MINUTES

Date: July 22, 2014

MEETING CALLED BY	Texas HIV Care Services Group
TYPE OF MEETING	Standards Workgroup conference call
FACILITATOR	Teena Edwards, DrPH, MSN, RN
ATTENDEES	See page 12

OLD BUSINESS

None

DISCUSSION	
CONCLUSION	

NEW BUSINESS

WELCOME	**Teena Edwards, Facilitator**
	Process: Go down and list of general comments and discuss each one. (Item number corresponds to the number on the General Comments on Case Management Standards

Texas HIV Case Management Standards - General Comments

TOPIC/ITEM 1	The current DSHS standards as well as the draft monitoring tool do not capture the expectations for case managers to provide benefits counseling and enrollment assistance disease;
DISCUSSION	DSHS proposed to include this in the Payor of Last Resort standards and tool. Discussion results in what HRSA guidance was and how to implement that guidance. Stakeholders stated that they felt HRSA was clear that they want to have expanded roles of the case managers in the ACA enrollment process. Talked about the different service categories having that role as well, so DSHS would like to make it an agency policy and not specific to one-two service categories. Decision was to table this discussion because this will require a larger conversation and review of the payor of last resort standards.
CONCLUSION	Table this discussion until release of the payor of last resort standard and monitoring tool
FOLLOW-UP ACTIONS	Discussion to take place after the standard has been released - target date November/December 2014
PERSON RESPONSIBLE	Teena Edwards, DSHS

TOPIC/ITEMS 2 and 3	Once the standards are created, will the POPs (Program Operating Procedures) go away?
DISCUSSION	POPs will be revised as needed to further implement the Standards as appropriate. The POPs also contains information from some of the other programs, the POPs will never go away.
CONCLUSION	Our portion of the POPs will be updated after all of the standards have been written
FOLLOW-UP ACTIONS	Review POPs in early 2015 for updating
PERSON RESPONSIBLE	Janina Vazquez, DSHS

TOPIC/ITEM 4	Does all of this really need to be re-evaluated for all case management clients and does all of this really need to be re-

	evaluated for non-case management clients. How often?
DISCUSSION	If a client needs case management services, then they all need a complete assessment. In other words, if a client isn't being case managed, they do not need the comprehensive assessment, the needs assessment, screened for substance use or mental health or an acuity score. All they need is eligibility determination completed and attested to at the six month point with full determination completed annually. As long as no case management services have been provided and entered into ARIES, it will not trigger missed assessments in ARIES on the RSR. This also applies to those clients who have graduated from case management.
CONCLUSION	Clarification provided
FOLLOW-UP ACTIONS	None
PERSON RESPONSIBLE	

TOPIC/ITEM 5	BVCOG requires non-case managed clients to have a needs assessment annually or after a life changing event. Or after hospitalization. The rational is that if they are never assessed, how do you know they don't need case management
DISCUSSION	If the AAs wants to add an annual needs assessment for non case managed clients. they may do so for their region. As long as the requirement is more stringent than these minimal requirements, that is okay. However the requirement needs to be based on a sound rationale, promising practice, or emerging practice.
CONCLUSION	Clarification provided
FOLLOW-UP ACTIONS	None
PERSON RESPONSIBLE	

TOPIC/ITEMS 6, 7, and 8	Three comments regarding the intake/assessment process. 1) The intake process is not “brief” by any measure and

	requires an assessment that is of a level that I would not feel could be addressed by a staff member who was not part of the case management team as emergent needs and interventions are part of the initial intake process. 2) The Initial Comprehensive Assessment is a repeat of the information gathered less than 30 days prior and some clients are resentful of having to answer the same questions and review the same material with another staff member. For us, the intake assessment is fairly "comprehensive" as that is the best way to determine an "emergent" need. 3) In my humble opinion…this initial process needs to be refined and streamlined into something that is more client friendly and doesn't require as much of a time commitment from them.
DISCUSSION	There seems to be confusion between the assessment and the intake since for a long time they were one and the same. DSHS split these two because in some regions intake specialists do the intake process while case managers do the assessment. The brief intake is minimal. The assessment can be completed at the same time, but it is a promising practice to complete over several visits. If the client lives far away and it is not realistic for them to travel in for appointments, over the phone completion is acceptable. The standards require one face-to-face meeting.
CONCLUSION	Clarification provided regarding intake and assessment processes
FOLLOW-UP ACTIONS	None
PERSON RESPONSIBLE	

