Texas HIV Case Management Standards

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Texas DSHS HIV Case Management Standards

Acknowledgments

The Texas DSHS HIV Program would like to express our gratitude to everybody around the state who contributed to the creation of these Standards – without input from our stake holders, we would never be able to create effective, comprehensive Standards that allow us to meet the needs of our clients. In addition, we'd like to acknowledge the following groups/programs:

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Intent

This document establishes universal core standards for HIV case management services funded by the Texas Department of State Health Services (DSHS) HIV Program. The standards set a minimum service level for programs providing HIV case management regardless of setting, size, or target population.

Universal core case management standards have been developed to:

- Promote quality of case management services
- Clearly define case management and describe levels of case management service
- Clarify service expectations and required documentation across HIV programs providing case management
- Simplify and streamline the case management process
- Encourage more efficient use of resources

The overall intent of the *Texas HIV Case Management Standards of Care* is to assist providers of case management services in understanding their case management responsibilities and to promote cooperation and coordination of case management efforts. These standards are solely about case management services and do not provide standards for other Ryan White services. For other service standards, please see the *Texas HIV and STD Program Operating Procedures and Standards Manual* (http://www.dshs.state.tx.us/hivstd/pops/).

As the numbers of Texans living with HIV increase and as efforts to engage individuals who are not enrolled in care into medical care escalate, the current systems of case management, many of which are operating above ideal capacity, are no longer sustainable without expanding their capacities. This current revision of case management standards is intended to develop new systems of case management in which clients are enrolled based on a defined need for the service. Additionally, a new system is envisioned which acknowledges that not all HIV infected individuals will require case management and that sustainability relies on promoting self-management for those clients who are able.

Although these standards set minimum requirements for Texas DSHS HIV program funded case management programs, Administrative Agencies and local agencies as approved through their Administrative Agency, may establish additional requirements or modify the standards to fit particular settings, objectives, and target populations.

Texas DSHS HIV Program Models of Case Management

Case Management

Case management is a multi-step process to ensure timely access to and coordination of medical and psychosocial services for a person living with HIV. Medical and non-medical case management are not the provision of one-time services and are not gate-keeping or brokerage mechanisms for providing necessary resources. Medical and non-medical case management are distinct service categories on their own, and the role of these services is to link clients with multiple needs to a continuum of health and social service systems. Case managers, through the mechanisms of advocacy, assistance and education, support the client in accessing community resources to meet identified needs and reduce barriers to care. Clients who do not need ongoing assistance with managing and maintaining their medical care do not need to be case managed if they are self-sufficient (e.g. only require insurance co-payments. oral health care referrals or other vouchers); rather, their ongoing independence should be praised and encouraged. As the client gains self-efficacy, the involvement of their case manager should decrease.

The doorway of case management should not be the only entry point to other services, since clients can be engaged in the system in an array of ways. Clients must be able to access medical care or other services through many different avenues. Regional or agency-based policies and practices should be constructed to help a client continue to receive ongoing support that does not require case management. Staff who provide case management services (both medical and non-medical) may also provide other services to clients not receiving/needing case management services (e.g. one time services such as food pantry or other vouchers; occasional services such as insurance co-payments).

Case management systems must have clearly defined outcomes which can be monitored for the purpose of ensuring accountability. Viewing case management as a service driven by client need allows for the development of standard outcomes based on the elements of those needs. The expectations for both providers and clients must be clearly stated and followed. This will strengthen the delivery of service across the state as well as increase the quality and consistency of service delivery by creating accountability measures for the system, the client, the case manager and the case management supervisor.

The goal of case management is to promote and support independence and self-sufficiency. As such, the case management process requires the consent and active participation of the client in decision-making, and supports a client's right to privacy, confidentiality, self-determination, dignity and respect, nondiscrimination, compassionate non-judgmental care, a culturally competent provider, and quality case management services.

The intended outcomes of HIV case management for persons living with HIV include:

- Early access to and maintenance of comprehensive health care and social services;
- Improved integration of services provided across a variety of settings;
- Enhanced continuity of care;
- Successful adherence to agreed upon medical treatment goals;
- Prevention of disease transmission and delay of HIV progression;
- Increased knowledge of HIV disease;
- Greater participation in and optimal use of the health and social service system;
- Reinforcement of positive health behaviors;
- Personal empowerment;
- An improved quality of life.

Key activities of HIV case management include:

- Initial assessment of service needs;
- Development of a comprehensive, individualized care plan;

- Coordination of services required to implement the plan;
- Client monitoring to assess the efficacy of the plan; and
- Periodic re-evaluation and adaptation of the plan as necessary over the client's enrollment in case management services.

Case Management Service Categories

Recognizing changes occurring in the HIV epidemic and in the needs of persons living with HIV, the Texas DSHS HIV Program currently funds two categories of case management service: **Medical Case Management** and **Non-Medical Case Management**.

Medical Case Management (MCM)

HRSA HIV/AIDS Bureau: Medical Case management services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan at least every 6 months, as necessary while the client is enrolled in case management. It includes client-specific advocacy and/or review of utilization of services.

Medical Case Management (MCM) is a proactive case management category intended to serve persons living with HIV with multiple complex health-related needs that focuses on maintaining HIV infected persons in systems of primary medical care to improve HIV-related health outcomes. MCM is designed to serve individuals who have complex medical needs and may require a longer time investment, and who agree to this level of case management service provision.

Medical Case Managers act as part of a multidisciplinary medical care team, with a specific role of assisting clients in following their medical treatment plan and assisting in the coordination and follow-up of the client's medical care between multiple providers (if necessary). The Medical Case Manager could be one of many access points to medical care and should not serve as a gatekeeper. The goals of this service are 1) the development of knowledge and skills that allow clients to adhere to the medical treatment plan without the support and assistance of the Medical Case Manager and 2) to address needs for concrete services such as health care, entitlements, housing, and nutrition, as well as develop the relationship necessary to assist the client in addressing other issues including substance use, mental health, and domestic violence in the context of their family/close support system.

Non-Medical Case Management (N-MCM)

HRSA HIV/AIDS Bureau: Non-Medical Case Management includes advice and assistance in obtaining medical, social, community, legal, financial and other needed services. Non-Medical Case Management does not involve coordination and follow-up medical treatments, as Medical Case Management does.

The Non-Medical Case Management (N-MCM) model is responsive to the immediate needs of a person living with HIV and includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, entitlements, housing and other needed services. N-MCM is suitable for persons with discrete needs that can be addressed in the short term, or for people who have on-going psychosocial needs that impact their ability to access and maintain medical care. Non-Medical Case Management is also an appropriate service for clients who have been discharged from Medical Case Management services due to fulfilling all goals of their care plan, but still require a maintenance level of periodic support from a case

manager or case management team. N-MCM does not involve coordination and follow-up of medical treatments.

Central to the N-MCM model is follow-up by the case manager or team to ensure that arranged services have been received and to determine whether more services are needed. The goal of N-MCM is to meet the immediate health and psychosocial needs of the client at their level of readiness in order to restore or sustain client stability, and/or to establish a supportive relationship that can lead to enrollment in MCM services, if needed. Non-Medical Case Management can be long-term or brief.

Case Management Levels of Contact

Case Management levels of contact (frequency of case manager initiated required contact with the client) should only be determined once a client has been assigned to one of the above categories (MCM, N-MCM). See Polices and Procedures Requirements for all Case Management Programs (Guidance for Policy Development in Specific Service Areas, Section A: Case Management, Point 5 Client Contacts – pp. 14) and Case Management Level and Client Contact (pp. 26) for more guidance.

POLICIES AND PROCEDURES (P&P) REQUIREMENTS FOR ALL CASE MANAGEMENT PROGRAMS

Each agency providing case management services must establish written policies and procedures specific to each of the services they provide. In addition general agency operation policies must be established and documented. The Policies and Procedures manual should be reviewed on an annual basis and updated as indicated.

DEFINITIONS

Standard: an established norm or requirement. It is usually a formal document that establishes uniform criteria, methods, processes and practices.

Standard of Care: established norms or requirements that direct service providers to adhere to industry standards of practice.

> *Interpretation*: The standard of care for HIV case management in Texas is outlined in the "Texas HIV Case Management Standards of Care" available online at http://www.dshs.state.tx.us/hivstd/contractor/hivmedical.shtm.

Policy: a high-level overall plan embracing the general goals and acceptable procedures especially of a governmental body.

> *Interpretation:* A policy outlines the general practice for a particular area of service that will direct how an agency will meet the established standard of care. Policies should be established at a minimum for each service area and for general agency activities that contribute to the successful provision of service.

Procedure: a specified series of actions, acts or operations which have to be executed in the same manner in order to consistently obtain the same result under typical circumstances. To a lesser extent, this term can indicate a *sequence* of activities, tasks, steps, decisions, calculations and processes, that when undertaken in the sequence indicated produces the described result, product or outcome.

> *Interpretation:* Procedures should exist for each policy that directs staff members on how to specifically complete a task in order to establish a standardized and equitable level of service for all clients.

MINIMUM REQUIREMENTS FOR ESTABLISHING POLICIES AND PROCEDURES (P&Ps)

All policies and procedures should be reviewed, updated, and approved on an annual basis (or as circumstances dictate). These dates, as well as the original effective date, should be on the written policy along with the supervisory staff position responsible for monitoring compliance with the policy. Each of the policies should include a description of appropriate documentation, eligibility criteria for recipients and limitations or established caps on services (if applicable).

For each of the guidelines, a description and instructions are provided.

Description: a brief explanation of what the policy should outline

Instructions: guidelines for drafting the policy and procedures and what needs to be included.

Each grantee agency should establish policies, as they are applicable to the grantee agency, for the following areas.

Service Eligibility and Enrollment Procedures

Description: eligibility requirements and enrollment procedures for case management and all other services (i.e. income restriction, county residency) with the purpose of equitably appropriating care for eligible individuals.

