HIV Case Management Standards of Care

Texas Ryan White Part B and State Services

2015 Update

TEXAS
Department of
State Health Services

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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 stakeholders and partners, 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 from whom we borrowed generously:

Washington State Dept, of Health HIV/AIDS Program
New York State Dept. of Health, AIDS Institute
The District of Columbia (DC) HIV/AIDS, Hepatitis, STD & TB Administration
Contra Costa Health Services HIV/AIDS Program

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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 provisions 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 and/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 persons that 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.

Not all clients need to be case managed, and clients who are capable of self-management should be encouraged to do so.

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; and
- 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 Models

Case Management can be provided on a long or short-term basis. Clients should be evaluated during the assessment process to determine how much time will be needed to enable and empower clients to manage and maintain their own health. Case management need can be separated into three categories: No case management indicated short-term case management, and long-term case management. Clients may move from one category to another as life circumstances change.

No Case Management: Client has good understanding of HIV disease and how treatment impacts health; Client has evidence of maintenance in care and adherence to treatment; Client has undetectable viral load; Client has good understanding of risk reduction techniques; Client doesn't exhibit any major barriers to care; Client needs access to other agency resources.

Short-Term case management (MCM or N-MCM): Client is naïve to treatment and needs minimal education to understand HIV disease and how treatment impacts health; Client needs minimal assistance to understand how to access the care system and treatment options; Client needs minimal assistance to understand risk behaviors and risk reduction techniques; Client's viral load is unknown or detectable; Client has minimal barriers to care that can be addressed in 3-6 months

Long-Term case management (MCM or N-MCM): Client has history of being in and out of care; Client has history of poor compliance to prescribed treatment; Client is naïve to treatment and needs ongoing education to understand HIV disease and how treatment impacts health; Client needs ongoing assistance to understand how to access the care system and treatment options; Client has active or recent substance use or mental health issues; Client does not understand risk behaviors or risk reduction techniques and needs ongoing assistance; Client's viral load is unknown or detectable; Client has multiple adverse health conditions; Client has multiple barriers to care that can't be addressed in 3-6 months

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 more intensive 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, public benefits and assistance, 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.

Core components of MCM services are:

1) Coordination of Medical Care – scheduling appointments for various treatments and referrals including labs, screenings, medical specialist appointments, mental health, oral health care, and substance abuse treatment
2) Follow-up of Medical Treatments – includes either accompanying client to medical appointments, calling, emailing, texting or writing letters to clients with respect to various treatments to ensure appointments were kept or rescheduled as needed. Additionally, follow-up also includes ensuring clients have appropriate documentation, transportation, and understanding of procedures. MCM staff must also encourage and enable open dialogue with medical healthcare professionals.
3) Treatment Adherence – the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments.

Clients that meet any of the criteria listed below must automatically be enrolled in MCM services, with contact between the case manager and the client every two weeks:

- Homeless
- Recently released from incarceration

- Pregnant
- CD4 count below 200 or VL > 10,000 copies/ml
- Newly diagnosed
- Untreated mental illness (including substance use disorders)
- New to Antiretroviral therapy
- Not in care/re-engaging in care
- Non-adherence to HIV medication
- Unable to navigate System of Care due to language

Clients meeting any of the above criteria must remain in MCM for at least a three-month period, with contact every two weeks, in order to address the immediate challenges associated with these issues. Clients may be reassigned to a lower level of frequency of contact, if appropriate, after re-assessment.

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. N-MCM is also an appropriate service for clients who have been discharged from MCM 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 services is to facilitate access to support services and to assist the client to become as self-sufficient as possible in their daily life. N-MCM can be long-term or brief.

Providing specific services such as housing assistance or transportation are not case management; but identifying the need for housing assistance, transportation, or other services, and arranging to have that assistance provided is case management.