TOPIC/ITEM 9	The requirement that clients who have been out of services for 3 months need a new intake is excessive. Eligibility, acuity, reassessment can be addressed through the Comprehensive Assessment/Reassessment processes. I

	would suggest that a new intake is not needed until the client has been out of services for at least one year. The current process of new intake after 3 months puts additional barriers in the client's path of returning to services and some of them already resist the process because of the amount of documentation and time we require of them to maintain services.
DISCUSSION	There may be a misunderstanding regarding out of service. This pertains to someone who has been discharged from case management. If after 3 months after they have been discharged, they seek services, the case manager needs to complete the brief intake at a minimum. This includes asking the basic demographic questions. The case manager does not need to complete the initial paperwork as the client's file has not been destroyed - just update the information.
CONCLUSION	Clarification provided. The 3 month requirement pertains to discharged clients only; not those who have just been out of care over a three month period or hasn't received case management services for 3 months or longer depending on the acuity.
FOLLOW-UP ACTIONS	None
PERSON RESPONSIBLE	

TOPIC/ITEM 10	Also, being part of the HIV Syndicate that is looking at viral suppression/adherence, we were hoping to see the role of case managers as it relates to viral suppression/adherence defined in the case management standards.
DISCUSSION	One of the primary goals of case management services is to help clients understand and manage their disease effectively. DSHS is understanding that stakeholders want us to strengthen the definition and the role of the case manager in medical adherence and identify tools that the case manager may use to assist

	them in determining adherence. The monitoring of this item will remain the same as case manager are currently documenting adherence counseling in the case notes.
CONCLUSION	Additional information needs to be added to the Standards to further explain the role of case managers in medical adherence.
FOLLOW-UP ACTIONS	Section will be added to the Case Management Standards to include role of the case manager and what markers, such as lab work and medication they need to look for in assessing medical adherence. Also that the case managers need to be part of a medical care/coordination team and case conference with the clinical care team. Medical adherence assessment tool will be included in the online toolkit for case managers once the HIV Syndicate Viral Suppression workgroup determines best tools.
PERSON RESPONSIBLE	Ann Dills and Teena Edwards, DSHS

TOPIC/ITEM 11	The Standards are written as minimum standards, but are difficult to implement due to caseload size. The Standards are reflective of a caseload of 25, when in fact the caseload is generally 100+.
DISCUSSION	DSHS is starting to see case managers graduate their clients, but it still appears that some agencies may have larger case loads (metro agencies have large case loads because their HIV population is large). Stakeholders discussed the fact that with additional training to case managers, standard acuity, and dropdown options for recertification, we may can a clearer picture of what is case management.
CONCLUSION	Implementation of several training and processes will help case managers manager this better and we should see how this plays out at the agency level in

	the next couple of years.
FOLLOW-UP ACTIONS	None
PERSON RESPONSIBLE	

TOPIC/ITEM 12	Standards are difficult to follow. New employees are challenged to pick up the standards and clearly understand role.
DISCUSSION	Supervisors in the agencies need to train the new case managers over a longer period of time. There is a lot of turnover in case management staff and training is ongoing. Some comments from the field is that standards are not user friendly and the case managers are confused regarding the frequency of doing the tasks needed. In addition, in some agencies more than one staff person completes components of the assessment and follow-up.
CONCLUSION	Develop a flow sheet/tracking form that lists the different components and the frequency for staff to initial when completed. This would become part of the primary clients record system/case notes as appropriate. This will not only help case managers determine what needs to be completed, but also decrease duplication.
FOLLOW-UP ACTIONS	DSHS to develop flow sheet
PERSON RESPONSIBLE	Ann Dills, DSHS