Instructions: Written P & Ps for Service Eligibility and Enrollment Procedures should cover:

- How to determine program eligibility:
  - Requirements
    - HIV status
    - HIV disease stage
    - Demographics, such as--but not limited to:
      - Residency
      - Age
      - Income
  - Eligibility screening:
    - Process
    - Required documentation
    - Forms
    - Approval/Denial of client services
      - Responsible staff
      - Client notification
        - Method
        - Time frame
      - Client referrals (denial)
        - Responsible staff
        - Follow-up
        - Forms
        - Documentation
  - Wait list protocol
- How to complete a client intake.
  - Time frame for completion of client intake (post-eligibility screening)
  - Responsible staff
  - Initial intake assessment and acuity screening
  - Required documentation:
    - Agreement to become a client
    - Review of client's rights
    - Proof of P & P reviews:
      - Client Confidentiality
      - Grievances
    - Releases of Information (ROIs)

- ▪ Receipt/Review of agency client handbook
- ▪ Emergency contact(s)
- ▪ Review of eligible services (e.g., food pantry, financial assistance, health insurance assistance)
  - o Provision of interpretation/translation services to non-English speaking clients
  - o Client assignment
    - ▪ Process for assigning clients to CM provider
    - ▪ Responsible staff
    - ▪ Time frame from intake into services
  - o Initial care plan (for clients receiving case management services)

Crisis Intervention
Description: protocol for addressing client crises during business, as well as nonworking hours, as it relates to mental health, substance abuse, or other emergency issues.

Instructions: Written P & Ps for *Crisis Intervention* should cover:
- • Dealing with suicidal/homicidal clients, including assessment and referral.
- • Handling workplace violence, including notification of responsible (departmental and/or administrative) parties in case of emergent situations.
- • Plan for staff training and development regarding crisis intervention strategies
- • Staffing to cover non-working hours to ensure availability for client crisis interventions
  - o 'Staffing' can include ensuring that contact information for referrals for mental health crises, medical emergencies, etc. is available on agency voicemail

Documentation
Description: procedures for establishing client case records and recording on-going activities (i.e. assessment, reassessment, service provision, problem logs).

Instructions: Written policies and procedures (P & Ps) for *Documentation* should cover:

- • Supervisory review and signature verification of client records (e.g. assessment forms, reassessments, case closures) and their proper documentation (i.e. paper and/or electronic files).
- • Client record format, order (within the record), retention, security, and proper disposal.*

*The case management record retention policy must adhere to the Texas Department of State Health Services (DSHS) rules of record retention and disposal: http://www.dshs.state.tx.us/hivstd/retention/default.shtm

Client Confidentiality
Description: policy detailing compliance with confidentiality guidelines per the Texas Health and Safety Code, Title 2, Subtitle D, Chapter 85, subchapter A, section 85.115 (http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.85.htm) and the federal HIPAA privacy rule (if applicable).

Instructions: Written P & Ps for *Client Confidentiality* should cover:
- • Disclosure of client information
  - o Voluntary
  - o Involuntary (mandatory reporting)
- • Release of information
  - o Medical
  - o Non-medical
  - o Designate ARIES status: shared or non-shared client
  - o Verbal vs. Written
- • Breach of Confidentiality (reference the Bureau of HIV/STD Prevention Global Policies Affecting All Programs (policy numbers 303.001-03) for additional information: http://www.dshs.state.tx.us/hivstd/policy/policies.shtm
  - o Definition of "breach"
    - ▪ Confidentiality

- Protocol
    - Reporting
        - Responsible staff
            - Required documentation / forms
    - Notification
        - Client
        - Administrative Agency
        - DSHS
    - Investigation
        - Responsible staff
        - Time frame (from incident report date)
        - Action steps
    - Follow-up
        - Responsible staff
        - Time frame (from completion of initial investigation)
        - Action steps
    - Maintenance of files
- Agency safeguards
    - Case records
        - Security
        - Storage
        - Disposal
- Client privacy
    - Waiting room / lobby
    - Meetings spaces
    - Communications and correspondence, such as:
        - Caller ID
        - Return addresses on envelopes
        - Voicemails

Client Grievance Procedure
Description: the steps a client may take to file a grievance and the process program staff must take to respond to a grievance.

Instructions: Written P & Ps for *Client Grievance Procedure* should cover:

- How to file a grievance
    - Levels of appeal and staff responsible for review and resolution of grievance
    - Required documentation
    - Review process
    - Appeal process
    - Time frames
    - Maintenance of client confidentiality
    - Process for advising client and staff of outcome
    - Utilization of client 3rd party representation

Client Input and Satisfaction
Description: process for soliciting client views and feedback on current and planned program services including activities such as a Client Advisory Board, focus groups, and client satisfaction surveys.

Instructions: Written policies and procedures (P & Ps) for *Client Input* should cover:
- Agency activities to obtain client input
    - time frame and frequency of activities
- Agency activities to review and utilize client input
    - Time frame and frequency of activities

Data/Reporting

Description: procedure for entering data into electronic records for the purposes of consistency of care, movements towards goals, internal tracking and state/federal required reporting.

Instructions: Written P & Ps for *Data/Reporting* should cover:
- Data entry, as indicated by agency department, detailing:
    - Person(s) responsible for entering data
    - Frequency and timeframe for data entry
    - The process for internal review of data
    - Process for reporting data to the state and federal government.

Quality Management (Quality Assurance and Quality Improvement)

Description: process agency will use for measuring quality of case management and other services to make improvements to the quality of services provided.

Instructions: **Subcontractors:** For assistance in developing a plan, please contact your Administrative Agency for guidance*. **For Grantees**: For assistance in developing a plan or answering sub-contractor queries, please contact the Texas DSHS HIV Care Services Group and speak to your assigned Services Consultant. Written P & P for *Quality Management, including Quality Assurance (QA) and Quality Improvement,* should cover the basic elements found below, but may be less comprehensive given the current stage of development (for updated information, please visit the Texas DSHS QM System website - http://www.dshs.state.tx.us/hivstd/qm/default.shtm):

- Quality Management (QM) program structure:
    - Quality Statement
    - QM Infrastructure
        - Leadership
        - Roles and responsibilities
        - Membership
        - Meetings
            - Frequency and Time
            - Communication strategy
                - Minutes
                - Updates / Meeting summaries
                    - Access to stakeholders
                        - Internal
                        - External
    - Performance Measurement
        - Quality of care indicators
    - Annual Quality Goals
        - Based on data
        - Role of quality improvement teams
    - Description of the QM Plan Activities and Oversight
        - Quality Management Plan
            - Quality Assurance (QA) Overview
                - Responsible staff
                - Required documentation
                - Reviews
                    - Random
                    - Peer
                    - Administrative
                - Review of results
            - Quality Improvement (QI) Overview
                - Responsible staff
                - Required documentation
                - Client involvement
                - Development and measurement of key indicators

- o Review of results
- o Execution
    - ▪ QM Workplan
        - • Table of QM (QA/QI)activities
            - o Activities
            - o Responsible staff
            - o Frequency
            - o Timeframe
            - o Completion status
    - ▪ Participation of Stakeholders (agency)
        - • Internal
        - • External (recommendations differ per Ryan White Part)
        - • Clients
        - • Training and Capacity-Building for QM (QA/QI)
    - ▪ Evaluation
        - • Responsible parties and assigned roles/tasks
        - • Required documentation
        - • Schedule and/or timeframes
            - o Reviews
                - ▪ Annual
                - ▪ QI team projects (final)
                - ▪ Data review for following year's plan/goal setting

Staffing
Description: protocol for hiring, training and supervision of case management staff members.

Instructions: see instructions as they relate to specific areas below.
Staff Qualifications

Description: description of qualifications necessary for all agency staff positions, utilizing the P&P Requirements for All Case Management Programs.

Instructions: indicate what criteria should be in place for each member of the case management staff utilizing the Texas HIV Case Management Standards of Care as a minimum (see Case Manager Qualifications and Training on pp 17-19.)

Staffing Structure
Description: staffing plan for the delivery of case management and peripheral services.

Instructions: indicate model(s) of case management to be delivered (i.e. non-medical, medical), individual or team approach to staffing and line(s) of supervision. Include a job description for each position, and organizational chart of agency and case management program.

Staff Supervision
Description: description of on-going supervision of case management staff and their activities.

Instructions: include staff responsible for supervision, type and frequency of supervisory activities (including evaluations of staff job performance), and required documentation. Written policies and procedures (P & Ps) for *Staff Supervision* should cover:

- • Staff positions responsible for supervision
- • Type and frequency of supervisory activities, including:
    - o Case reviews with case management staff
    - o Staff job performance
- • Necessary documentation, including:
    - o Necessary forms

        ○ Location of documentation
        ○ Steps taken to ensure confidentiality of staff information

Staff Training
Description: description of how staff will be trained, including orientation, required training topics, and frequency of training.

Instructions: Written policies and procedures (P & Ps) for *Staff Training* should cover:
- Mandatory training for case management staff, as indicated by governing body, funder, agency administration, best practices, and/or local Standards Of Care*
- Case manager training and certification must comply with the training requirements put forth by the Texas HIV Case Management Standards of Care found on pp 17-30.
- Staff training records must be maintained by supervisors and are subject to review by Texas DSHS HIV Care Services Group staff.

*Any mandatory training should include, but is not limited to, those which increase provider knowledge and proficiencies in such a way as to enhance and increase the efficacy of provided case management services (e.g. confidentiality, cultural competency, Motivational Interviewing, mental health/substance abuse issues, ethics, ARIES)

Corrective Measures
Description: description of agency response to the mismanagement of professional responsibilities by staff members.

Instructions: Written P & Ps for *Corrective Measures* should cover:
- the process for identifying incidents that require corrective measures
- description of how any mismanagement of professional responsibilities by staff members will be handled by supervisory staff, including:
    - Examples of job infractions which necessitate corrective measures
    - Levels of correction
    - Documentation utilized to record corrective measures
    - Clear indication of the department(s) authorized to access said documentation at any given level of corrective measures

GUIDANCE FOR POLICY DEVELOPMENT IN SPECIFIC SERVICE AREAS

A. Case Management (non-medical and/or medical):

1. Assessment/Reassessment and Acuity Level
Description: protocol for conducting an assessment including required documentation as stated in the Texas HIV Case Management Standards of Care.

Instructions: Written policies and procedures (P & Ps) for *Assessment and Acuity Level* should cover:
- An outline of the timeframe for completion of initial assessment, indicating frequency of subsequent reassessments
- An outline of timeframe for completion of initial acuity level measure, indicating frequency of subsequent reviews
- Staff responsibilities
- Required documentation
- Review process (reassessment)
- The client's role.

2. Care Plan
Description: protocol for drafting a care plan in compliance with the standards established by the Texas HIV Case Management Standards of Care.

Instructions: Written P & Ps for *Care Plan* should cover:
- An outline the timeframe for completion of initial (intake) care plan, indicating frequency of subsequent revisions
- Staff responsibilities
- Necessary documentation
- Client role in the process

3. Case Conferencing

Description: process, documentation, and frequency of required case conferencing with a client's providers in order to facilitate care coordination.

