

Ryan White Title I Case Management Record Review 2003

Prepared for the Miami-Dade County
Office of Strategic Business Management
Ryan White Title I Program

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Introduction

Case management continues to be an integral part of the Ryan White Title I program of care and treatment for people living with HIV and AIDS. Case management services were received by three-quarters of the more than 11,000 people served by Ryan White Title I in Miami-Dade County during the fiscal year beginning March 1, 2002 and ending February 28, 2003. This review includes the records of individuals who were enrolled with their provider agencies between May, 2002 and April 2003 and who received case management services in Ryan White Title I Year 13 or Year 14. Nineteen agencies providing case management services were reviewed.

The federal government requires accountability for service quality and outcomes. The government further expects that clients will be able to receive care of equal quality and appropriateness regardless of where it is received, with zero disparities and equal access. The Miami-Dade County Ryan White Title I program has developed a Performance Improvement Plan and program to address these requirements. Annual record reviews of case management services are a key element of that program.

This review is the second conducted with Title I case management providers and builds on the 2001 review. Comparison of results of this review with the 2001 review indicate improvement in every category, with the overall score increasing from 56 percent to 77 percent. Although the 2003 review was somewhat more comprehensive and detailed than the initial review, improvement is still clear.

The quality improvement activity undertaken since the 2001 review may have contributed to the increase in scores in the 2003 review. New, standard forms were introduced to assist in comprehensive assessment, care planning and documentation. Monthly case manager training sessions have addressed not only documentation and compliance issues but also supplemental topics of importance to case managers. Orientation for new case managers and training for case management supervisors has also been held. Surveys of case managers and of case management client satisfaction conducted in 2004 will provide additional direction in planning for improvement. A workgroup to address acuity levels of case management clients and the impact of that on case loads has been established and will study the issue and recommend improvements to efficiency and effectiveness.

Ryan White Title I Case Management

Case management functions include assessment and identification of needs, collaborating with clients to plan for services to meet those needs, and follow up to ensure that needs are met and services are received. It is the case manager's duty to initially assess eligibility for services and to help the client obtain appropriate services. Case managers are also responsible for developing a plan of care, providing follow-up, monitoring the client's progress and reassessing needs as situations change. They are in a position to ensure continuity of care regardless of the funding source for other services and to help the client utilize funding sources in the most cost efficient and effective way.

The System-wide Standards of Care, Case Management Standards of Care and Title I case management service description provide a complete overview of Ryan White Title I case management and the expectations of those providing the service. The standard elements of case management are made clear:

- Implement a comprehensive needs assessment of health, financial eligibility, and needs for support services, using a standard tool
- Develop and document an individualized care plan
- Coordinate services across funding streams
- Assist clients with obtaining services
- Use available funds and services in the most efficient and effective manner
- Help with adherence to the care plan through counseling
- Empower the client to remain as independent as possible
- Improve the service outcomes

The Review Process

Williams, Stern & Associates, the managers of the quality improvement program, conducted the review utilizing the services of external independent consultants. The 2003 review tool was an enhancement of the 2001 instrument and was developed with collaboration from case managers, supervisors, providers and the Care and Treatment Committee of the Miami-Dade HIV/AIDS Partnership. The review process was detailed in the September 5, 2003 letter from the Title I grantee.

The following procedure was used:

- Reviewers were selected and trained in use of the review instrument.
- Following general provider notification, individual providers were contacted by telephone to make arrangements for the visit and review. Effort was made to accommodate provider schedules.
- The list of charts to be reviewed was sent to the provider agency approximately five days prior to the scheduled review date, so that charts would be readily available for reviewers upon arrival.

- The review was conducted on site, usually over a period of two days. The reviewers initially asked the provider to orient them to the charts and go through one to help locate the required material.
- The review instrument was used uniformly at all Title I case management providers.
- The review covered the services provided and documented during the previous year of service.

Review Sample

Case management records were reviewed at 19 organizations: America Helping America, Care Resource, Center for Haitian Studies, Community Health of South Dade (CHI), Christ Crusaders, Community Case Management, Empower U, Economic Opportunity Family Health Center, Liberty City Health Service Center, Mercy Hospital, Miami Beach Community Health Center, M.O.V.E.R.S., North Dade Health Center, P.E.T. Center, South Florida AIDS Network (SFAN), South Shore Hospital, and Village South.

A total of 310 records were reviewed, a random sample of those who had at least one unit of case management billed in the Ryan White Title I Service Delivery System (SDIS) in Year 13 or 14. The number of records reviewed at each provider ranged from nine to 23 with fewer records being reviewed at providers with fewer clients and more records reviewed at providers with more clients. After the number of records to be reviewed at each provider site was determined, clients were randomly selected. Samples were adjusted to ensure representation for clients with many units of service, since there were many with very few units. This was done to obtain a more balanced sample for review. WSA provided the reviewers with lists of identification numbers for clients to be reviewed at each provider. Two lists were used to accommodate for records that could not be located or for other issues as they arose.