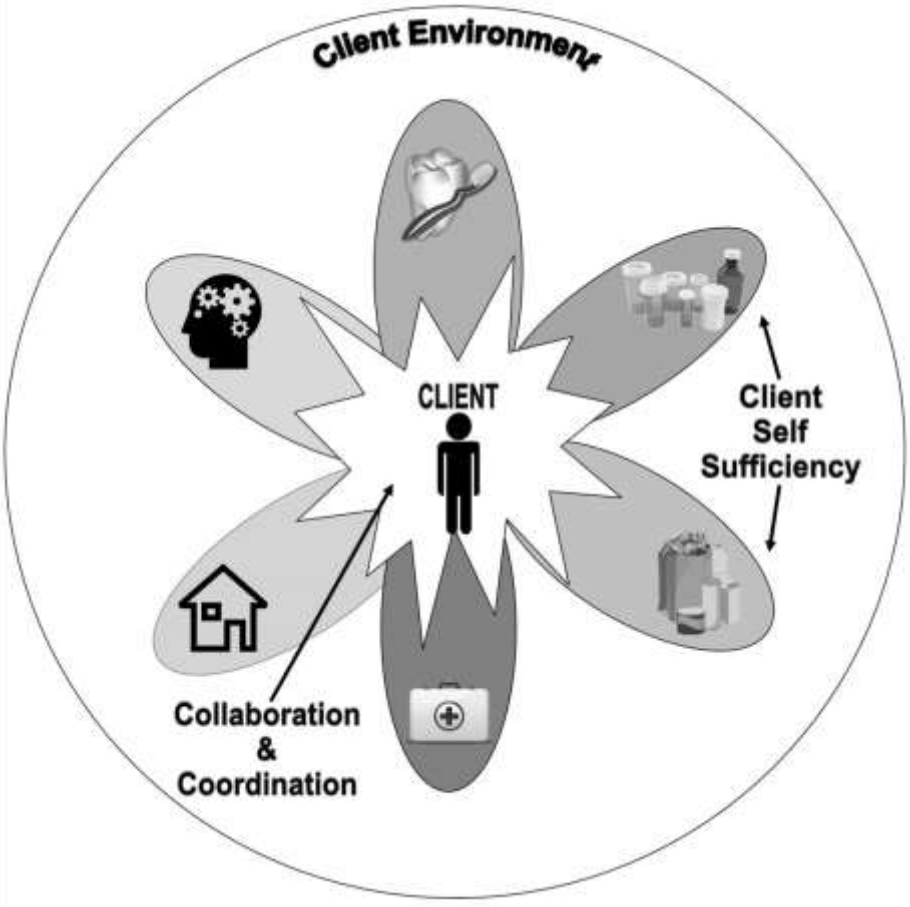
Please view the table below for guidelines on what client issues are appropriate for these service categories:

No CM	MCM	N-MCM
• Client shows evidence of medical adherence (appropriate lab work, history of keeping medical appt.) • Client has episodic financial assistance needs that do not require any additional work on staff beyond the provision of the service (monthly transportation, monthly insurance assistance, quarterly OAMC assistance) • Client has one-time needs (signing up for insurance, applying for ADAP)	• Newly diagnosed client (or any client) that needs education/training about HIV disease and treatment • Multiple and/or complex health-related needs that the client can't manage on their own • Pregnant women • Substance Use issues • Mental Health issues • Medication and/or treatment adherence issues • History of being 'out of care' in the past	• Clients who do NOT require coordination or follow-up of medical care and treatments Referral, coordination and follow-up of certain ancillary services (e.g. housing, food, transportation) to help stabilize the client toward benefiting more effectively from medical intervention • Clients who need assistance in applying for and ongoing assistance maintaining public/private benefit programs • Other financial assistance needs*

***** One-time or infrequent service provision only (i.e. initial application for Medicaid or providing infrequent financial assistance only) does not require case management services.