TOPIC/ITEM 13	Expectations for frequency of case management contacts should be delineated in the Standards based on acuity.
DISCUSSION	DSHS will be sending out a draft of an acuity as far as frequency of contact for your review.
CONCLUSION	Draft acuity for statewide use
FOLLOW-UP ACTIONS	Send out draft by end of august 2014
PERSON RESPONSIBLE	Ann Dills, DSHS

TOPIC/ITEM 14	Examples of care plans should be in the Standards
DISCUSSION	DSHS will put sample care plans on the HIV/STD website
CONCLUSION	Sample care plan will be made available
FOLLOW-UP ACTIONS	Posted to HIV/STD website by end of August 2014.
PERSON RESPONSIBLE	Ann Dills, DSHS

TOPIC/ITEM 15	Best practices highlighted in the Standards are not evidence based and therefore aren't true best practices (think the term "promising practice" was used during HIV Syndicate Meeting).
DISCUSSION	Agree
CONCLUSION	DSHS will change the term to promising practices in the Standards
FOLLOW-UP ACTIONS	Update Standards
PERSON RESPONSIBLE	Ann Dills, DSHS

TOPIC/ITEM 16	The role of the case manager in treatment adherence isn't clearly identified.
DISCUSSION	Already discussed
CONCLUSION	Additional information needs to be added to the Standards to further explain the role of case managers in medical adherence.
FOLLOW-UP ACTIONS	Section will be added to the Case Management Standards to include role of the case manager and what markers, such as lab work and medication they need to look for in assessing medical adherence. Also that the case managers need to be part of a medical care/coordination team and case conference with the clinical care team. Medical adherence assessment tool will be included in the online toolkit for case managers once the HIV Syndicate Viral Suppression workgroup determines best tools.
PERSON RESPONSIBLE	Ann Dills and Teena Edwards, DSHS

TOPIC/ITEM 17	The Standards are written as minimum

	standards, but are difficult to implement due to caseload size. The Standards are reflective of a caseload of 25, when in fact the caseload is generally 100+.
DISCUSSION	Discussed earlier
CONCLUSION	Develop a flow sheet/tracking form that lists the different components and the frequency for staff to initial when completed. This would become part of the primary clients record system/case notes as appropriate. This will not only help case managers determine what needs to be completed, but also decrease duplication.
FOLLOW-UP ACTIONS	DSHS to develop flow sheet
PERSON RESPONSIBLE	Ann Dills, DSHS

TOPIC/ITEM 18	The role of the Ryan White case manager is evolving in response to the ACA, but this isn't reflected in the Standards.
DISCUSSION	Discussed earlier
CONCLUSION	Table further discussion until release of payor of last resort standard
FOLLOW-UP ACTIONS	Release of payor of last resort standard November/December 2014
PERSON RESPONSIBLE	Janina Vazquez, DSHS

TOPIC/ITEM 19	The role of intake/eligibility/brief intake should be better explained. Recommend presenting in a table format.
DISCUSSION	Stakeholders felt implementation of a flow sheet will help with this.
CONCLUSION	Develop a flow sheet/tracking form that lists the different components and the frequency for staff to initial when completed. This would become part of the primary clients record system/case notes as appropriate. This will not only help case managers determine what needs to be completed, but also decrease duplication.
FOLLOW-UP ACTIONS	DSHS to develop flow sheet
PERSON RESPONSIBLE	Ann Dills, DSHS

TOPIC/ITEM 20	Intake-no CM isn't referenced in the Standards
DISCUSSION	This will be addressed in the taxonomy
CONCLUSION	Update taxonomy
FOLLOW-UP ACTIONS	Due early 2015 after all standards have been completed
PERSON RESPONSIBLE	Teena Edwards, DSH

