Moving Beyond Widgets: Measuring for Outcomes in Social Services

The AIDS Foundation of Chicago Experience

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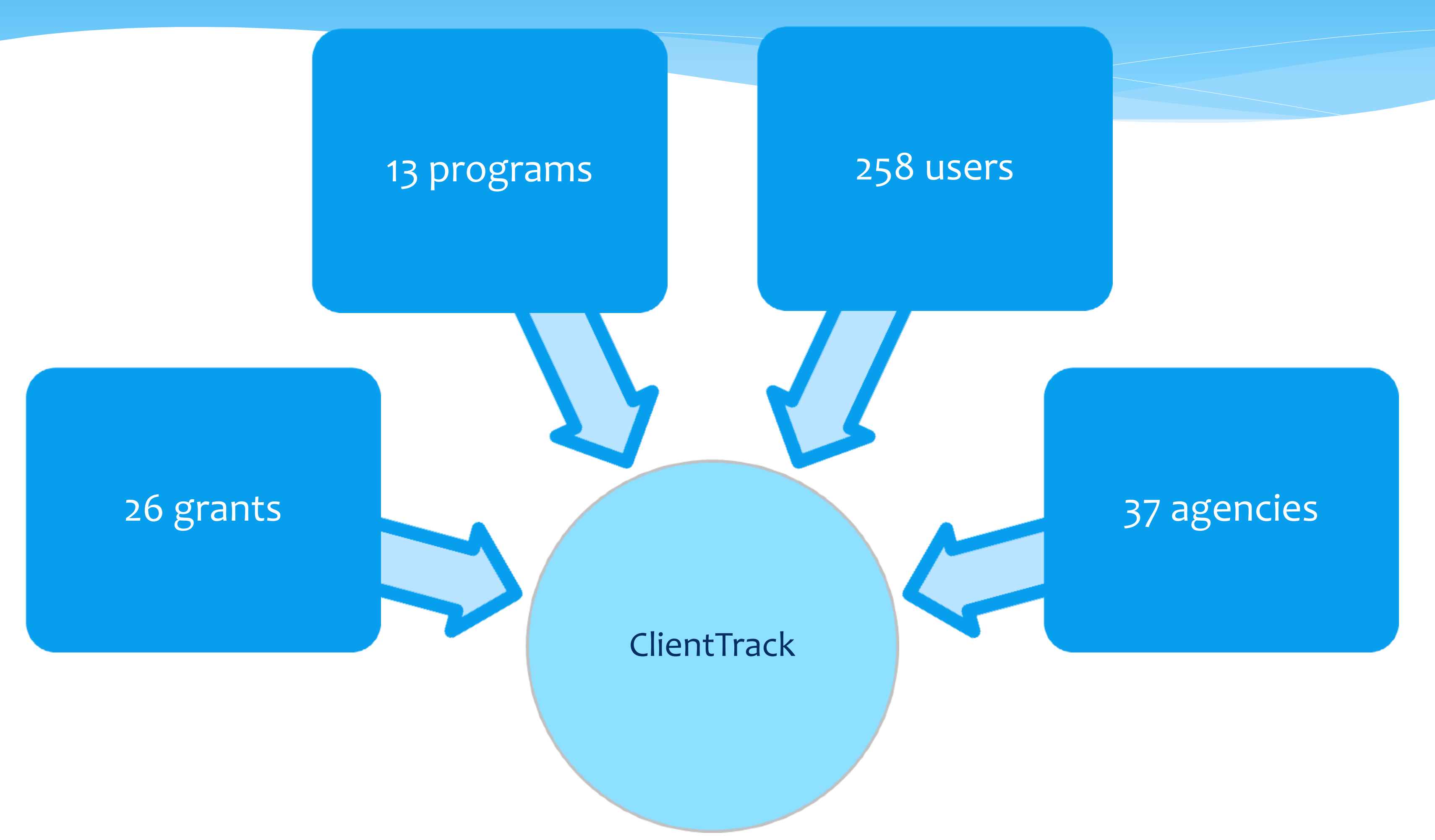
ClientTrack: Multiple Partners and Users



ClientTrack: Multiple Partners and Users

13 programs

258 users

26 grants

gencies

- Case Management for HIV+ Pregnant Women (PACPI)
- Case Management for people leaving correctional facilities
- Case Management for those needing rehabilitative services (DRS)
- CM for those needing assistance maintaining medical care (RW Medical)
- CM providing assistance with social service needs (RW Supportive)
- CM and Housing for chronically ill homeless persons (SHP)
- SAMSHA mental health and substance use services
- Long term housing assistance
- Short term/emergency financial assistance
- Part B non-CM services
- Housing outreach services
- Peer-based services
- Housing advocacy