Case Management Activity Status

Status	Definition
Active	Client has had a *successful* contact with HIV case management services within the last 3-6 months. *Successful* contact means contact initiated by a case manager or client and care plan focused.
Inactive	Client who has not had a *successful* contact with HIV case management services within the last 6-9 months. *Successful* contact means contact initiated by a case manager or client and care plan focused.
Lost to follow-up (LTF)	3 unsuccessful attempts to contact the client in 3 months. *Successful* contact means contact initiated by a case manager or client and care plan focused. (See Case Closure/Graduation standard on p. 34)
Graduated	Client who has reached the goals and objectives outlined in their care plan and therefore no longer require case management services to maintain their HIV health. (See Case Closure/Graduation standard on p. 34)
Discharged	Client who is no longer available for case management services. Reasons include, but are not limited to: death, transfer to another agency, relocation from services area or violation of agency rules. (See Case Closure/Graduation standard on p. 34)



Coordinated System of Case Management*

*US DHHS. Recommendations for Case Management Collaboration and Coordination in Federally Funded HIV/AIDS Programs. August 2008.

        - Reporting
            - Responsible staff
                - Required documentation / forms
        - Notification
            - Client
            - Administrative Agency
            - DSHS
        - Investigation/Mitigation
            - 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* must be client-centered and 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 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 (QI),* 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

        - Review of results
        - Execution
    - QM Workplan
        - Table of QM (QA/QI)activities
            - Activities
            - Responsible staff
            - Frequency
            - Timeframe
            - 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
            - 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 P & Ps for *Staff Supervision* should cover:

- Staff positions responsible for supervision
- Type and frequency of supervisory activities, including:
    - Case reviews with case management staff
    - Process for randomized client file review and monitoring of caseloads

    - Staff job performance
- Necessary documentation, including:
    - 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 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

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 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 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 (e.g. 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
  - Guidance should include the requirement for written notification of consumer regarding the suspension of service/alternate method of accessing service that includes:
    - Statement of which services are being impacted by the suspension/alternate access
    - Description of alternate method of accessing services and contact information for staff/agency
    - Steps that the consumer can take to return to regular access to services
    - Signed acknowledgement by consumer of receipt of the notification
  - 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 indicate.

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 and State Services funded programs (both MCM and N-MCM). 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 *Promising Practices*. While these are highly recommended, the *Promising 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 not been active in case management services for more than six 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. A sample Client Intake Form can be found at the DSHS HIV Case Management portal.

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.).	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 • Documentation of HIV status • 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 is here. • 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. 6) The Brief Intake and Eligibility Determination is documented in the primary client record system. See policy number 231.004 "Documenting Case Management Actions in ARIES" for further details

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 (service categories considered an

urgent need are outpatient ambulatory medical care, or [OAMC, and local pharmaceutical assistance program, or LPAP, to provide other services during the conditional eligibility period, please consult with your Administrative Agency). All service agencies must make a reasonable effort to assist clients to obtain the necessary documentation.

Please see policy number 220.001 "Eligibility to Receive HIV Services" for further details:

dshs.texas.gov/hivstd/policy/policies.shtm

Promising Practice
Use the intake period to collect information about all the agencies the client is working with so that your agency can have all necessary releases of information and consents signed to ensure continuity of care.

POPULATIONS REQUIRING CASE MANAGEMENT AT INTAKE

Clients that meet any of the criteria listed below should automatically be enrolled in Medical Case Management services with contact every two weeks:

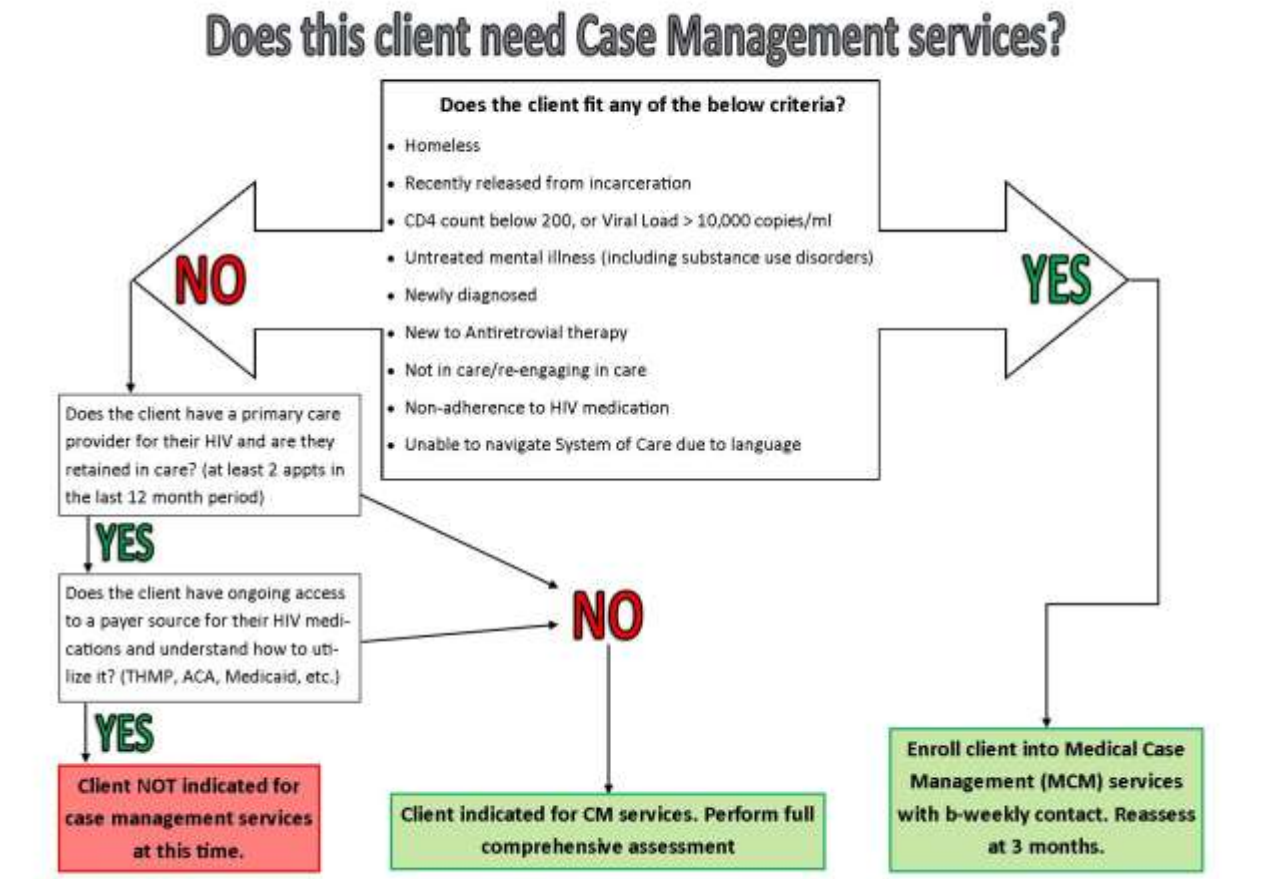
- Homeless
- Recently released from incarceration
- Pregnant
- CD4 count below 200 or VL > 10,000 copies/ml
- Newly diagnosed
- Untreated mental illness (including substance use disorders)
- New to Antiretroviral therapy
- Not in care/re-engaging in care
- Non-adherence to HIV medication
- Unable to navigate System of Care due to language

Clients meeting any of the above criteria must remain in Medical Case Management with contact every two weeks for at least a three-month period in order to address the immediate challenges associated with these issues. Clients may be reassigned to a lower acuity level, if appropriate after re-assessment.

Promising 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.



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, and
- An ongoing assessment of the client's knowledge of relevant disease process(es) (e.g. 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 • Routine health maintenance (ex. well women exams, pap smears) • Immunizations • 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 the DSHS HIV Case Management portal for the SAMISS tool.) • Mental Health (see the DSHS HIV Case Management portal for the SAMISS tool.) • 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, two verbal and one 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 primary client records system. See policy number 231.004 "Documenting Case Management Actions in ARIES" for further details.