Scoring of the Questions

Table 1 shows a question by question breakdown of review items for all Ryan White Title I case management providers combined.

Not all questions are applicable to all clients. “Valid Records” is the number of charts to which that question or category applies. For example, the question “Is there a current (not > 6 months) financial assessment?” only applies to those clients who have been receiving services for more than six months.

“Percent” refers to the percentage of applicable, valid records in which the answer to the question is “Yes”.

The order of questions in the review tool has been changed for this report, to align with the categories of the 2001 record review report. General categories include Required Documents, Health Assessment, Financial Assessment, Other Assessments, Plan of Care, and Coordination and Monitoring of Services.

**Ryan White Title I
Case Management Record Review 2003
All Providers – Table 1**

	Number of Valid Records	Percent of Records with Item
Required Documents		
Is there proof client is a Miami-Dade County resident?	310	91%
Is there proof client is HIV+?	310	82%
Is there initial proof of financial eligibility?	310	76%
Is there current (not > 6 mos.) proof of financial eligibility?	262	37%
Is there evidence clients are assessed for 3rd party payers?	310	81%
Is a social security number present?	300	88%
Is there a picture ID?	310	91%
Is there a signed, dated confidentiality notice?	310	89%
Is there a signed, dated Rights and Responsibilities?	310	89%
Is there a signed, dated grievance procedure?	310	87%
Is there evidence of right to choose providers?	310	81%
Is there a signed, dated SDIS Consent to Release and Exchange Information?	310	91%
Are there copies of CD4 results?	310	81%
Are there copies of VL results?	310	74%
Score for Required Documents	310	81%
Health Assessment		
Does the assessment include current medications?	262	60%
Does the assessment include adherence to prescription drugs?	262	65%
Does the assessment include name of current PCP or referral to PCP?	283	83%
Does the assessment include adherence to PCP appointments?	283	80%
Does the assessment include HIV disease status?	290	86%
Score for Health Assessment	290	77%
Financial Assessment		
Is there an initial financial assessment?	310	95%
Does the assessment include current employment status?	301	91%
Does the assessment include income?	301	95%
Does the assessment include number in household?	301	86%
Does the assessment include percent of FPL?	301	78%
Is there a current (not > 6 mos.) financial assessment?	260	35%
Are all sections of the current financial screening completed?	106	65%
Score for Financial Assessment	310	78%

Other Assessments		
Is there assessment of the social support system?	290	92%
Is there assessment of the housing situation?	290	94%
Is there assessment of transmission and prevention knowledge?	290	86%
Is there assessment of psychosocial needs?	290	92%
Is there assessment of substance abuse?	290	89%
Score for Other Assessments	290	91%
Plan of Care		
Is there an initial plan of care (POC)?	310	92%
Is the initial POC signed and dated by both client and case manager?	287	79%
Is the POC based on needs identified in the assessment?	287	83%
Does the POC include clear goals or plans to address identified needs?	287	75%
Is there a current (not > 6 mos) POC?	269	58%
Score for Plan of Care	310	74%
Coordination and Monitoring of Services		
Is there a progress note that documents the initial assessment & POC?	287	69%
Do progress notes reflect counseling on medication adherence?	286	44%
Are progress notes dated?	287	97%
Are progress notes signed?	287	75%
Are progress notes legible?	287	97%
Is the service referred for included in the POC?	211	57%
Does referral include the service?	218	90%
Does referral include the service provider?	218	84%
Does referral include the referral date?	218	81%
Does referral include the duration of service?	218	20%
Does referral include the frequency of service?	218	14%
Is date of follow up noted?	196	19%
Is there documentation that follow up was done?	197	23%
Score for Coordination and Monitoring of Services	294	64%
Overall Score	310	77%

Table 2 compares the results of the 2001 and 2003 case management record reviews overall, by provider, and by category of documents within the record. Borinquen Health Care Center and Douglas Gardens CMHC were not reviewed in 2003, as they did not deliver Ryan White Title I services during the review period, fiscal year 2002-2003. Therefore their 2001 results are noted but there are no results for 2003. Also, Christ Crusaders, Empower U and The Village South have 2003 results but none for 2001, as they did not deliver Ryan White Title I case management services in 2001.

Table 2 Percentage of Records Containing the Information

Provider	Required Documents		Health Assessment		Financial Assessment		Assessment of Other		Plan of Care		Coordination of Services		Overall Score	
	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003
America Helping America	42	75	45	91	29	71		100	5	94	57	68	36	83
Borinquen Health Care Center	54		12		78				6		51		40	
Care Resource	86	94	62	65	40	85		93	30	90	34	60	50	81
Center for Haitian Studies	43	60	25	61	14	88		68	4	25	20	38	21	57
CHI	70	86	47	71	34	79		98	21	85	35	67	42	81
Christ Crusaders		74		72		86		88		49		58		71
Community Case Management	68	81	31	97	31	69		88	31	78	23	79	37	82
Douglas Gardens CMHC	95		78		88				89		96		89	
Empower U		82		71		68		100		91		49		77
EOFHC	77	81	96	94	57	76		100	85	86	60	64	75	83
Liberty City	71	77	24	98	31	60		100	25	62	28	58	36	76
Mercy Hospital	92	86	60	83	93	86		100	42	78	61	68	69	84
Miami Beach CHC	79	93	80	82	60	90		100	40	76	73	65	66	84
M.O.V.E.R.S.	71	79	27	47	22	53		79	25	87	27	87	34	72
North Dade Health Center	93	80	93	69	50	73		78	48	55	73	59	72	69
PET Center	94	92	100	54	86	80		73	97	82	88	81	93	77
SFAN	96	76	47	86	36	88		95	45	74	65	63	58	81
South Shore Hospital	96	80	93	97	69	94		97	52	66	78	68	77	84
The Village South		87		61		72		87		78		56		74
All Providers	77	81	57	77	51	78		91	40	74	54	64	56	77