Instructions: Written P & Ps for *Case Conferencing* should cover:
- Requirements for ensuring that the appropriate Release(s) of Information are in place for all parties involved
- Requirements for initiating case conferencing according to service level or presenting issue(s)
- Frequency of case conferencing according to service level or presenting issue(s)
- Mandatory participants
- Required documentation of outcomes
  - Paper file
  - Electronic

4. Caseload Management

Description: Criteria and process utilized in determining client case assignment, continuity, and/or transfer of care to assure optimal provision of client services.

Instructions: Written P & Ps for Caseload Management should cover:
- Caseload management
  - Responsible staff
  - Methods
  - Tools
  - Required documentation
- Case reviews
- Continuity/Transfer of care
  - Change in case manager
  - Client relocation

5. Client Contacts

Description: the minimum expected type and frequency of case management contacts with client as indicated by client acuity and/or presenting issue(s).

Instructions: Written policies and procedures (P & Ps) for *Client Contacts* should cover:
- A CM/client contact schedule
  - Initial CM contact (post-intake)
  - Contact requirements by acuity (minimum)
    - Phone
    - Face-to-face
  - Exceptions (presenting issue(s) vs. acuity score)
- Outline the process for documenting and tracking these contacts
  - Tools
  - Required documentation
- Internal supervisory oversight and quality assurance.

6. Referrals and Follow up

Description: process for making, monitoring, and following up on client referrals to other providers (including intra-agency) and services.

Instructions: Written P & Ps for *Referrals and Follow-up* should cover:
- Tracking of referrals, including:
  - An outline of the process for assigning referrals and subsequent follow-up
  - Required documentation (i.e. referral tracking sheet). List any preferred or regular referral agencies and contact information.
- Internal supervisory oversight and quality assurance.
- Updating (at least annually) a current list of primary agencies that provide appropriate referral services (e.g. food pantry, housing, mental health / substance abuse services)
- Establishing Memorandum of Understanding (MOU) with provider network to meet client needs

7. Case Closure (Discharge) / Transfer (internal / external)
Description: protocol for the closure or inter-agency transfer of case management cases, including criteria for determining appropriateness for transfer, closure, closure process, and required documentation.

Instructions: Written P & Ps for *Client Discharge (closure) / Transfer* (internal / external) should cover:

- Transferring a client's case management record to another provider (internal / external), including:
  - outline the time frame and process for case transfers
  - Necessary documentation
  - Guidance on indicators for appropriateness of transfer
  - Expectations regarding staff efforts to communicate with clients (number and method of attempted contacts) the reason and need for transfer
  - Identify supervisory position(s) that will review and/or approve case transfers, if indicated.
- Discharging, terminating, or closing of a client's case management record and inactivating case management services, including:
  - outline the time frame and process for case closures
  - Necessary documentation
  - Guidance on what defines a client as having completed case management goals and no longer needing case management services
  - Guidance on what types of client behavior is serious enough to lead to suspension / termination of services
  - Expectations regarding staff efforts to locate and communicate with clients (number and method of attempted contacts) who have not appeared for, or engaged in, case management services in accordance with the agency's policies and the Texas HIV Case Management Standards of Care.
  - Identify supervisory position(s) that will review and/or approve case closures, if indicated.

B. Other Support Services
Description: protocol for approving and distributing support service assistance, such as (but not limited to):

- Transportation
- Dental
- Mental Health / Substance Abuse
- Medical Nutritional Services
- Food Pantry
- Support Groups
- Early Intervention Services
- Legal
- Health Insurance Assistance
- Financial Assistance

: outline the process for documenting and tracking services and/or deliverables, as well as client eligibility criteria for clients and staff responsible for approval and service delivery and management.

Case Manager Qualifications and Training

QUALIFICATIONS

Case management providers must staff their agency with qualified individuals at the case manager, supervisor, support staff and administrative levels. Each agency staff person who provides case management services to clients shall be properly trained in case management. An HIV case manager must be able to work with clients and develop a supportive relationship to enable clients to make the best choices for their well-being and facilitate access to, and use of, available services. To accomplish these goals, the following have been identified by stakeholders as basic skills, traits and/or attitudes that HIV case managers should possess:

- communication and interpersonal skills;
- creativity, flexibility and accountability;
- time management skills;
- the ability to develop rapport;
- an emphasis and understanding of professionalism, ethics and values ;
- ability to use a strengths-based perspective when working with clients;
- utilization of a holistic approach;
- and the ability to establish and maintain appropriate boundaries.

> For more information about the Texas HIV Case Management Project and the stakeholders involved, please visit: http://www.dshs.state.tx.us/hivstd/contractor/casemanage.shtm

Case Manager

Minimum qualifications for case managers (both medical and non-medical): established regionally by Administrative Agencies. *DSHS preferred* qualifications for a case manager: a degree in health, human or education services and one year of case management experience with people living with HIV and/or persons with a history of mental illness, homelessness, or chemical dependence. All case managers must meet the minimum training requirements established in this document.

Case Manager Supervisor

Case manager supervisors must demonstrate guidance, direction and support in providing case management services to persons living with HIV and should be skilled in directing and evaluating the scope and quality of HIV case management services.

Minimum qualifications for case manager supervisors: degreed or licensed in the fields of health, social services, mental health or a related area (preferably Masters' level). Additionally, case manager supervisors must have 3 years experience providing case management services, or other similar experience in a health or social services related field (preferably with 1 year of supervisory or clinical experience).

TRAINING REQUIREMENTS

Each agency is responsible for providing new case management staff members and supervisors with job-related training that commences within 15 working days of hire and is completed no later than 90 days following hire. Mandatory agency training should include the provision of agency's policy and procedure manual and employee handbook to familiarize new staff with the internal workings and processes of their new work environment. Core training of staff, using supportive supervision techniques (e.g. job shadowing, performance evaluation, and immediate (responsive) job counseling/training) should be provided on an ongoing basis -- frequency based on staff experience and performance -- by supervisors. Supervisors should expect to expend more time than usual in providing such training to staff during their probationary period of employment. During the probationary period, new case managers should be monitored for

satisfactory completion of core, case management specific tasks (e.g. assessments, care planning and interventions). These activities should be monitored in person by appropriate supervisory staff -- or qualified designees -- at least once weekly for the entire probationary period before the case manager is approved to provide services independently. A record of all trainings (administrative and core), CM/client observations (job shadowing), and performance evaluations must be included in each case managers personnel file. The record should highlight specific training topics pertinent to the development of individual case managers (employees initials next to each training topic), as well as training completion dates and proof of attendance (e.g. certificates of completion, sign-in sheets).

In addition, all agencies receiving case management funding through Ryan White Part B or State Services funds must comply with the following training requirements:

Beginning September 1, 2011, all case managers at agencies receiving Ryan White Part B or State Services case management funds (both medical and non-medical) must complete (or have completed prior) the following within 6 months of hire (it's desired that staff complete training within 3 months of hire):

Initial Courses REQUIRED for all Case Managers:

1. **Unified Health Communication 101: Addressing Health Literacy, Cultural Competency and Limited English Proficiency (on-line)***
2. **Texas HIV Medication Program (on-line)***
3. **HIV Case Management 101: A Foundation (on-line)***
4. **HIV Case Management 101: A Foundation Part Two**

These courses are all available through the TRAIN (TrainingFinder Real-time Affiliate Integrated Network) Texas learning management system (www.tx.train.org).

The above courses address the following core competencies:

Case Management role and processes
Funding
Harm Reduction
Client-Centered approach
Medical Literacy/HIV knowledge
Mental Health
Patient Education
Substance Abuse

Exceptions to this rule *may* be waived by Texas DSHS HIV Program training staff. For current training requirements or to request an exemption, contact the HIV Case Management Training Specialist with the Texas DSHS HIV Program at HIVCMTraining@dshs.state.tx.us.

REQUIRED Medical Case Manager Training

Beginning **January 1, 2012,** staff performing medical case management at agencies receiving Ryan White Part B or State Services case management funds must fulfill the **Texas DSHS HIV Program Medical Case Manager Competency Training Course** requirements. New Medical Case Managers must complete all components of the MCM Competency Training Course within 12 months of hire (it's desired that staff complete training within 9 months of hire). This course addresses the following core competencies:

Medical Literacy and HIV knowledge
Harm Reduction
Mental Health / Substance Use
Confidentiality/Legal/Consent
Behavioral Intelligence and Skills
Cultural Competency

Intake/Assessment/Reassessment
Patient Education
Family Violence

Exceptions to this rule *may* be waived by Texas DSHS HIV Program training staff. For current training requirements or to request an exemption, contact the HIV Case Management Training Specialist with the Texas DSHS HIV Program at HIVCMTraining@dshs.state.tx.us.

Ongoing Courses REQUIRED for all Case Managers

In addition, all case managers (medical and non-medical) must complete a minimum of 12 hours of continuing education in relevant topics annually. Examples of relevant topics include:

Core Proficiencies:

HIV Confidentiality and the Law	Ethics and HIV
Cultural Competency	Hepatitis A, B, C
Working with Special Populations (undocumented, LGBT, Women, African-American, Latino, over 50, etc.)	Screening Tools (substance use, mental health, risk behavior)
Family Violence	HIV Disclosure
Intake/Assessment/Reassessment	Harm Reduction
Monitoring/Outcomes	Mental Health/Substance Use
Records Management	Substance Use
Resource Development/Use	HIV Medications
Safety	Opportunistic Infections
Care Planning and Implementation	STDs

Please contact the HIV Case Management Training Specialist for available training opportunities; a list will be provided of pre-approved training courses. Other topics not listed above may be used to fulfill the requirement; however, courses must be approved by DSHS and should be submitted prior to attending training – this could include trainings taken to fulfill professional licensure requirements. Participants should submit a copy of the training agenda to the HIV Case Management Training Specialist (HIVCMTraining@dshs.state.tx.us) for consideration.

Individual agencies and case management supervisors are responsible for monitoring case manager compliance with on-going training requirements, including ensuring that all potential training opportunities are authorized through DSHS Case Management Training staff. Personnel records related to training and certification are subject to review during routine audits.