Promising 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 client's 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 during the Comprehensive Assessment period. Acuity must be updated as needed with significant changes in a client's needs and formally reviewed every six (6) months to ensure it's still appropriate for the client's needs. Acuity levels must be associated with frequency of case manager initiated contact.	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 primary client record system. 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 can be found at the DSHS HIV Case Management portal. 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 5) Acuity is documented in the primary client record system. See policy number 231.004 "Documenting Case Management Actions in ARIES" for further details.

Suggested Acuity Levels and Frequency of Case Manager Initiated Contact

(Acuity levels based on the System Acuity Measurement Tool (SAM) located here XXX)

14-16 - CM not indicated. If you feel a client still needs to be case managed at this level, discuss with supervisor and document [e.g. client is one of the priority populations indicated for automatic inclusion in CM such as recently released, pregnant, recently diagnosed]).

17-28 - Level 1 (Low): CM Client Monitoring. CM initiated contact bi-annually. HIV-positive symptomatic individuals with aggravating, but not acute medical, financial. or psychosocial needs who request assistance from the provider agency with case management and/or medical strategy decisions and who may benefit from moderate care assistance

29-44 - Level 2 (Moderate): Basic Case Management. CM Initiated contact quarterly. Client may require routine follow-up to ensure ongoing access to services, or referrals to maintain their access to specific supportive services. Significant amount of collateral contacts.

45-60 - Level 3 (High): Intensive Case Management. CM initiated monthly contact. HIV-positive clients with complex and acute medical, financial, or psychosocial needs whose needs require emotional and/or environmental support in order to manage their own care/service plan. Expect a significant amount of collateral contacts.

61+ - Level 4 (Highest): Crisis Case Management. CM initiated contact every two weeks minimum. HIV-positive clients have an immediate crisis or situation that requires immediate and ongoing action by CM. Clients with severe and acute medical, financial, or psychosocial crisis that may have difficulty in successfully managing a personal care/service plan. Expect intensive service coordination with other agencies/providers.

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. Care Plan samples may be found at the DSHS HIV Case Management portal .

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.
 	
Time Requirement: Following completion of the Comprehensive Assessment/ Reassessment. Care Plans must be updated as needed with significant changes in a client's needs and formally reviewed every 6 months to ensure it's still appropriate for the client's needs. A temporary Care Plan may be executed following completion of the Brief Intake based upon immediate needs or concerns.
	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
	
	2) A new Care Plan must 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) Care Plans must be documented in the primary client record system. See policy number 231.004 "Documenting Case Management Actions in ARIES" for further details.

Promising 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 the client need to do in order to get this accomplished?
- Time specific – what period of time has been set to get this accomplished?

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

MCM ONLY – Viral Suppression/Treatment Adherence

A core component of MCM services is to assist clients to achieve and maintain viral suppression. Treatment adherence support includes interventions to ensure readiness for, and adherence to, complex HIV/AIDS treatment. With the advent of effective medical treatments, HIV has evolved into a chronic, manageable disease. However, medications only work if they are taken as prescribed. Successful HIV treatment requires the cooperation and coordination of a complex network involving clients, social networks, and providers. An assessment of treatment adherence support needs and client education should begin as soon as clients enter MCM services and should continue as long as a client remains in MCM services. Treatment adherence support is an on-going process, which may change with client needs, goals, objectives, medical conditions, and living conditions.

The goal of treatment adherence interventions is to provide the client with the necessary skills, education, and support to follow mutually agreed upon goals to achieve optimal health. This includes, but is not limited to: 1) Taking all medications as prescribed; 2) Making and keeping appointments; 3) Overcoming barriers to care and treatment; and 4) Adapting to therapeutic lifestyle changes as necessary. Studies demonstrate that most clients who take their medications exactly as prescribed 95% of the time are more likely to achieve viral suppression and are less likely to develop drug resistance. MCM services should involve an individually-tailored adherence intervention program, and **staff providing MCM should reinforce treatment adherence at every contact, whether it is during face-to-face contact or telephone contact.**

The following criteria can help MCM staff and clients examine the client's current and historical adherence to both medical care and treatment regimens and can help guide care planning.