Conclusions

Seventeen of the providers increased their individual overall score from 2001 to 2003. The average overall score for all providers increased from 56 percent to 77 percent. Scores for all providers increased in each of the six categories as well. A summary comparing year to year overall scores is in the following chart.

Case management agencies are to be commended for the improvements in case management documentation over the past two years. Providers increased their scores by an average of 15 percentage points, and seven providers increased their scores by more than 30 percentage points.

In the category of Required Documents, nine of the 14 providers with comparative data showed an increase in percentage of records with the required documents. This category refers to such items as proof of residency, of financial eligibility, and documents such as grievance procedures, confidentiality notices and rights and responsibilities forms. Although overall scores are high in this category, this is an area of compliance with legal, regulatory and procedural mandates that requires near perfect documentation. The overall score for all providers of 81 percent in that category leaves significant room for improvement.

Scores in the Health Assessment and Financial Assessment categories do not equal the very high scores in the category of Other Assessment. It is possible that assessment of housing, psychosocial and substance abuse needs might be driven by the desire to make referrals within one's agency, or that these assessments may be easier to complete than the financial and health assessments. An appropriate goal may be to bring the scores for health and financial assessments up to the 91 percent of the "Other" assessment category.

Areas continuing to score lower and to indicate opportunities for improvement include Coordination of Services and Plan of Care. The category of coordination and monitoring of services includes such activities as progress notes, referrals and follow-up on referrals. Within that category, several key issues emerge overall. Only 44 percent of the records overall have progress notes that reflect counseling on medication adherence. Duration and frequency of the service are rarely noted on referrals (20 percent and 14 percent, respectively). Documentation of follow-up is only noted in 23% of the files. These areas will require further study and increased attention.

As outlined in the Miami-Dade County Ryan White Title I Performance Improvement Plan, the results of this review will be discussed with providers and the County in a meeting of the Performance Improvement Advisory Team. Recommendations will be made collaboratively for action plans to address system-wide or agency specific improvements. In addition, agencies will have the opportunity to discuss results individually with the Miami-Dade County Office of Strategic Business Management and to request technical assistance. Future reviews will build upon these to continue tracking the progress of case management providers.

This report was reviewed and discussed during the May 21, 2004 meeting of the Performance Improvement Advisory Team. All of the case management providers were asked to attend that meeting. The following summarizes the recommendations that emerged from the meeting.

Case Management Systems Issues

- Case management training should reinforce the requirement to update financial eligibility documentation at least every six months, and more frequently if there is a major change.
- Providers should address the need for improvement in updating financial assessments, plans of care and proof of financial eligibility every six months.
- Providers should address the need for improvement in documenting progress notes, referrals and follow-up of services.
- Electronic versions of progress notes should be validated by a signature either stamped electronically or placed on a signature page in the chart, referring to the electronic progress notes.
- SDIS should be adjusted to print only what is relevant to changes in eligibility documentation, not the entire eligibility section.
- Further assessment may be required on the issue of selection of the survey sample and provider tracking of current and former clients. Charts are chosen for review based on the agency having billed for case management for that client during the time period being reviewed. In discussing the record review process, providers claimed that some charts requested were those of individuals who are not clients of that agency.

Record Review Issues

- A formal step in the record review protocol should be to have the provider “walk through” a chart with the reviewer at the beginning of the review, so that agency differences in file format and procedure will not interfere with the review.
- A distinction will be made in future reviews between referrals for specialty medical care for those for support services. Only referrals for support services will require duration and frequency of services to be noted.
- Future reviews should address the documentation of client signatures acknowledging the receipt of services.

Next Steps

- A goal should be set to achieve an overall average of 85% for all areas of the 2004 case management record review except for the Required Documents for medical eligibility, financial eligibility and proof of residency. The goal for these areas should be 100%.
- Lower scoring agencies should be referred to the Miami-Dade County Office of Strategic Business Management (OSBM) for assistance in developing action plans to increase compliance to documentation standards. The Performance Improvement Advisory Team may provide further assessment or assistance as requested by OSBM.
- Case management providers who have shown improvement in review scores from 2001 to 2003 should be recognized publicly, with special recognition for newer providers who have achieved dramatic improvements.

Year to Year Comparison