HIV Case Management Standards

The following section includes each of the standards of care established for HIV Case Management Services in Texas for Part B funded programs. These standards are the minimum standards established by the Texas DSHS HIV Program – local and regional agencies may require higher standards beyond this for their area(s) (with approval from their Administrative Agency). Included in many standards are recommended *Best Practices*. While these are highly recommended, the *Best Practices* discussed are not DSHS requirements. The standards are outlined below:

Brief Intake and Eligibility Determination

When requesting services funded through the Ryan White Part B, State Services, or HOPWA (Housing Opportunities for Persons With AIDS) grants, all new clients and returning clients who have been discharged from case management services for more than three months must have an intake screening to determine eligibility and need for program services, including determining if a client needs case management services in order to access and maintain care. A brief intake will be performed at the initial meeting in order for the case manager (or case management program staff) to collect and verify any eligibility documentation necessary to initiate services. Appropriate intervention(s) for any identified emergent need(s) will also be provided to the client at this time; moreover, information collected during the brief intake will be used to gauge client willingness and need to participate in case management services, as well as assist in creating future client care plan goals (short or long-term). Brief intakes may be performed by non-case management staff; however, such staff should be able to successfully demonstrate a skill set (e.g. assessment, service linkage) comparable to that of a qualified case manager (per determination by their respective supervisor(s)) and/or successful completion of the Texas DSHS HIV Case Management Initial training courses required for all case managers. Eligibility (section a. Basic Information) must be re-evaluated every 6 months for active case management clients.

Standard	Criteria
Key information concerning the client, family, caregivers and informal supports is collected and documented to: 1) determine need for ongoing case management services and appropriate level of case management services; 2) determine client eligibility; 3) establish relationship with client; and 4) educate client about available services, resources and the care system **Time Requirement:** Due within 10 working days of initial contact with client or designated agent (caretaker, guardian, etc.). **Eligibility must be re-evaluated every 6 months for active case management clients.**	1) Presenting problem and immediate needs are identified during the Brief Intake process. 2) Immediate needs are addressed promptly. 3) Brief Intake documentation includes, at minimum: **a. Basic Information** • Contact and identifying information (name, address, phone, birth date, etc.) • Language(s) spoken • Literacy level (client self-report) • Demographics • Emergency contact • Household members • Other current health care and social service providers, including other case management providers • Pertinent releases of information • Documentation of insurance status • Documentation of income (including a "zero income" statement) • Documentation of state residency • Photo ID or two other forms of identification • Review of policies relevant to Client Confidentiality and mandatory reporting requirements (see Texas DSHS HIV Program's "P&P REQUIREMENTS FOR ALL CASE MANAGEMENT PROGRAMS") • Grievance policy review • Acknowledgement of client's rights **b. Brief overview of status and needs regarding:** • Food/clothing • Finances/benefits • Housing • Transportation • Legal services • Substance use • Mental health • Domestic violence

- Support system
- HIV disease, other medical concerns
- Access to and engagement in health care/supportive services
- Prevention of HIV transmission
- Prevention of HIV disease progression

4) Immediate referrals should be made under the following circumstances (any client denial of offered referrals must be documented in the URS and the client's record):
- Client is not engaged in medical and/or psychiatric care and demonstrates symptoms of active medical and/or mental illness
- Client is on medication but will run out in less than 10 days
- Client states they are in danger, a danger to themselves, or a danger to others
- Client indicates they are homeless (HUD definition: http://portal.hud.gov/hudportal/HUD?src=/topics/homelessness/definition)
- Client indicates they are about to be evicted and/or have their utilities terminated.
- Client states they have no food

5) Texas DSHS HIV Program's "P&P REQUIREMENTS FOR ALL CASE MANAGEMENT PROGRAMS" contains instructions on developing policies for all services including the intake and assessment process.

A client with an urgent need and who doesn't have the required documentation of HIV status or Texas residency at intake may have conditional eligibility for 30 days. All service agencies must make reasonable effort to assist clients to obtain the necessary documentation. The following are acceptable forms of documentation:

Proof of Texas Residence (one of the following)
- a valid Texas drivers license or Texas state identification card;
- mortgage or rental lease agreement in recipient's name;
- Texas utility bill in recipient's name;
- a letter postmarked to a Texas address in the recipient's name in the last 30 days; or
- a letter of identification and verification of residency from a verifiable homeless shelter or community center serving homeless individuals.

Proof of HIV status (one of the following)
- a positive Western Blot laboratory result that includes the name of the client;
- a report of detectable HIV viral load that includes that name of the client;
- a positive qualitative Nucleic Acid Amplification Test (NAAT) or other diagnostic assay for HIV infection approved by the Food and Drug Administration that includes the name of the client;
- a signed statement from a physician, physician's assistant, an advanced practice nurse or a registered nurse attesting to the HIV positive status of the person; or,
- a hospital discharge summary documenting HIV positive status.

Please see policy number 220.001 "Eligibility to Receive HIV Services" for further details: http://www.dshs.state.tx.us/hivstd/policy/policies.shtm

Best Practices
Staff with good interviewing skills who can put clients at ease, obtain key personal information, and recognize potentially urgent situations should perform the Brief Intake. Placement into the appropriate category of case management and provision of initial case management services depend on using capable, empathetic staff.

Information obtained during the Brief Intake and Eligibility Determination should be shared, after client consent, with other providers to coordinate services and avoid duplication of efforts.

It is recommended that agencies define and establish priority populations that are automatically assigned into case management at entry to ensure entry to, and continuity of care. Priority populations may include client that fit into the following categories:

- Newly diagnosed
- Recently released
- Pregnant
- Homeless
- Substance Use Disorders
- Mental Health Disorders
- Youth

Initial Comprehensive Assessment

The Initial Comprehensive Assessment is required for clients who are enrolled in case management services. It expands upon the information gathered in the Brief Intake and Eligibility Determination to provide the broader base of knowledge needed to address complex, longer-standing medical and/or psychosocial needs.

The 30 day completion time permits the initiation of case management activities to meet immediate needs and allows for a more thorough collection of assessment information. Information obtained from the assessment is used to develop the Care Plan and assist in the coordination of a continuum of care that provides:

- Timely access to medically appropriate levels of health and support services,
- An ongoing assessment of the client's needs and personal support systems,
- A coordinated effort with in-patient (including hospital and incarceration) case management services to expedite discharge, as appropriate, to access post-discharge care,
- Prevention of unnecessary hospitalization,
- An ongoing assessment of the client's knowledge of relevant disease process(es) (i.e. HIV, Hepatitis A/B/C, other chronic conditions), medication adherence, and risk behaviors for risk reduction counseling.

Standard	Criteria

An Initial Comprehensive Assessment describes in detail the client's medical, physical and psychosocial condition and needs. It identifies service needs currently being addressed and by whom; services that have not been provided; barriers to service access; and services not adequately coordinated.
 	
The assessment also evaluates the client's resources and strengths, including family and other close supports, which can be utilized during care planning.
 	
Time Requirement:
Due within 30 calendar days of Brief Intake with client or designated agent (caretaker, guardian, etc.) and includes all required documentation.
	1) Initial Comprehensive Assessment includes at a minimum:
	
	  a) Client health history, health status and health-related needs, including but not limited to:
	
	    Core Services
	    • HIV disease progression
	    • Tuberculosis
	    • Hepatitis
	    • Sexually Transmitted Infections and/or history of screening
	    • Other medical conditions
	    • OB/GYN, including current pregnancy status
	    • Medications and adherence
	    • Allergies to medications
	    • Complementary therapy
	    • Current health care providers; engagement in and barriers to care
	    • Oral health care
	    • Vision care
	    • Home health care and community-based health services
	    • Alcohol/Drug use (see Forms section for SAMISS tool. SAMISS, or other validated substance use screening tool must be used annually)
	    • Mental Health (The SAMISS or other validated mental health screening tool must be used annually)
	    • Medical nutritional therapy
	    • Clinical trials
	
	  b) Client's status and needs related to:
	
	    Support Services
	    • Nutrition/Food bank

	• Financial resources and entitlements • Housing • Transportation • Support systems (including disclosure of status to family and friends) • Identification of vulnerable populations in the home (i.e. children, elderly, and/or disabled) and assessment of need (i.e. food, shelter, education, medical, safety (CPS/APS referral, as indicated) • Parenting/care giver needs • Partner services (elicitation and notification of sexual and needle sharing partners) • Domestic Violence • Legal needs (e.g. health care proxy, living will, guardianship arrangements, landlord/tenant disputes) • Linguistic services, including interpretation and translation needs • Activities of daily living • Knowledge, attitudes and beliefs about HIV disease • Behavior risk assessment and risk reduction counseling • Employment/Education c) Additional Information • Client strengths and resources • Other agencies service client and collaterals • Brief narrative summary • Name of person completing assessment and date of completion • Supervisor signature and date, signifying review and approval, for case managers during their probationary period 2) The case manager has the primary responsibility for the Initial Comprehensive Assessment and meets face-to-face with the client at least once during the assessment process. 3) If all relevant information is not received from the client by the end of the 30 days, 2 verbal and 1 written request must be filed by the case manager within the following 30 days of non-receipt. If no response is received from the client within the additional 30 days, the client must be discharged. 4) The Initial Comprehensive Assessment is documented in the Universal Reporting System (URS) and the client's record. See policy number 231.004 "Documenting Case Management Actions in ARIES" for further details: http://www.dshs.state.tx.us/hivstd/policy/policies.shtm.

Best Practices
A comprehensive assessment performed over time (still in the 30 day time frame) rather than in one sitting is often more complete and less intrusive for a client. Information is gathered from client self report and (with appropriate releases) a variety of sources, including providers serving the client and the clients' collaterals.

Case Management Acuity Level and Client Contact

The Texas HIV services program is a needs-based program which strives to provide the appropriate level of support to clients with the greatest level of need to help them access and maintain quality medical care and manage their disease effectively. An acuity scale, in conjunction with information from the Brief Intake and/or the Initial Comprehensive Assessment, must be used to determine the client's level of need for services and how those needs impact the case management system.

Standard	Criteria
Clients are enrolled in a case management acuity level (frequency of contact) appropriate to their level of need. Acuity should also be used to help show the impact that the client will have on the system and ensure that case management loads are distributed evenly at an agency level. **Time Requirement:** Case management/ acuity level should be completed within 30 calendar days of the Brief Intake and annually thereafter or as life circumstances change.	1) Acuity scales are *tools* for case managers to use; acuity scales complement professional case management assessment interviews -- they don't replace them. 2) The case manager and the client use the Brief Intake and/or the Initial Comprehensive Assessment to collaboratively develop a Care Plan for the client based on need and client readiness. The acuity score should be based on the results of the intake/assessment. 3) The frequency of case manager initiated contact should be assigned based on the client's current acuity score and the case manager's professional judgment. If the intensity of the case management intervention does not match documented acuity, case managers should document their rationale in the client's record and the Universal Reporting System (URS). 4) Each interaction with a client has the potential to change acuity scores in specific categories. Any changes in a client's acuity should be documented appropriately. Though DSHS does not require the use of a specific acuity scale tool, successfully tested (or similarly structured) acuity scale tools are highly recommended and are included in the Forms section. Any acuity scale used must, at a minimum, measure client need in the following areas: • medical/clinical • basic necessities/life skills • mental health • substance use • housing/living situation • support system • insurance benefits • transportation • HIV-related legal • cultural/linguistic • self-efficacy in daily functioning • HIV education and risk reduction • employment/income • medication adherence

Care Planning

Care Planning is a critical component of case management activities and guides the client and the case manager with a proactive, concrete, step-by-step approach to addressing client needs. Together, the client and the case manager identify problems and issues to address, as well as barriers to care and strategies for overcoming those barriers. The Care Plan can serve additional functions, including: assisting a client and case manager to focus on client-identified priorities and broader goals, especially after crisis periods; teaching clients how to negotiate the service delivery system; ensuring that objectives have achievable tasks; and serving as a tool at reassessment to evaluate accomplishments, barriers, and re-direct future work.