ClientTrack: Multiple Partners and Users

26 grants

State Grants
- Corrections
- PACPI
- DRS
- Supportive Services (IDHS)
- 100,000 Homes Campaign (DFSS)

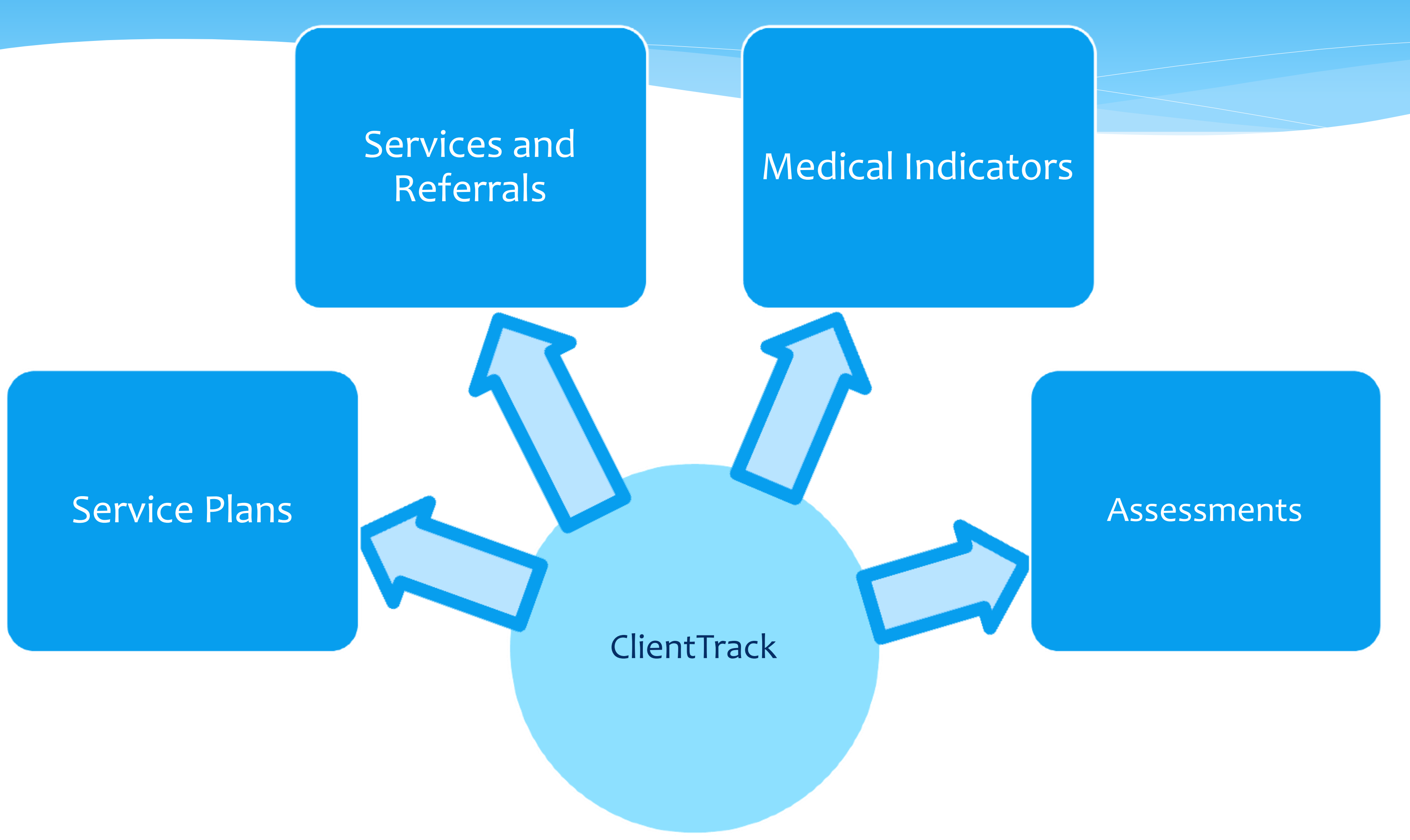
Federal Grants
- Safe Start I (HUD)
- Samaritan Supportive Housing Program (HUD)
- Chronic Homeless Initiative (HUD)
- Chicago Housing for Health Partnership (HOPWA-SPNS)
- Renaissance Care Network (HOPWA-SPNS)
- Re-entry for Housing and Health Partnership (HOPWA-SPNS)
- Medicaid Supportive Housing (HUD)
- Healthy Connections (SAMHSA)
- Access to Wellness (SAMHSA)

