A QI Action Plan to Improve Medical Case Management

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Background

The Medical Case Management Program (MCM) Partnership for Care Program and Living Together Program/ Family Services of Westchester (FSW) were concerned that clients were not utilizing all services available to them that could help them maintain their treatment goals, including regular medical care. In particular, it was thought that clients were not fully accessing the services within the Partnership For Care Program, possibly because transitional staff were not informing clients of their options, or because clients were not aware of how to access these services.

To examine this idea further, the Medical Case Management and Living Together Program began a project to improve the usefulness and quality of the reassessment packet in expectation that it would increase client/coordinator discussion of available services.

Project Aim

To better address client needs and to improve the effectiveness of the Medical Case Management program, FSW will be using and applying the methods and techniques of quality management to increase client utilization of the services that will help them meet and maintain their treatment goals.

By December 2017, we expect to see an increase of at least 33% in the volume of services that are being accessed by existing FSW clients.

MCM Action Plan

FSW MEDICAL CASE MANAGEMENT 2017 QI ACTION PLAN TO IMPROVE UTILIZATION			
ACTIVITIES	STAFF	MEASURES	TIMEFRAME
Examine Current Practices	PFC Director	Informational	Ongoing, 2017
Review Service Plans with Clients	MCM Staff	Services Utilized	March, 2017
Clarify Role and Goals with Case Managers	MCM supervisor	Training review	Summer, 2017
Conduct Survey with Living Together	MCM staff	Survey Responses	April-May, 2017
Discuss and review PCSM with clients	MCM staff	N/A	Ongoing, 2017
Implement New Reassessment Template	MCM supervisor and staff	Utilization	Ongoing, 2017
Mailings to	Admin and MCM staff	Utilization	Autumn, 2017
Annual Services Review	PFC Director, MCM staff	1.eSHARE data entry 2.Chart review of notes and service plans	December, 2017

Activities

Our QI team developed a quality management workplan to help us stay on track to complete the steps in this project. Because of the co-location of Living Together at FSW, we worked with them as well.

The project began with FSW staff speaking with patients and then conducting a chart review in March 2017. Staff found that at least 50% of the charts did not contain updated medical information. There was concern that clients were not working optimally with case managers, who should be assisting them with their care needs.

While many clients with HIV may be involved with multiple agencies and receiving several services, they may not always be clear on the role of the case manager, or aware of the ways the MCM program can assist them. We decided to survey our clients to get a projection of their utilization and extent of participation with the FSW MCM program.

To examine this idea further, the Medical Case Management program also began a project to improve the usefulness of the reassessment packet, in expectation that it would increase client/coordinator utilization of services.

We anticipate that by implementing a new Reassessment template, both the clients and coordinators will be able to integrate any requests for service information to help clients address their needs and any challenges. This collaboration should promote identification of clinical and service needs, allowing the MCM to make appropriate follow-ups. It will continue to be important to review utilization after this implementation.

Results/Next Steps

In the beginning of this project, we found that clients were often not fully utilizing the services provided to them within the Partnership for Care Program at FSW. The ongoing efforts we have been making in the MCM program led to these results and next steps.

- ❑ Follow-up with clients on weekly basis to inform them of the kinds of services available to them. Check-in to see if any there have been any changes in their circumstances/lifestyle that could impact their needs.
- ❑ Sending out material to clients with specific information on ways to maintain better health care
- ❑ Implementing a new reassessment template and optimizing the six month reassessment session allows staff to assist clients and their families with knowledge about available services. It also allows MCM coordinators and clients to collaboratively address all service needs.