Standard	Criteria

Client needs identified in the Assessment/Reassessment are prioritized and translated into a care plan which defines specific goals, objectives and activities to meet those needs. The client and the case manager will actively work together to develop and implement the care plan.	1) Care Plan includes at a minimum:
	 • Problem statement (Need)
	 • Goal(s)
	 • Intervention
	   • Task(s) - measurable
	   • Referral(s)
	   • Service Deliveries
	 • Individuals responsible for the activity (e.g., case manager, client, team member, family)
	 • Anticipated time frame for each task
	 • Client signature and date, signifying agreement

Time Requirement: Following completion of the Comprehensive Assessment/ Reassessment. Care Plans should be updated as needed with significant changes in a client's needs. A temporary Care Plan may be executed following completion of the Brief Intake based upon immediate needs or concerns. **Clients receiving Medical Case Management must have periodic re-evaluation and adaptation of the Care Plan at least every 6 months, or sooner if client circumstances change**	2) A new Care Plan should be created for each new need. 3) The case manager has primary responsibility for development of the Care Plan. 4) The Care Plan is updated with outcomes and revised or amended in response to changes in client life circumstances or goals. Tasks, referrals and services should be updated as they are identified or completed, not at set intervals. 5) Issues noted in the Care Plan should have ongoing case notes that match the stated need and the progress towards meeting the goal identified. 6) All Care Plans are entered and updated in the URS. See policy number 231.004 "Documenting Case Management Actions in ARIES" for further details: http://www.dshs.state.tx.us/hivstd/policy/policies.shtm

Best Practices*

Care Plans negotiated face-to-face with clients encourage their active participation and empowerment. Care Plans are living documents for planning and tracking client goals, tasks, and outcomes for specific needs and a copy should be offered to the client to emphasize the partnership.

In general, Care Plans should follow these guidelines:
- Client centered – how does this benefit the client?
- Client driven – has the client expressed this as a need or have you assessed this as a need and the client agrees?
- Delineates responsible person(s) – who will make this appointment/decide what is to be done?
- Outcome based – what need will this satisfy for the client?
- Action oriented – what does the case manager and/or client need to do in order to get this accomplished?
- Time specific – what period of time has been set to get this accomplished?

*Best Practice courtesy of Brazos Valley Council of Governments HIV Administrative Agency

Comprehensive Reassessment

The Comprehensive Reassessment is required for all clients enrolled in case management services. Comprehensive Reassessment provides an opportunity to review a client's progress, consider successes and barriers and evaluate the previous period of case management activities. In conjunction with updating the Care Plan, Reassessment is a useful time to determine whether the current level of case management services is appropriate, or if the client should be offered alternatives.

Standard	Criteria

A comprehensive reassessment reevaluates client functioning, health and psychosocial status; identifies changes since the initial or most recent assessment; and determines new or on-going needs.
 	
Time Requirement:
 	
For clients receiving Non-Medical Case Management services, the Comprehensive Reassessment is required, at a minimum, annually after completion of the Initial Comprehensive Assessment, or sooner if client circumstances change significantly.
 	
For clients receiving Medical Case Management services, the Comprehensive Reassessment is required, at a minimum, every 6 months, or sooner if client circumstances change significantly.
	1) Each comprehensive reassessment includes at a minimum:
	  a. Updated personal information
	    • Current contact and identifying information
	    • Emergency contact
	    • Confidentiality concerns
	    • Household members
	    • Insurance status
	    • Other health and social service providers, including other case management providers
	    • Current proof of income and residency
	  b) Client health history, health status and health-related needs, including but not limited to:
	
	  Core Services
	    • HIV disease progression
	    • Tuberculosis
	    • Hepatitis
	    • Sexually Transmitted Infections and screening history
	    • Other medical conditions
	    • OB/GYN, including current pregnancy status for females
	    • Medications and adherence (see Forms section for sample medication adherence assessment tool)
	    • Allergies to medications
	    • Complementary therapy
	    • Current health care providers; engagement in and barriers to care
	    • Oral health care
	    • Vision care
	    • Home health care and community-based health services
	    • Alcohol/Drug use (see Forms section for SAMISS tool. SAMISS, or other validated substance use screening tool must be used annually)
	    • Mental Health (see Forms section for SAMISS tool. SAMISS, or other validated mental health screening tool must be used annually)
	    • Medical nutritional therapy
	    • Clinical trials
	
	  c) Client's status and needs related to:
	
	  Support Services
	    • Nutrition/Food bank
	    • Financial resources and entitlements
	    • Housing
	    • Transportation
	    • Support systems
	    • Identification of vulnerable populations in the home (i.e.

	children, elderly, and/or disabled) and assessment of need (i.e. food, shelter, education, medical, safety (CPS/APS referral, as indicated) • Parenting/care giver needs • Partner Services (elicitation and notification of sexual and needle sharing partners) • Domestic Violence • Legal needs (e.g. health care proxy, living will, guardianship arrangements, landlord/tenant disputes) • Linguistic services, including interpretation and translation needs • Activities of daily living • Knowledge, attitudes and beliefs about HIV disease • Behavior risk assessment and risk reduction counseling (see Forms section for sample Behavioral Risk assessment tool) • Employment/Education d) Additional Information • Client strengths and resources • Other agencies service client • Brief narrative summary of session with client • Name of person completing assessment and date of completion • Supervisor signature and date, signifying review and approval 2) The case manager has the primary responsibility for the Comprehensive Reassessment and meets face-to-face with the client at least once during the assessment process. 3) If all relevant information is not received from the client by the end of the 30 days, 2 verbal and 1 written request must be filed by the case manager within 30 days of non-receipt. If no response is received from the client within the additional 30 days, the client must be discharged. The Comprehensive Reassessment is documented in the Universal Reporting System (URS) and the client's record. See policy number 231.004 "Documenting Case Management Actions in ARIES" for further details: http://www.dshs.state.tx.us/hivstd/policy/policies.shtm.

Best Practices

A case conference with key parties before or during the reassessment process can augment and verify reassessment information and bring all parties into the care planning process.

See also Best Practices under Comprehensive Assessment.

Referral and Follow-Up

Case management is effective when it utilizes all the resources of the community on behalf of the client. Referrals to outside agencies (including agencies outside the Ryan White system) for specified services are often needed in order to meet Care Plan goals and to ensure that Ryan White funding is used as the payment of last resort. To be effective, case managers must learn how to work with providers to ensure that referrals are well received and services delivered. Establishing formal links among agencies, especially through developing Memorandums of Understanding (MOU), can facilitate the information flow and referral process among providers.

Standard	Criteria
Each client receiving Case Management services will receive assistance to facilitate access to those services critical to achieving optimal health and well being and help with problem solving when barriers impede access. The case manager advocates for the client by collaborating and working with individual service providers. **Time Requirement:** Referrals should be initiated immediately upon identification of client needs and with the agreement of the client. Referrals denied by the client should also be documented in the URS and the client's record.	1) Referrals should be appropriate to client situation, lifestyle and need. The referral process should include timely follow-up of all referrals to ensure that services are being received. Agency eligibility requirements should be considered part of the referral process. 2) The case manager will initiate referrals immediately upon a need being identified. 3) The case manager will work with the client to determine barriers to referrals and facilitate access to referrals 4) The case manager will utilize a referral tracking mechanism to monitor completion of all case management referrals. 5) Follow-up is a systematic process to determine if the client is accessing services. The case manager will ensure that clients are accessing needed referrals and services, and will identify and resolve any barriers clients may have in following through with their Care Plan. 6) The case manager will document follow-up activities and outcomes in the client record and in the URS. This includes documentation of follow-up after missed referral appointments.

Best Practices

Agencies that coordinate with a variety of service providers and hold multiple MOUs can best meet diverse client needs.

When clients are referred for case management services elsewhere, case notes include not only documentation of follow-up but also level of client satisfaction with referral.

Case Closure/Graduation

Clients who are no longer engaged in active case management services should have their cases closed based on the criteria and protocol outlined below. A closure summary usually outlines the progress toward meeting identified goals and services received to date.

Common reasons for case closure include:
- Client completed case management goals
- Client is no longer in need of case management services (e.g. client is capable of resolving needs independent of case manager assistance)
- Client is referred to another case management program
- Client relocates outside of service area
- Client chooses to terminate services
- Client is no longer eligible for services due to not meeting eligibility requirements
- Client is lost to care or does not engage in service
- Client incarceration greater than 6 months in a correctional facility
- Provider initiated termination due to behavioral violations
- Client death

Standard	Criteria

Upon termination of active case management services, a client case is closed and a closure summary documenting the case disposition is documented	1. Closed cases include documentation stating the reason for closure and a closure summary (brief narrative in progress notes and formal discharge summary).
	
	2. Supervisor signs off on closure summary indicating approval (electronic review is acceptable).
	
	3. In the event that a client becomes ineligible for case management services:
	
	    a. Case manager notifies supervisor of intent to discharge client
	    b. Case manager reports to supervisor on the client's circumstances that make them ineligible for continued services (decrease in acuity level, behavior, etc.)
	
	4. Client is considered non compliant with care if 3 attempts to contact client (via phone, e-mail and/or written correspondence) are unsuccessful and the client has been given 30 days from initial contact to respond. Discharge proceedings should be initiated by agency 30 days following the 3rd attempt.
	
	5. In accord with written policies and procedures established by each agency, the case manager notifies the client (through face-to-face meeting, telephone conversation or letter) of plans to discharge the client from case management services.
	
	6. The client receives written documentation explaining the reason(s) for discharge and the process to be followed if client elects to appeal the discharge from service.
	
	7. Other service providers are notified and this is documented in the client's chart.
	
	8. Information about reestablishment is shared with the client.
	
	    a. Client is provided with contact information and process

	for reestablishment
	9. The Texas DSHS HIV Program's "P&P REQUIREMENTS FOR ALL CASE MANAGEMENT PROGRAMS" contains instructions on developing policies for all services including the discharge process.

