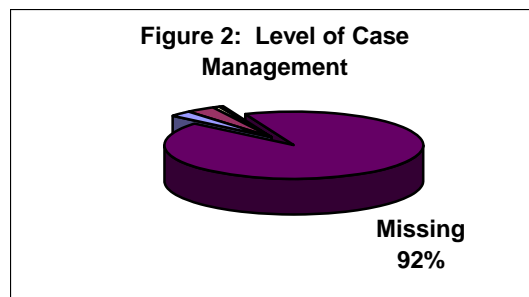


Client Chart Abstraction

Phase 1: Client identification is the beginning of the case management process. An agency is responsible for screening clients, verifying a client’s eligibility for Ryan White services, and assessing individuals in crisis to determine appropriate interventions. A significant majority (94%) of charts documented an initial screening and 91% included a crisis assessment. While a majority of charts contain an initial eligibility verification, a much smaller percentage of charts contain two eligibility checks as required by the Standards of Care [Figure 1].

Phase 2: During the intake phase, eligible clients receive information regarding case management services and are informed about client rights and agency policies. Based on their needs, clients are assigned a level of case management, which specifies expectations of frequency and type of case manager-client contact.

Most charts (89%) contained a completed intake and focused on addressing emergencies (91%) where applicable, but fewer charts documented referrals to primary care when needed (72%). Distribution of agency policies were present in approximately half of the reviewed records. Most charts (92%) did not document the level of case management required [Figure 2].

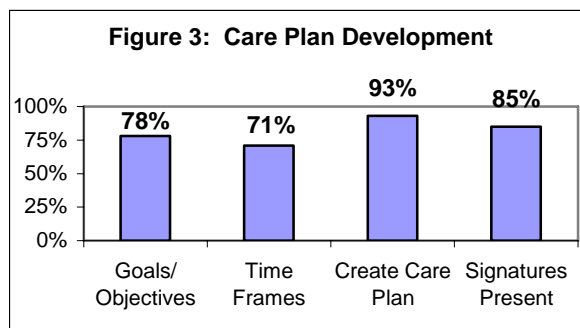


Phase 3: During this phase, the case manager conducts a psychosocial needs assessment to evaluate the client’s level of functioning, his/her needs, and any barriers to the client meeting these needs. The EMA Case Management Standard outlines specific topics to be included in the assessment.

CQM findings indicate that case managers consistently completed needs assessments. The majority of clients (86%) had a needs assessment completed, and 89% of these records documented that these needs were discussed with the clients. Although it is not currently required by the local Standards of Care, physical and sexual abuse histories were only documented in 7% of assessments.

Phase 4: Following the client’s intake and assessment, the case manager and client formulate an individualized plan of care. The plan consists of specific goals and objectives to meet the client’s previously identified needs, as well as time frames for the completion of these goals. The care plan must be signed by the client and case manager.

Over three-quarters (78%) of the reviewed charts contained goals and objectives. Of these charts, 71% also established time frames and 93% incorporated the goals and objectives into a formal written care plan. Most care plans (85%) were signed and dated by the client and case manager [Figure 3].

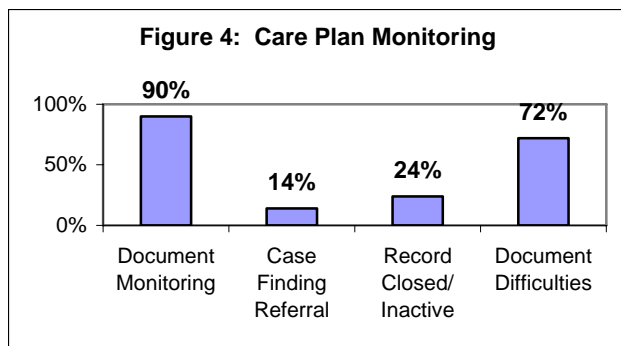


Phase 5: In addition to other responsibilities during this phase, the case manager is expected to connect the client to services at other agencies through referrals, and to document the outcomes of these referrals on the client's care plan and/or in progress notes.

Referrals and outcomes were consistently documented throughout the EMA. Eighty-eight percent of charts documented a referral and 88% of these charts also documented an outcome. Only 12% of reviewed records did not meet this standard.