Medication Adherence: Relates to current level of adherence to ARV medication regimen and client's ability to take medications as prescribed.

Appointments: Relates to current level of completion of appointments for core medical services and understanding of the importance of regular attendance at medical and non-medical appointments in order to achieve positive health outcomes.

ARV Medication Side Effects: Relates to adverse side effects associated with ARV treatment and the impact on functioning and adherence.

Knowledge of HIV Medications: Relates to client's understanding of prescribed ARV regimen, the role of medications in achieving positive health outcomes, and techniques to manage side effects.

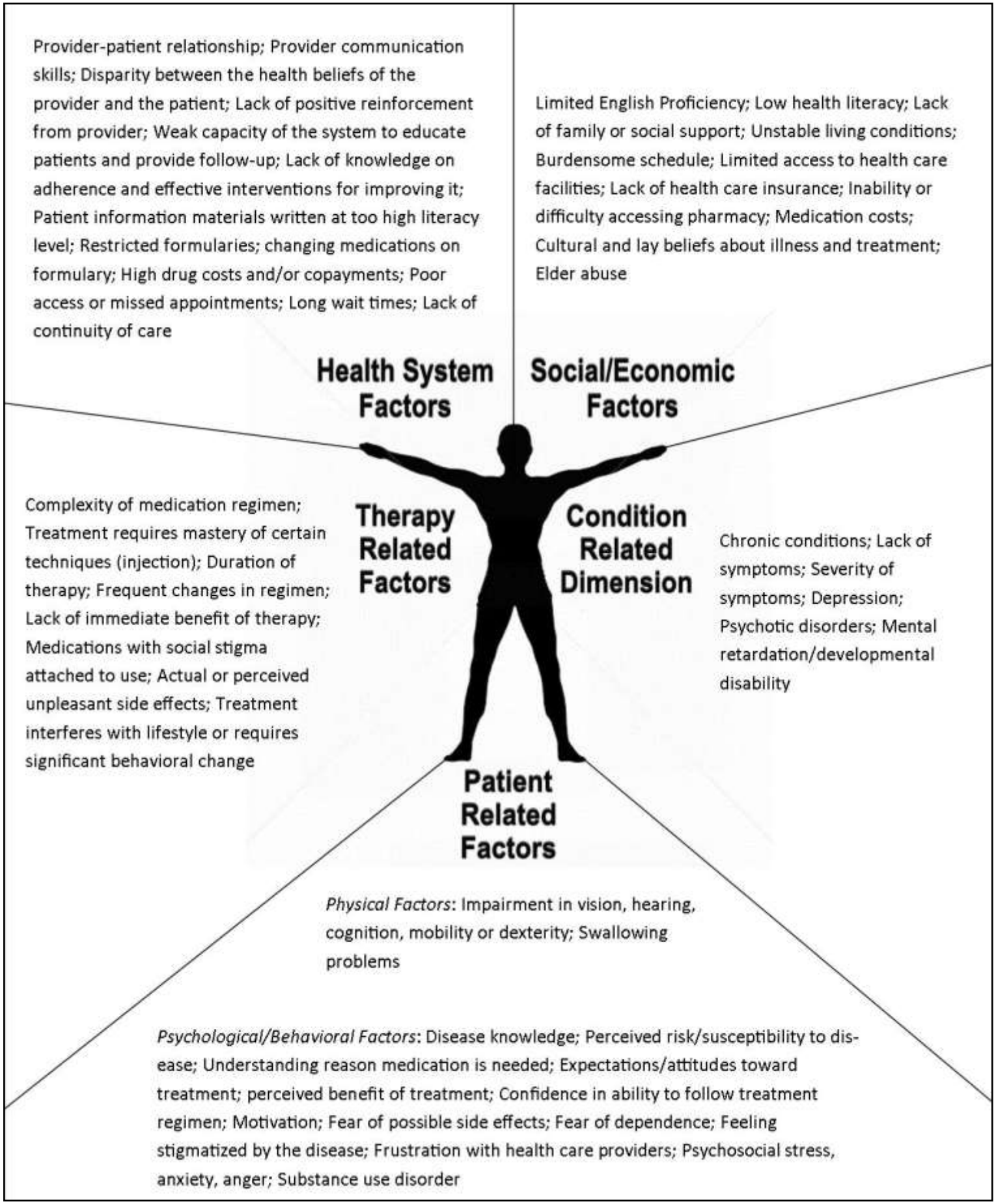
Treatment Support: Relates to client's relationship with family, friends, and/or community support systems, which may either promote or hinder client adherence to treatment protocols.