Best Practices

Case manager attempts to reconnect clients lost to care services may require contact with a client's known medical and human service providers (with prior written consent).

When services are terminated, an exit interview is conducted if appropriate.

Case managers attempt to secure releases that will enable them to share pertinent information with a new provider.

Other documents related to HIV Case Management services in Texas

HIV Medical and Support Services Taxonomy

This taxonomy reflects service categories fundable though Ryan White Program Part B, DSHS State Services and HOPWA formula funds awarded to the State only. It may not reflect fully services fundable through other Ryan White Program Parts, direct HOPWA or other funding sources.

Find it here: http://www.dshs.state.tx.us/hivstd/taxonomy/default.shtm

Child Abuse Reporting Requirements

Texas requires that all suspected cases of child abuse be reported. More information on this requirement and the process for reporting can be found in the link below.

Find it here: http://www.dshs.state.tx.us/childabusereporting/default.shtm

HIV and STD Program Operating Procedures and Standards manual

Guidelines for delivery of consistent quality services for DSHS HIV/STD contractors. Please note that program and contract policies established by the HIV/STD Program are separate documents and are not included in the HIV/ STD Program Operating Procedures manual except by reference.

Find it here: http://www.dshs.state.tx.us/hivstd/pops/default.shtm

HIV/STD Program Procedures

Procedures developed by the DSHS HIV/STD Program.

Find it here: http://www.dshs.state.tx.us/hivstd/policy/procedures.shtm

HIV/STD Program Security Policies and Procedures

Complete list of HIV/STD Program policies and procedures regarding security.

Find it here: http://www.dshs.state.tx.us/hivstd/policy/security.shtm

HIV/STD Laws and Regulations (Texas and Federal) –

State and Federal laws, rules, and authorization regarding HIV/STD.

Find it here: http://www.dshs.state.tx.us/hivstd/policy/laws.shtm

Documenting Case Management Actions in ARIES

A guide to Ryan White and State Service funded case management agencies on the use of the AIDS Regional Information and Evaluation System (ARIES) including, but not limited to, required fields of data entry.

Find it here: http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=61670 (*PDF*)

Eligibility to receive HIV services

Requirements to receive services funded though Ryan White Part B, States Services and/ or HOPWA grants.

Find it here: http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=22501 (*PDF*)

Texas HIV Program: Common Acronyms

AA	Administrative Agency
ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
AIDS	Acquired Immune Deficiency Syndrome
ARIES	AIDS Regional Information and Evaluation System
ARV	Antiretroviral
ASH	Austin State Hospital
ASL	American Sign Language
ASO	AIDS Service Organization
BRFSS	Behavioral Risk Factor Surveillance System
BVCOG	Brazos Valley Council of Governments (AA)
CADR	CARE Act Data Report renamed in 2007 – see RDR
CARE Act	Ryan White Comprehensive AIDS Resources Emergency Act – renamed in 2006 and 2009. Commonly referred to as the Ryan White Program.
CBO	Community Based Organization
CDC	Centers for Disease Control
CHIP	Children's Health Insurance Program – Medicaid
CLD	Client Level Data
CLI	Community Level Intervention
CM	Case Manager or Case Management
CMS	Centers for Medicare and Medicaid Services (Federal)
COBRA	Consolidate Omnibus Reconciliation Act
CPG	Community Planning Group
CQI	Continuous Quality Improvement
CRCS	Comprehensive Risk Counseling and Services
D&HH	Deaf and Hard of Hearing
DD	Developmental Disabilities
DEBI	Diffusion of Effective Behavioral Interventions
DIS	Disease Intervention Specialists
DNA	Deoxyribonucleic Acid
DSHS	Department of State Health Services (Texas)
EBI	Evidence Based Intervention
EFA	Emergency Financial Assistance
EIS	Early Intervention Services
EMA	Eligible Metropolitan Area
EPT	Expedited Partner Therapy
FDA	Food and Drug Administration
FTE	Full Time Equivalent
FTM	Female To Male (Transgender)
FQHC	Federally Qualified Health Center
GLBT	Gay, Lesbian, Bisexual, Transgender
GLI	Group Level Intervention
HAART	Highly Active Antiretroviral Therapy
HAB	HIV/AIDS Bureau (Federal)
HARS	HIV/AIDS Reporting System
HAV	Hepatitis A Virus
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for People With AIDS
HPV	Human Papillomavirus
HRH	High Risk Heterosexual
HRSA	Health Resources and Services Administration
HUD	Housing and Urban Development
IDU	Injection Drug Use(r)
MAI	Minority AIDS Initiative
MH/SA	Mental Health/Substance Abuse

MMP	Medical Monitoring Project
MMWR	Morbidity and Mortality Weekly Report
MSM	Men who have Sex with Men
MSM/IDU	Men who have Sex with Men who are Injection Drug Users
MTF	Male To Female (Transgender)
NAAT	Nucleic Acid Amplification Testing (for HIV)
NASTAD	National Alliance of State and Territorial AIDS Directors
NNRTI	Non-Nucleoside Reverse Transcriptase Inhibitor
NRTI	Nucleoside Reverse Transcriptase Inhibitor
OMB	Office of Management and Budget (Federal)
OSHA	Occupational Safety and Health Administration
PBC	Protocol Based Counseling
PCR	Polymerase Chain Reaction (test or assay)
PEMS	Prevention Evaluation Monitoring System
PI	Protease Inhibitor
PID	Pelvic Inflammatory Disease
PLWH	People Living With HIV
POL	Popular Opinion Leader
POPS	Program Operating Procedures and Standards
PSE	Public Sex Environment
QA	Quality Assurance
QI	Quality Improvement
QM	Quality Management
RDR	Ryan White Program Data Report (replaces CADR)
RFP	Request For Proposals
RNA	Ribonucleic Acid
SAM	System Acuity Measurement
SAMHSA	Substance Abuse and Mental Health Services Administration (Federal)
SAMISS	Substance Abuse and Mental Illness Symptoms Screener
SCSN	Statewide Coordinated Statement of Need
SEP	Syringe Exchange Program
SPAP	State Pharmacy Assistance Program
SPNS	Special Projects of National Significance
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TA	Technical Assistance
TB	Tuberculosis
TDCJ	Texas Department of Criminal Justice
TGA	Transitional Grant Area
THMP	Texas HIV Medication Program
TIPP	Texas Infertility Prevention Project
TTY	Text Telephone
VL	Viral Load
WSW	Women who have Sex with Women
YRBS	Youth Risk Behavior Survey

Sample Forms

The following section contains suggested forms and tools to use to assist case managers in their daily activities.

**The Substance Abuse and Mental Illness
Symptoms Screener (SAMISS) – Key**

Substance Abuse:
Respondent screens positive if sum of responses to questions 1–3 is equal to or greater than 5, response to question 4 or 5 is equal to or greater than 3, or response to question 6 or 7 is equal to or greater than 1.

1. How often do you have a drink containing alcohol?

Never **0**   Monthly or less **1**   2–4 times/mo **2**   2–3 times/wk **3**   4 or more times/wk **4**

2. How many drinks do you have on a typical day when you are drinking?

None **0**   1 or 2 **1**   3 or 4 **2**   5 or 6 **3**   7–9 **4**   10 or more **5**

3. How often do you have 4 or more drinks on 1 occasion?

Never **0**   Less than monthly **1**   Monthly **2**   Weekly **3**   Daily or almost daily **4**

4. In the past year, how often did you use nonprescription drugs to get high or to change the way you feel?

Never **0**   Less than monthly **1**   Monthly **2**   Weekly **3**   Daily or almost daily **4**

5. In the past year, how often did you use drugs prescribed to you or to someone else to get high or change the way you feel?

Never **0**   Less than monthly **1**   Monthly **2**   Weekly **3**   Daily or almost daily **4**

6. In the past year, how often did you drink or use drugs more than you meant to?

Never **0**   Less than monthly **1**   Monthly **2**   Weekly **3**   Daily or almost daily **4**

7. How often did you feel you wanted or needed to cut down on your drinking or drug use in the past year, and were not able to?

Never **0**   Less than monthly **1**   Monthly **2**   Weekly **3**   Daily or almost daily **4**

Mental Illness:
Respondent screens positive if response to any question
is "Yes."

8. In the past year, when not high or intoxicated, did you ever feel extremely energetic or irritable and more talkative than usual?

Yes ☐   No ☐

9. In the past year, were you ever on medication or antidepressants for depression or nerve problems?

Yes ☐   No ☐

10. In the past year, was there ever a time when you felt sad, blue, or depressed for more than 2 weeks in a row?

Yes ☐   No ☐

11. In the past year, was there ever a time lasting more than 2 weeks when you lost interest in most things like hobbies, work, or activities that usually give you pleasure?

Yes ☐   No ☐

12. In the past year, did you ever have a period lasting more than 1 month when most of the time you felt worried and anxious?

Yes ☐   No ☐

13. In the past year, did you have a spell or an attack when all of a sudden you felt frightened, anxious, or very uneasy when most people would not be afraid or anxious?

Yes ☐   No ☐

14. In the past year, did you ever have a spell or an attack when for no reason your heart suddenly started to race, you felt faint, or you couldn't catch your breath? (If respondent volunteers, "Only when having a heart attack or due to physical causes," mark "No.")

Yes ☐   No ☐

15. During your lifetime, as a child or adult, have you experienced or witnessed traumatic event(s) that involved harm to yourself or to others?

Yes ☐   No ☐

If yes: In the past year, have you been troubled by flashbacks, nightmares, or thoughts of the trauma?

Yes ☐   No ☐

16. In the past 3 months, have you experienced any event(s) or received information that was so upsetting it affected how you cope with everyday life?

Yes ☐   No ☐

This questionnaire is based on the validated screening instrument developed by the University of North Carolina at Chapel Hill, Departments of Psychiatry, Medicine, Public Policy, and Community and Family Medicine; and the Health Inequities Program of Duke University.

System Acuity Measurement (SAM) Tool

1   Medical/Clinical

This category concerns access to primary medical care, oral health services, specialty clinical care for HIV disease, physical therapy and access to HIV specific medications.

Scoring Considerations:

- General stability of health (regardless of specific diagnosis),

- Client's ability to maintain an ongoing relationship with providers of medical and clinical services,

- Client's access to and local availability of medical and clinical services, and/or,

- Client's medical condition as it relates to the amount of time you will spend with the client (case management time) and resources necessary to initiate and maintain their access to care and medications

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Score Suggestions

1   Stable health status. Client has stable, ongoing access to primary HIV medical care and treatment. Client is fully empowered for self-care and can independently maintain medical care with information and very occasional referral.