Private Grants
- Homelessness Prevention Funds (Emergency Fund)

State Pass Through of Federal Grants
- Part B Cook
- Part B Collar
- IDPH HOPWA

City Pass Through of Federal Grants
- Part A Medical CM
- Part A Supportive CM
- Part A Emergency Assistance
- Part A Transportation
- Part A Early Intervention Services
- Part A Housing Assistance
- HOPWA Formula (CDPH Pass through)
- Housing, Health, and Independent Living (HOPWA-SPNS, CDPH)

ClientTrack: Capturing Service Encounter and Outcomes Data



Example

Tracking Client Care

11/28
- Initial referral
- Newly diagnosed
- Assigned to agency same day

11/29
- Call setting initial intake

12/7
- Intake
- Set goals to obtain medical care and ADAP
- CM calls clinic on client's behalf to schedule first appointment

12/16
- CM receives medical form verifying appointment and medical information

2/2
- Follow-up call from CM
- Client reports taking HIV medications

This is a real example from one of our clients flowing through care.
For most of our clients this flow is more complex with multiple issues being addressed.

Tracking Care at a System Level

System level uses of data

- Understand how case management is being implemented
- Able to measure how system is comparing to standards of care
- Estimate impacts of policy or procedure changes
- Estimate eligible population for new services
- Easier and more in-depth reporting

Most Frequently Discussed Topics

- Health (80% of 2167 clients)
- Emotional Support (56%)
- Medication Adherence (53%)
- Mental Health (44%)
- Benefits Maintenance (42%)

Most Frequent Goals

- Improve adherence to medical appointments (25% of 986 clients)
- Improve adherence to medications (24%)
- Obtain dental care (21%)
- Maintain ADAP assistance (16%)
- Participate in Individual Counseling (14%)

Most Frequent Referrals

- Oral Health (21% of 533 clients)
- Housing (15%)
- Food (13%)
- Medication Assistance (13%)
- Eye Doctor (12%)

Data from July-December 2011

Example

Quality Improvement

* Medical Case Manager Standards
  * Developed from best practices, consultation with key informants
  * Based on a one year period, most standards require two instances within the year
    * Case Management Face-to-Face Visits (CM V)
    * Medical Visits (Med V)
    * Case Management Assessments (CM AS)
    * Care Plan Development and Update (CARE P)
    * Care Plan Has Medical Goal (MED G)
    * Adherence Counseling Provided (ADHER)
    * Communication between Primary Care Provider and Case Manager (PCP C)

Example

Quality Improvement

Case Manager Tools : To Do List

Client Name	Begin Date	Program	Intake	Need Re-Assess	Last Face 2Face	Medical Form	Last ISP Goal
Ouchy, Big	11/28/2011	Hospital to Housing (AFC)	Complete	Not Needed	<=6 months	None	<=6 months
Rubble, Barney	09/30/2010	RW Medical Case Management	Complete	Needed	6-12 months	Up To Date	None
Test, Beater	08/01/2010	RW Medical Case Management	Not Complete	Needed	None	None	None
Testalot, Testy	07/30/2010	Pediatric AIDS Chicago Prevention Initiative	Complete	Needed	None	None	None
Test, Leslie	07/29/2010	Hospital to Housing (AFC)	Complete	Needed	<=6 months	Need New	None

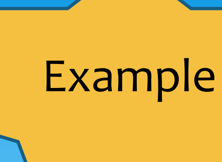
Case Manager Tools : Indicators Check List

NORTHEASTERN ILLINOIS HIV/AIDS CASE MANAGEMENT COOPERATIVE

MEDICAL CASE MANAGEMENT PERFORMANCE MEASURES

Report End Date: 2/22/2012 Print Date: 02/22/12

Case Manager	Client	CM V	MED V	CM AS	CARE P	MED G	ADHER	PCP C
Keri L. Rainsberger	Ouchy, Big	No	No	No	No	No	No	No
Keri L. Rainsberger	Rubble, Barney	No	No	No	No	No	No	No