Treatment Adherence Support at Every Client Contact and Stage in the MCM Process

Intake	• Ask if client is on medication; schedule primary care appointments or ensure existing ones are kept • Ensure client has access to health/drug payer programs – e.g. THMP, Medicare, Medicaid, or Public Insurance, including the Affordable Care Act/Marketplace Plans
Assessment	• Utilize treatment adherence screening tools found here XXX to determine client needs, strengths, and barriers • Identify and address barriers to treatment adherence • For clients on ARVs, reinforce adherence
Care Plan	• Develop client-centered strategies to maintain optimal adherence • Communicate with the primary care providers
Care Plan Implementation and Monitoring	• Ask about treatment adherence at every client encounter. Viral suppression is the goal • Educate on adherence to avoid resistance and for viral suppression • Use adherence tools and interventions to support client (sample tools found here XXX)
Reassessment	• Reinforce client's strengths in treatment adherence and formally reassess the care plan to ensure tasks are appropriate for viral suppression goals and are contributing towards medical improvements

Standard	Criteria
A core component of Medical Case Management Services, Treatment Adherence Counseling and Viral suppression should be a primary focus of MCM services. Every MCM encounter should involve discussion around treatment adherence. MCM programs have a responsibility to provide treatment adherence services, either directly or through active referrals.	1) MCM staff will assess clients for medication/treatment adherence and in coordination with the client, develop specific treatment adherence care plans. 2) MCM staff will educate the client about the goals of therapy. 3) MCM staff will discuss side effects of medications as challenges and barriers to treatment adherence, including diarrhea, nausea, rash, headache, vomiting, swallowing, and problems due to thrush. Other barriers include fear, making lifestyle behavior changes, homelessness, mental health issues, and drug use. These should be reported to clinical personnel for follow-up (with appropriate releases of information). 4) MCM staff will discuss the importance of medication adherence and consequence of missing doses (leading to viral resistance and mutations). 5) MCM staff will use any available treatment adherence tool to promote adherence. These include pillboxes, pocket-sized medication records, reminder sheets, text reminder systems, etc. Samples of treatment adherence tools can be found here XXX. 6) MCM staff in non-clinical settings will establish formal linkages and relationships with primary care providers and monitor treatment adherence. Staff providing MCM must be part of the client's clinical care team and have access to the client's medical records, regardless of setting. 7) MCM staff will reinforce treatment adherence at every contact. 8) MCM will encourage clients to discuss taking over-the-counter (OTC) medications (including herbal treatments) with clinical personnel prior to taking them in order to avoid adverse interactions with HIV medications. 9) MCM staff will provide basic HIV information ("HIV 101") as needed. This includes an explanation of HIV/AIDS, viral load and viral suppression, CD4 counts, and the significance of other relevant laboratory values. 10) MCM staff will encourage sexual health literacy and provide education on harm reduction (either directly or through referral) and encourage the use of condoms as appropriate, to avoid transmission and reinfection of HIV, and to avoid contracting different strains of HIV. 11) Treatment adherence discussions and interventions are documented in the primary client record system. See policy number 231.004 "Documenting Case Management Actions in ARIES" for further details.