2   Client's health stable or may have moderate health problems. Client needs active occasional assistance to access or maintain access to medical, clinical and/or oral health services.

3   Client is medically fragile but still able to maintain the activities of daily living. Client requires regular assistance to access and maintain access to appropriate medical, clinical and/or oral health services. May require active coordination of multiple care providers.

4   Client has serious-to-severe medical issues; may be life threatening or one-time medical crisis as a result of multiple adverse health diagnoses or events. Client may require complex coordination between multiple providers or agencies; may have end of life issues.

Notes about scoring this category:

Availability and access of medical services should be considered; limited services may lead to more time needed to assist the client in locating or coordinating among providers. This would increase the impact on the care case management system (i.e., increasing system acuity).

2   Basic Necessities/Life Skills

This category concerns food, clothing, skills related to activities of daily living (ADLs) and access to household items necessary for daily living.

> **Scoring Considerations:**
>
> - General ability of client to function/cope with daily activities (e.g. get to and from work, medical appointments and/or cook for self or other dependent family members),
>
> - Client's ability to maintain basic personal and household hygiene standards,
>
> - Client's ability to manage activities of daily living (ADL) in light of mental health, substance use, disease progression, effects of medications, living situations, and/or education level, and/or,
>
> - If applicable, the client's attention to a dependent family member's basic needs (i.e. clothing, feeding and caring for children)

Score Suggestions

1   Client's basic needs being adequately met; client has high level of skills, no evidence of inability to manage ADL.

2   Client has the ability to meet basic needs and manage ADL, but may need referral and information to identify available resources

3   Client needs assistance to identify, obtain and maintain basic needs and manage ADL. Poor ADL management is noticeable and pronounced.

4   Client is unable to manage ADL without immediate, ongoing assistance; in acute need of caregiver services.

Notes about using this category:

There may be interactions with other categories such as mental health, substance use, and/or self-efficacy. A person's mental health or substance use could affect their ability to deal with basic needs. However, a person's life skills may not always be affected by mental health or substance use; deficiencies could be related to other factors such as education. This category concerns the client's ability to manage their basic needs regardless of the root of their problems.

A client's ability to maintain ADL may be related to their disease progression and/or effects of medications. Fatigue related to treatment may prevent a client from brushing his/her teeth, bathing and/or cooking.

It is appropriate to consider the client's family or relationship dynamics and the role these may play in a client's ability to maintain their basic needs. Clients who are in abusive relationships might not be able to access resources for daily living because of power dynamics within the relationship (e.g. have access to money to pay for groceries).

3   Mental Health/Psychosocial

This category broadly involves the client's level of impairment with respect to emotional stability, mental health status, history of past or current clinical depression, social adjustment disorders or other potentially significant mental health issues.

> **Scoring Considerations:**
>
> - Client's ability to demonstrate appropriate behavior and coping skills in everyday interactions and problems,
>
> - Client's ability to deal with family and other significant relationships,
>
> - Client's history of mental health issues (counseling, treatment, stabilization dependent on medication and/or treatment, and/or,
>
> - Client's current mental health (harm to self or others, emotional instability, current diagnoses).

Score Suggestions

1   No known history or evidence of mental illness, high level of social functioning, appropriate behavior and coping skills.

2   History of mental illness with appropriate treatment, stabilized as a result of past treatment, ongoing compliance with outpatient counseling, emotional stability and coping skills are adequate to manage ADL, minimal difficulty in family or other significant relationships.

3   Moderate emotional stress in significant relationships, ongoing diagnosis/treatment of chronic or major mental illness, limited access to mental health services, inability to maintain adherence to psychiatric medication, inappropriate social behaviors, mild to moderate impairment in ADL.

4   Danger to self or others, highly depressed, suicidal, violent thoughts towards others, frequent or ongoing psychotic, violent or threatening behaviors, in crises, immediate psychiatric intervention needed.

Notes about using this category:

This category is weighted, reflecting the potential impact that mental health issues may have on the level of care case management time and resources needed in multiple categories. The most current edition of the Diagnostic and Statistical Manual of Mental Disorders can be useful for understanding some of the mental health terms and most common mental health conditions such as post-traumatic stress disorder; clinically significant depression; schizophrenia; bi-polar disorder I and II and borderline personality disorder. Also, some HIV medications have potentially dangerous side effects that can trigger or mimic psychotic episodes. **Mental health conditions should only be diagnosed by a qualified mental health provider licensed for clinical practice.**

4   Substance/Alcohol Use

This category covers addictive, dependent or abusive use of mind/mood altering substances (alcohol, illicit, nonprescription and prescription drugs). Behavioral, legal or family-related problems associated with substance use should be considered.

> **Scoring Considerations:**
>
> - Client's history and current level of substance use,
>
> - The degree to which substance use is affecting the client's ability to function,
>
> - Concurrent mental health issues which may be aggravated by substance use, and client's willingness to acknowledge substance use issues (denial, in or seeking treatment),
>
> - The degree to which another's substance use is affecting the client's life (child, primary relationship, adherence to medical or mental health treatment), and/or,
>
> - Client's ability to access services (motivation, health coverage, access and availability).

Score Suggestions

1   No evidence to suggest that client's use of substances constitutes abuse or dependence; no evidence of behavioral disturbances related to substance use.

2   Client has history of substance use/moderate abuse; no current indication of dependency or abuse; may need education or referral.

3   History of substance and/or alcohol abuse and is currently using; functional difficulties because of own or family member's substance abuse; client identifies need for treatment; services are available and client has ability to access services with referral and support.

4   Ongoing substance abuse crisis, emergency medical detoxification indicated; major impairment of function, refusal of treatment services, family crises, dangerous infection-risk behaviors, etc. May require intensive effort to maintain adherence to substance abuse treatment.

Notes about using this category:

This category is weighted, reflecting the potential impact that substance use/abuse may have on care case management time and resources in multiple categories. It should also be understood that there are frequently mental health issues that are a result of substance or alcohol use and that individuals with undiagnosed mental health issues often self medicate by using legal or illicit substances. Family member or significant other's substance abuse issues may be considered in scoring this category if they have the potential to adversely affect client's recovery. It may also be difficult for persons who have a criminal record or substance use issues to access treatment services or housing, especially difficult if they are primary providers with dependents (children or adults).

5   Housing/Living Situation

This category is specific to physical shelter, living environment, access to critical utilities (heat, water, etc.) and the relationship of the client to others residing within the living environment (partner/family).

Scoring Considerations:

- Client's current physical living situation (own house, rent, homeless),

- Client's ability to pay rent, utilities and other housing requirements,

- Client's living environment, who resides with the client (dependents, partner with shared income, abusive relationship), and/or

- Client's ability to maintain access to housing services (history of incarceration, substance use, availability of housing in the area).

Score Suggestions

1   Secure, fully adequate housing, stable living situation, client is independently capable of financial and physical maintenance and is in no danger of losing housing.

2   Adequate current housing situation; client may infrequently need short-term rent or utilities assistance or may have mild stress in their living situation.

3   In transitional or unstable housing, may have unhealthy, stressful living environment. Client may be in continuous financial strain, eviction risk or risk of utility shutoff. Clients in this range are at risk of losing housing.

4   Client is homeless, in crises, living in shelter, sleeping on streets or in his/her car. Client's living situation presents immediate health hazard or physical danger from abuse. Client may be unable to qualify for housing opportunities due to criminal behavior.

Notes about using this category:

This category is weighted, reflecting the potential that inadequate, dangerous or socially untenable housing situations adversely impact care case management time and resources needed to keep the client engaged in primary HIV care or other supportive services. It is appropriate to consider the nature of the client's living situation with respect to the people they reside with; issues of domestic violence, physical and emotional abuse may adversely affect client stability. History of incarceration, substance use with client or a primary partner or dependent(s) may disqualify clients from some housing programs.

6   Support System

This category refers specifically to the network of formal and informal relationships providing appropriate emotional support to the client. This includes friends, family, faith communities, agencies and support groups.

Scoring Considerations:
• Client's current support system,
• Client's level of need for additional support,
• Client's ability to identify additional supportive services, and/or
• Availability of supportive services in the area needed by the client (support groups at a time and place client can access them).

Score Suggestions

1   Client has, and is aware of, extensive, appropriate and supportive relationships providing emotional support.

2   Moderate gaps in availability and adequacy of support network. Client may need additional skills to recognize and access support.

3   Client is chronically unable to access supportive network; support that is available is inadequate and unstable; client may be new to community with no friends, family or community support; client may need routine referral and follow-up.

4   Client is in acute crisis situation and cannot or will not access supportive relationships and may be isolated and/or depressed.

Notes about using this category:

Clients with supportive needs should be referred to emotional support groups, mental health counseling or to faith communities to assist them in fostering and independent support network.

7   Insurance Benefits

This category concerns the client's eligibility for, and access to, private or public insurance coverage adequate to provide a continuum of care for medical, dental or psychosocial services. This category also includes access to HIV medications through the AIDS Drug Assistance Program (ADAP).

Scoring Considerations:

- Client's current medical coverage,

- Client's current need for insurance coverage,

- Client's eligibility for private or pubic insurance benefits, and/or

- Client's ability to identify benefits and/or follow up on insurance enrollment requirements (produce needed documents, navigate the paperwork/system).

Score Suggestions

1   Client is insured with coverage adequate to provide access to the full continuum of clinical, dental and medication services available. Client may need occasional information or periodic review for renewal of eligibility.

2   Client needs assistance to complete eligibility reviews and may need directions and assistance compiling and completing documentation and application materials.

3   Client needs assistance meeting deductibles, co-payments and/or spend down requirements. Client may need significant active advocacy with insurance representatives, providers or DSHS to resolve billing and eligibility disputes.

4   Client is without coverage adequate to provide minimal access to care, is unable to pay for care through other sources and needs immediate assistance with eligibility reviews, etc.

Notes about using this category:

Current public and private insurance programs available in their service area may impact the SAM score in this category. Knowledge of available insurance programs and eligibility criteria is necessary to adequately evaluate clients in this category.

8   Transportation

This category covers the client's ability to travel for medical, psychosocial support, groceries and other essential HIV-related purposes.

> **Scoring Considerations:**
>
> - Client's current transportation methods (car, taxi, bus, walking, etc.),
>
> - Client's ability to access transportation (have money for bus, bus route close to medical care, can physically get to medical care, transportation appropriate for dependents), and/or
>
> - Client's lack of transportation affecting their ability to access medical care or other essential needs (e.g., grocery)/

Score Suggestions

1   Client is fully self-sufficient and has access to reliable transportation for all HIV-related needs.

2   Client needs occasional, infrequent assistance in obtaining transportation for HIV-related needs. Client may need assistance in reading and understanding bus schedules; may need referral to volunteer or other transportation services.