Agency Indicator Review

Total Number of Clients Enrolled at least 6 months:	29	
This number is used as the denominator for all percentages below.		
Data from enrollments.		
A.3 Case Management Visits	24	82.76%
Clients should have two or more face to face visits with their case manager, at least 90 days apart.		
Data from service entry.		
A.8 Medical Visits	22	75.86%
Clients should have two or more medical visits, at least 90 days apart.		
Data from medical eligiblity form.		
B.1 Client Assessment	17	58.62%
Clients should have an updated assessment two or more times, at least 90 days apart.		
Data from assessment entry.		
C.1 Care Plan	12	41.38%
Clients should have a care plan developed and updated two or more times, at least 90 days apart.		
Data from service plan goals (started 6/2011).		
C.3 Service Plan Goal	27	93.10%
Clients should have at least one goal related to medical care.		
Data from service plan goals (started 6/2011).		
D.2 Adherence Counseling/Support	21	72.41%
Clients should have two or more adherence counseling discussions, at least 90 days apart.		
Data from case management topics.		
E.2 PCP Communication	17	58.62%
Client's chart should document communication between CM and PCP two or more times, at least 90 days apart.		
Data from medical eligibility form.		
HRSA Demographics	29	100.00%
Client chart should document required demographic elements (Name, birthdate, gender, ethnicity, race, housing arrangement, zip code, household size, income, HIV/AIDS Status, AIDS diagnosis year, risk factor, and insurance source).		
Data from assessments.		

Example

Quality Improvement

* **System Indicator Review (used by agencies and AFC)**

NORTHEASTERN ILLINOIS HIV/AIDS CASE MANAGEMENT COOPERATIVE
MEDICAL CASE MANAGEMENT PERFORMANCE MEASURES

System Totals for All Agencies

Print Date: 2/22/2012 Report End Date: 2/22/2012

Total Number of Clients Enrolled at least 6 months: 919

Measure	Count	Percent
A.3 Case Management Visits	610	66.38%
A.8 Medical Visits	242	26.33%
B.1 Client Assessment	349	37.98%
C.1 Care Plan	62	6.75%
C.3 Service Plan Goal	441	47.99%
D.2 Adherence Counseling/Support	416	45.27%
E.2 PCP Communication	222	24.16%
HRSA Demographics	842	91.62%

Example

Quality Improvement

AFC Program Coordinator indicator review

RW MCM Part A Clients enrolled at least 6 months in the 12 month period ending the first day of the listed month

2 CM Visits 90 days apart

Agency	Trend	January	February
Agency 1		50.0%	30.0%
Agency 2		88.1%	83.3%
Agency 3		40.0%	66.7%
Agency 4		73.8%	62.9%
Agency 5		61.1%	55.6%
Agency 6		76.1%	78.7%
Agency 7		45.7%	44.3%
Agency 12		78.9%	60.9%
Agency 13		81.7%	86.4%
Agency 14		44.4%	55.6%
Agency 15		40.0%	38.9%
Agency 16		54.1%	56.4%
Agency 17		54.5%	50.0%
Agency 18		34.2%	36.8%
Agency 19		76.7%	77.8%
Agency 20		75.0%	85.7%
Agency 21		44.0%	45.5%
Average		**58.7%**	**58.2%**

Legend	
(pink)	1 standard deviation below average
(green)	1 standard deviation above average

AFC's Visions for Future Development: Robust quality improvement process

* Automated chart audits
  * Implemented first stage this round
  * Allows review of 100% of charts virtually
  * Will be made available to agencies to do their own interim reviews
* Quality Management Reports
  * Medical Case Management standards established
  * Reports for users at multiple levels (case managers, agency supervisors, AFC program coordinators)

Moving Toward Data Integration

* Service data is entered and reported to multiple databases
* Integration includes both the physical sharing of the data but also policies governing the sharing
* ClientTrack as a "data warehouse"

Export From ClientTrack

(Currently Done)

Import Into ClientTrack

(Current Goal)

HMIS

HRSA

Provide

VCM

SAMSHA

AFC's Visions for Future Development: Data coordination

* Opportunities abound for additional data coordination
* Shared definitions and standards important
* Client confidentiality in an era of increased data sharing

AFC's Visions for Future Development: Greater data analysis capabilities

- Assessing for outcomes
  - Clients assessed every 6 months
  - Researcher analyzing questions to see what outcomes we might be able to pull from this data
- Analyzing processes
  - Where do clients hit snags in receiving needed services
  - Is data being entered correctly
- Challenges of working with administrative data
  - Geared to users not researchers
  - Multiple sources of entry
  - Retrospective
  - In the "wild" rather than a laboratory

Challenges and lessons learned

* The "Rich Silo" effect
  * Non-cooperation and gamesmanship between data sources creates detailed data that is still not shared
* Quality data requires culture change
  * Requires a whole process outlook
* Balancing privacy and confidentiality with increasing capabilities
  * Consider the need to know and usefulness before collecting data
  * Ensuring client consents and education keep up with sharing capacity
* Standardization
  * Data can require a significant amount of recoding to be shared across databases
  * Ensuring programs are being integrated in a consistent way across providers
  * Deduplication