TOPIC/ITEM 21	The role of the medical vs. non-medical case manager should be better delineated.
DISCUSSION	DSHS will send out a table for your input outlining the differences between medical and non-medical case management
CONCLUSION	DSHS will delineate better in the Standards
FOLLOW-UP ACTIONS	DSHS to send out table within in the next couple of weeks
PERSON RESPONSIBLE	Ann Dills, DSHS

TOPIC/ITEM 22	Inconsistent messages from the Standards being written as minimum standards and DSHS staff presenting as more flexible and allowing for variance. If they are flexible, they should be written as flexible
DISCUSSION	Discussion regarding what information was inconsistent and the training clarified several points in the standards. Ann clarified use of acuity. The other concern voiced was regarding the domains within the comprehensive assessment and whether all needed to be assessed. Point was made that if the item didn't pertain to the client's situation (for example, parenting), then that domain did not need to be assessed.
CONCLUSION	Easier to understand for the case managers if the list was separated into those domains needing to be assessed on everyone and those domains that are optional depending on the client's situation.
FOLLOW-UP ACTIONS	DSHS will separate into two categories in the standards
PERSON RESPONSIBLE	Ann Dills, DSHS

TOPIC/ITEM 23	Documentation of case notes are prepared and enter differently by all direct service providers. Case Notes vary significantly. In monitoring is there a sample of progress notes we would be able to reference other than the Policy for Case Notes.
DISCUSSION	Sample progress notes/case notes is needed for clarification
CONCLUSION	DSHS will post sample progress notes/case note on our website
FOLLOW-UP ACTIONS	Posting of samples on HIV/STD website until the online case management toolkit is available
PERSON RESPONSIBLE	Ann Dills, DSHS

TOPIC/ITEM 24	Is it really necessary to keep a list of household members or is it unnecessary unless the client is receiving HOPWA.
DISCUSSION	DSHS response is yes, you need to keep a list of household members whether or not the client is receiving HOPWA.
CONCLUSION	It is part of eligibility determination
FOLLOW-UP ACTIONS	None
PERSON RESPONSIBLE	

TOPIC/ITEM 25	Minimum qualifications for CM supervisors. Direct service providers recommend they be established regionally.
DISCUSSION	DSHS established these qualifications statewide because we need the level of education and experience for all management supervisors to be the same across regions.
CONCLUSION	These qualifications will not be established regionally.
FOLLOW-UP ACTIONS	None
PERSON RESPONSIBLE	

Meeting Attendance

Teena Edwards	DSHS HIV Care Services Group
Janina Vazquez	DSHS HIV Care Services Group
Ann Dills	DSHS HIV Care Services Group
Samantha Barriento	DSHS HIV Care Services Group
Michelle Berkoff	DSHS HIV Care Services Group
Jamie Schield	North Central Texas Planning Council, Part A
Margie Drake	Tarrant County HIV Part A and B
Lisa Muttiah	Tarrant County Part A and B
Rene Castoreno	Tarrant County Part A and B
Greg Bolds	Austin Part A
Benda Mendiola	Austin Part A
John Waller	Austin Part A
David Garza	Austin Part A
Kimberly Williams	Austin Part A
Hugh Beck	Austin Part A
John Kaiser	South Texas Developmental Council, Part B
Maribel Rodriguez	South Texas Developmental Council, Part B
Cindy Garza	South Texas Developmental Council, Part B
Marisa Lira	South Texas Developmental Council, Part B
Shibu K. Sam	Dallas County Health and Human Services , Part A and B
Glenda Blackmon-Johnson,	Dallas County Health and Human Services , Part A and B
Rashida S. Francis	Dallas County Health and Human Services , Part A and B
Patrick Martin	HIV Resource Group - Houston, Part B