3   Client has limited access to public transport and is having routine difficulty accessing transportation services because of physical disabilities. Clients in this category may often miss appointments due to lack of transportation.

4   Client has no access to transportation, lives in an area not served by public transport and/or has no resources available for other transportation options. Clients with this score have an immediate need to be transported to HIV-related medical or supportive services.

Notes about using this category:

Current public transportation programs available in the service area may impact SAM scores in this category. Knowledge of available transportation programs is critical to adequately evaluate this category.

9   HIV-Related Legal

This category pertains specifically to *HIV-related* legal needs such as guardianship orders, medical durable power of attorney, social security insurance (SSI) benefits advocacy and assignment, living wills, do not resuscitate (DNR) orders and other needs directly related to the client's HIV status.

Scoring Considerations:

- Client's ability to identify need for legal services and knowledge of where to obtain them as they relate to their HIV status (power of attorney, guardianship for minor dependents), and/or

- Client's need for legal services directly related to their HIV disease.

Score Suggestions

1   Client has no unmet HIV-related legal needs.

2   Clients may need minimal, one time, assistance in completing documents or referral to appropriate legal services.

3   Client needs assistance identifying HIV-related legal needs and may require ongoing follow-up to insure that appropriate documents are available and appropriate orders are in place.

4   Client is in crisis situation, may not have valid power of attorney needed for immediate clinical decisions, or may be at risk of dying without a will; guardianship issues for minor children not properly resolved.

Notes about using this category:

When scoring this category the focus must be on legal issues directly related to the client's HIV status.

10   Cultural/Linguistic

This category relates to the client's ability to function appropriately in spoken and written English and the client's ability to fully understand what is happening to and around them. This category also encompasses issues relating to the cultural sensitivity of providers to client's needs based on gender identity, sexual orientation, religion, age, sight/hearing/physical disability, race and ethnicity.

Scoring Considerations:

- Client's ability to read, write and speak English or other languages essential to receiving services,

- Client's ability to understand their disease with respect to their educational, linguistic or cultural competence,

- Client's ability to access linguistically and/or culturally appropriate services (medical, supportive), and/or

- Client's immigration status as it relates to gaining access to services.

Score Suggestions

1   Client ahs no difficulty accessing services and is capable of high-level functioning within the linguistic and cultural environment.

2   Client may need infrequent, occasional assistance in understanding complicated forms, may need occasional help from translators or sign interpreters.

3   Client often needs translation or sign interpretation. Client may by functionally illiterate and needs most forms and written materials explained. Client may be experiencing moderate barriers to services due to lack of cultural sensitivity of providers.

4   Client is completely unable to understand or function within the service system, is in crisis situation and needs immediate assistance with translation or culturally sensitive system interpreters and advocates.

Notes about using this category:

It is appropriate for case managers to consider the client's full range of issues such as their first language, views on family, emotional development, spirituality, gender identity, beliefs about disease, values on alternative/non-western approaches to health care and ideas about confidentiality and disclosure. The client's immigration status may also be considered as it may cause significant stress and apprehension in seeking services.

11   Self-Efficacy

This category encompasses the client's ability to initiate and maintain positive behavioral changes, be an effective self-advocate and seek out and maintain services independently.

Scoring Considerations:

- Client's ability to make choices and put forth effort to change or access services or change behaviors (follow up on referrals, make phone calls, ask appropriate/needed questions),

- Client's ability to persist when confronted with obstacles to accessing services and/or making positive behavioral changes,

- Client's judgment of their capabilities to perform given tasks, and/or

- Client's ability to access services or make positive changes in behaviors.

Score Suggestions

1   Client is capable of initiating and maintaining access to services independently and is an effective self-advocate.

2   Client is able to initiate and seek out services with minimal assistance, may need information and referral.

3   Client needs frequent assistance getting motivated for an completing tasks related to their own care and often needs active follow-up to insure continued care.

4   Client is in crisis situation, unable to motivate to access needed care, unable to identify appropriate needs or actions, does not follow through on scheduled appointments. Client needs immediate care case management assistance.

Notes about using this category:

Case managers should consider the client's willingness and ability to be independent in filling out forms, making phone calls to set up their own appointments, their ability to correctly identify their own needs and their follow-through on commitments as appropriate criteria in scoring this category. A client's ability to be more self-efficacious reduces the impact on case management services in this category.

12   HIV Education/Prevention

This category covers the client's knowledge of HIV disease, HIV-transmission modes, his/her ability to identify past and present HIV transmission risk and ability and willingness to *engage* in and sustain behavior change interventions, including notifying past and present partners.

Scoring Considerations:

- Client's current and past risk taking behavior (sharing needles, anonymous sexual partners, unprotected sexual exposure, etc.),

- Client's knowledge of HIV transmission and prevention; awareness of his/her own risk,

- Client's willingness and skills level necessary to initiate and maintain risk reduction behaviors, including disclosure of HIV status with past, current or future needle sharing or sex partners,

- Client's participation in HIV behavior change interventions, and/or

- Client's history of other sexually transmitted diseases.

Score Suggestions

1   Client has adequate knowledge of multiple aspects of HIV treatment and prevention; has skills necessary to initiate and maintain protective behaviors and/or engages in positive behavior change, including harm reduction programs and partner services. Client reports no recent history of STDs.

2   Client is knowledgeable about most available HIV behavior change interventions and education services; client may have difficulty initiating or maintaining protective behaviors, may not be appropriately personalizing risk and may need education and referral. Client reports no recent history of STDs.

3   Client reports significant difficulty initiating and maintaining protective behaviors, inappropriately personalizes risk or reports frequent relapse to risk-behaviors. Client may report recent history of STD infection.

4   Client is active engaging in risk behaviors, unable or unwilling to identify and personalize transmission risk. Client in need of immediate, active referral to appropriate HIV behavior change interventions.

Notes about using this category:

Case managers should consider if the client is in an abusive relationship that might limit risk reduction for HIV transmission (e.g., sex industry workers). This may increase their SAM score.

13   Employment/Income

This category refers to the adequacy of the client's income, from all sources, to maintain independent access to care and to meet basic needs.

Scoring Considerations:

- Client's current source of income (employed, depend on other's income),

- Client's current need for income to cover basic needs (head of household with dependents, excessive debt, emergency situations), and/or

- Client's need for job placement/training or debt counseling.

Score Suggestions

1   Client's income is sufficient for basic needs; may be employed full-time or has alternate income.

2   Client's income may occasionally be inadequate for basic needs, may be employed part-time and may infrequently need emergency financial assistance or referral to other available services

3   Client has difficulty maintaining sufficient income from all sources to meet basic needs and requires frequent, ongoing case management referrals and benefits advocacy.

4   Client is in financial crisis and in danger of losing housing, access to basic utilities or critical health services because of inability to pay for co-pays or other bills. Client needs immediate, emergency intervention.

Notes about using this category:

Case managers should consider extenuating circumstances and conditions such as client being the head of a household with dependent children, pregnancy, genuine family emergency situations or other factors which make his/her financial situation more difficult.

14   Medication Adherence

This category refers to the client's ability to take all HIV-related medications as prescribed by their physician.

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Scoring Considerations:

- Client's need, desire and readiness to take HIV-related medications,

- Client's ability to take medications consistently,

- Client's ability to weigh pros and cons of taking antiretroviral medications, and/or

- Client's ability to access HIV-related medications (insurance, ADAP).

</div>

<u>Score Suggestions</u>

1   Client is following antiretroviral regimen, adherence greater than or equal to 95% or patient chooses not to take antiretroviral medications; no barriers to adherence; good access to resources. Client fully empowered for self-care in this category.

2   Client is on antiretroviral regimen, 90% to 95% adherent but may have some sporadic barriers to adherence. Client requires occasional case management information and referral to maintain optimal adherence.

3   Client is on antiretroviral regimen, 80% to 0% adherent, and experiencing ongoing barriers to adherence. Client needs continuing case manager follow-up to remain engaged with medication adherence programs or guidelines.

4   Client is in medication crisis, has stopped taking meds against medical advice or is being non-compliant for other reasons such as drug abuse, rapidly developing dementia, decreased ability to perform and maintain ADLs as part of disease progress, or mental health crises. Client needs immediate case management intervention.

Notes about using this category:

Case managers should consider factors such as scheduling medications around meals, side effects and the client's general ability to establish and maintain positive routines. You should also consider if the client is incarcerated, hospitalized, or detained in a mental health facility and how this may affect access to medications.

Scoring and applying System Acuity

The scoring schema for interpreting SAM scores incorporates weighting applied selectively to Mental Health, Substance Use/Abuse and Housing categories. Weighted scores can suggest the level of case management services most appropriate for the client at the time of measurement.

Scoring Directions

The following formula should be used to calculate weighted SAM scores:

> [Medical] + [BasicNeed] + ([Mental] x [Mental]) + ([Substan] x [Substan]) + ([Housing] x [Housing]) + [Support] + [Insurance] + [Transportation] + [Legal] + [Cultural] + [Efficacy] + [Educat] + [Income] + [Adherence] = Weighted System Acuity

> Where the integer value (1 - 4) for each category of need from the client acuity assessment is inserted in the appropriate bracket in the above formula. (Addition is indicated by '+' and multiplication by 'x').

Case Management Levels

Suggested case management levels based on weighted SAM scores:

Weighted Score	Suggested Level of CM Services
14 – 16	Open file, but ongoing case management not indicated
17 – 28	Case management client monitoring
29 – 44	Basic case management
45+	Intensive case management

Sample Charting Tool

Area of Service/Date of Assessment		02/11/08	03/18/08	03/21/08	05/20/08		
1	Medical/Clinical	2	1	1	1		
2	Basic Necessities/Life skills	1	1	1	1		
3	Mental Health	1	2	1	1		
4	Substance Use	1	1	1	1		
5	Housing	1	1	1	2		
6	Support System	2	1	1	1		
7	Insurance Benefits	1	2	1	1		
8	Transportation	1	1	1	1		
9	Legal	1	1	1	1		
10	Cultural/Linguistic	1	1	1	1		
11	Self Efficacy	2	1	1	1		
12	HIV Education/Prevention	1	1	1	1		
13	Employment/Income	1	1	1	1		
14	Medication Adherence	1	1	1	1		
	Raw Score	17	16	14	15		
	Weighted Score (see instructions)	**17**	**18**	**14**	**17**		