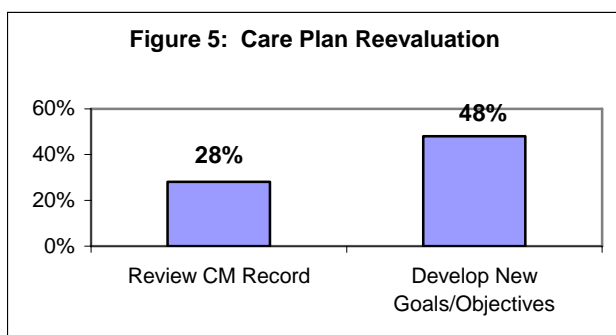
Phase 6: The case manager is required to monitor the implementation of the care plan through steady client contact and to document any difficulties faced during implementation. If the case manager cannot make contact with the client, the chart should be referred for case finding. If the client still cannot be located, the case manager should take specific actions to close the case management file.

Ninety percent of the reviewed records documented monitoring on a periodic basis. Only 14% of records were referred to case finding when the client could not be contacted and 24% of eligible charts were closed after 90 days without client contact. Almost three-quarters (72%) of charts documented difficulties in implementing the care plan [Figure 4].



Phase 7: A formal reassessment of the care plan is done a minimum of every six months to determine what progress has been made in achieving the care plan goals and to identify any new needs or problems. The client is involved in this process and in the formulation of any new goals.

Only records that had been open for longer than six months were considered for review. Of these charts, only 28% had a documented reevaluation of the case management record. Of the reevaluated charts in which the client's needs were determined to have changed, 48% contained the development of new goals and objectives based on the reassessment.



Agency Assessment

As part of the CQM process, case management agencies were asked to complete a survey on their policies and procedures. The purpose of the survey was to document the self-reported compliance with EMA standards for agencies providing case management services.

The agencies surveyed reported a high rate of compliance with the standards relating to staff licensing, knowledge, skills and experience. However, 19% of the agencies did not report compliance with the standard stating that their staff will have licenses to provide case management services.

All of the agencies reported having grievance, confidentiality and client rights policies, and all also reported asking clients for written consent. Most (94%) reported providing copies of their services and eligibility criteria to clients. Agencies reported similarly high rates of compliance for having written policies for eligibility, referral and linkage procedures, and timeframes and client contact. Lower rates were seen for assigning a 'level' of case management, referring to case finding and case closure.

Most agencies (88%) reported having a quality assurance plan and all reported having a process for clients to evaluate their agency. The majority of agencies (81%) reported having a consumer advisory board (CAB), 39% of agency CAB's met at least monthly, and 94% of agencies reported that their CABs were composed of agency clients.

Recommendations

The following section outlines some of the recommendations put forth by CQM to address the findings from the review process. For a comprehensive description of CQM's findings and recommendations, please refer to the case management EMA report.

The Baltimore EMA should develop strategies to reach out to the transgender community as it continues to be underrepresented in care. Possible strategies may include targeted literature, cultural competency training and focused outreach.

The Baltimore Planning Council should include an assessment for physical, sexual and emotional abuse in the next revision of case management standards.

Case managers should:

- Improve documentation of disease status. Currently, it is unclear when clients receive an AIDS diagnosis, in particular before the client's CD4 count drops below 200.
- Assist clients in attaining insurance coverage.
- Have case management clients sign acknowledgement of the receipt of agency policies.
- Assign a 'level' of case management services to the client at the time of intake. Proactively follow cases according to the level of case management assigned.
- Review care plans every 6 months, refer drop-outs to case findings after 60 days, and close records on clients with no contact for 90 days.

Agencies should:

- Ensure the proper licensure and certification of case managers providing care.
- Develop policies on assigning case management levels of care, referral to case finding, and procedures and timing for case closure.
- Maintain CAB sign in sheets and meeting minutes.

References

- 1 Greater Baltimore HIV Health Services Planning Council, *Standards of Care, Case Management*, revised October 2003, ratified November 2003.
- 2 For a detailed discussion of the findings presented in this fact-sheet, please refer to the Case Management EMA report. Please contact the CQM office at the number listed below to request a copy of the report.