Five Interacting Dimenstions of Adherence - World Health Organization, 2011



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, the Comprehensive 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 • Routine health maintenance (ex. well women exams, pap smears) • Immunizations • 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 the DSHS HIV Case Management portal for the SAMISS tool.) • Mental Health (see the DSHS HIV Case Management portal for the SAMISS tool.) • 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, for case managers during their probationary period 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, two verbal and one 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. 4) The Comprehensive Reassessment is documented in the primary client record system. See policy number 231.004 "Documenting Case Management Actions in ARIES" for further details.

Promising 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 Promising Practices under Comprehensive Assessment.

New Client Process

Client Intake

(see 'Client Intake Form')

Does client need Case Management services?

YES

Conduct comprehensive assessment to determine:

1) Model of case management services (MCM, N-MCM or both)
2) Intensity of CM services (short-term or long-term)
3) Acuity of client (frequency of CM initiated contact)

Care Plan; Acuity; Substance Use and Mental Health screen; Behavior risk screen

NO

No further assessment needed. Client can manage their health on their own. Client may need other agency services

6 months—all clients receiving Ryan White services *attest* to their eligibility (at least one service during period)

6 months—Acuity formally reviewed for all CM clients; Care Plan formally reviewed for all CM clients.

MCM—clients receiving MCM must have comprehensive reassessment performed.

12 months—acuity formally reviewed for all CM clients (N-MCM and MCM); Care Plan formally reviewed for all CM clients (N-MCM and MCM); comprehensive reassessment for all CM clients (N-MCM and MCM)

12 months—all clients receiving Ryan White services must have eligibility *determined* (at least one service during period)

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 (MOUs), 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 primary client record system	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 primary client record system. This includes documentation of follow-up after missed referral appointments.

Promising Practices

Agencies that coordinate with a variety of service providers and hold multiple MOUs can best meet diverse client needs. Being familiar with the processes of the agencies you are referring to can also be vital in completing a successful referral. Staff members who are unfamiliar with referral agencies should schedule a visit with the agency and staff.

When clients are referred for 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. Clients who are no longer receiving case management services may still access other needed services from the agency as appropriate.

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 six months in a correctional facility
- Provider initiated termination due to behavioral violations
- Client's death

Standard	Criteria
Upon termination of active case management services, a client's 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 three 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. Make sure appropriate Releases of Information and consents are signed by the client and meet requirements of HB 300 regarding electronic dissemination of protected health information (PHI). 5) In accordance 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. 10) Case Closure/Graduation is documented in the primary client record system.

Promising Practices

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

Case managers should utilize multiple methods of contact (phone, text, e-mail, certified letter) when trying to re-engage a client, as appropriate. Agencies must ensure that they have releases of information and consent forms that meet the requirements of HB 300 regarding the electronic dissemination of protected health information (PHI).

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 fully reflect 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 consistent quality services delivery 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
ACA	Affordable Care Act
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
FPL	Federal Poverty Level
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
HIPAA	Health Insurance Portability and Accountability Act
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)
LPAP	Local Pharmaceutical Assistance Program
MAI	Minority AIDS Initiative
MCM	Medical Case Management
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
N-MCM	Non-Medical Case Management
NNRTI	Non-Nucleoside Reverse Transcriptase Inhibitor
NRTI	Nucleoside Reverse Transcriptase Inhibitor
OAMC	Outpatient Ambulatory Medical Care
OMB	Office of Management and Budget (Federal)
OSHA	Occupational Safety and Health Administration
P & P	Policies and Procedures
PBC	Protocol Based Counseling
PCR	Polymerase Chain Reaction (test or assay)
PEMS	Prevention Evaluation Monitoring System
PI	Protease Inhibitor
PID	Pelvic Inflammatory Disease
PLWH	Persons 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