Comments on Case Management Standards

Round 2

#	Location	Comment	DSHS Response	Determination
1	p. 6	Page 6, I agree with the Case Management models, but question the short-term case management last sentence, client has minimal barriers to care that can be addressed in 3-6 months? We have to follow up with them in 3-6 months is that right only if they are case managed, right!	Correct	
2	p. 6	I like the idea of splitting up case management into short-term case management and long-term case management categories. I think in theory, this works, but I don't know that it is this easy to identify if client's need short-term or long-term case management from the first intake with client. Oftentimes, we find out after the initial appointment with client that they require more assistance and time than was expected, or vice versa. CHAMPS should always have contact with client at least every 3-6 months in order to re-assess needs. In theory, medical case managers can have contact with client while they attend clinic, but not all clients make their scheduled appointments.	It's expected that once a CM engages a client, it's possible that expectations for amount of time in CM could change based on receiving more info from the clients. The models are intended only as a guide to help with planning.	

3	p. 7 to address needs for concrete services such as health care, entitlements, housing, and nutrition,	Is there a better word to use here? This is sometimes a pretty loaded word.	How about 'public benefits and assistance'?	
4	p. 7 Acuity	On page 7, it states that to be in MCM, a client's acuity must be at its highest level for a period of 3 months. Acuity is an assessment or evaluation. Just because they are in the categories does not mean that their acuity will be at its highest level. What if their acuity isn't that high as many of the categories that someone on the list falls in are not weighted, such as homelessness or recently incarcerated. If their acuity remains relatively low, are they still eligible for medical case management. Acuity does not always equal need. If this is a requirement, we need to find a different tool that weights level of need differently than ours.	Removing 'acuity' from this situation – all client populations listed will move into MCM for 3 months, with CM initiated contact every 2 weeks during that 3 month period regardless of identified acuity level.	
5	p. 7	Page 7: Under MCM, "Clients that meet any of the criteria listed below must automatically be enrolled in the highest acuity level of Medical Case Management: homeless (not weighted), recently released from incarceration (not weighted), pregnant, CD4 count below 200 or vl > 10,000 copies/ml, newly diagnosed (not weighted), untreated mental illness-including substance use disorders, new to antiretroviral therapy (not weighted), not in care/re-engaging in care (not weighted), non-adherence to HIV medication (not weighted), unable to	See #4 response	

		navigate system of care due to language (not weighted). **While these categories are on the SAMS acuity tool that we use, not all of the categories listed are weighted. Therefore, even if they score over a 1 in those categories, it may not cause them to get a high acuity score. Where this gets confusing is in the highlighted portion above. How do we "enroll them in the highest acuity level of MCM" if they do not score that high on the acuity scale?		
6	p. 8	Page 8: Overall, the definitions of No CM, MCM and N-MCM are clear and easier to understand.		
7	p. 8 Table	Would you want to include the entire group of clients listed above as needing the highest level of CM service?	Yes	
8	p. 8 Table	N-MCM - I don't understand why clients who are N-MCM wouldn't need at least come coordination of care, follow up, referral and especially education and monitoring regarding viral suppression and treatment adherence. I'm also not sure what would prevent a non medical case manager being able to provide these services.	HRSA definitions make it very clear that N-MCM is NOT to involve coordination of medical care. If a client needs that scope of work, they should be receiving MCM services.	
9	p. 8 Table	MCM – This will literally encompass the majority of our clients and I refer back to my earlier comments. Also, based on my knowledge of our current clients, I don't feel that every client who is 1) Newly diagnosed and needing education, 2) has substance abuse issues, 3) Mental Health issues, 4)	Will discuss	

		Medication and/or treatment adherence issues, or 5) a history of being "out of care" in the past is appropriate for MCM. A client, in my opinion, would be appropriate for MCM services if 1) They are newly diagnosed AND have multiple and/or complex health-related needs that they can't manage on their own, 2) have multiple and/or complex health-related needs that they can't manage on their own, 3) have substance use issues that are significant enough to have an active impact on the client's health, medical adherence and viral suppression, 4) have MH issues that are significant enough to have an active impact on the client's health, medical adherence and viral suppression, or 5) have significant and ongoing medication and/or treatment adherence issues.		
10	p. 8 Clients meeting any of the above criteria must remain at the highest acuity level of Medical Case Management for at least a 3 month period in order to address the immediate challenges associated with these issues.	How would this be different in rural areas that are not funded for case management. For example, a non-medical case manger can complete an adherence screening tool with clients, so how will this work?	In those areas, the N-MCM staff need to work closely with where MCM is located to ensure continuity of services. Will discuss more.	

11	Clients meeting any of the above criteria must remain at the highest acuity level of Medical Case Management for at least a 3 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.	This would result in ALL new clients coming into services being assigned to Medical Case Management. Our agency is simply not currently in a position to do this. I have one MCM and one Non-MCM. My MCM would have to handle the entire client case load plus maintain the clinic activities as well. If we were able to make them relatively perfect patients (based on the guidelines on page age identifying clients appropriate for N-MCM status) in a 3-6 month period, the switch in case managers from Medical to Non-Medical staff would negate the relationship and trust that the client has been able to build with their initial MCM staff. If the client stays with the same staff, only receiving N-MCM services, that will still result in the MCM maintaining a much larger case load than can be managed effectively while also maintaining the clinic functions. Our only option would be to employ 2 Medical Case Managers which would significantly impact our limited budget.		
12	p. 8	Third, I believe there is still confusion over what is eligible to be labeled case management and what is not. On page 8 it lists that doing applications for assistance is not considered cm, but the assessment of the need, and something like developing a housing plan would be. It would be nice with a clear cut list of what can and cannot be counted are. Providers still look at services provided by a case manager to be case management and the guidelines want to change that perception but they do not go	Agreed – we need to continually work on the shift that case management is a service, not a person, and that folks who provide the service of case management may also be providing other services offered through the agency. The Unit of Service should be recorded based on what actual service is being received.	

		into detail. That detail would be helpful.		
13	*p. 9*	Page 9: I like the "Case Management Activity Status" chart. However, I have a question about the wording. It states "*Successful* contact means contact initiated by a case manager and care plan focused." So, if the client initiates the contact, but case management is still performed, does it not count as successful contact?	Change to 'initiated by Cm or client'	
14	p. 9	Page 9, Case Management activity, lost to follow up – 3 unsuccessful attempts to contact the client in 3 months. Successful contact means contact *initiated by a Case Manager* and care plan focused. Clarify initiated by a case manager, can one of our staff members initiate the contact for lost to follow up? Here again I wonder if they are focusing on a much larger RW provider with more case managers, than what we have.	See #13	
15	*p. 9 Case Management Activity Status*	I know that these don't necessarily have to match ARIES, but should there be any guidance on the subcategories under Case Management in ARIES and when to use them, or when that will be in the updated Taxonomy? Also, while we are talking ARIES, could there be some positive options to indicate the reason for a status change? For example, under "agency status", the choices are active, inactive, disenrolled, lost to follow up, discharged, reported deceased and confirmed	Will discuss	

		deceased. Under "reason for status change", the choices are: referred to another program, violation of rules, incarcerated, relocated and other. It seems that we should have another option for clients who have graduated from or no longer need case management or other services. Maybe "referred to self care" or "no longer need services" or some sort of positive option.		
16		P&P: all seems about the same	Correct	
17	p. 9	On page 9, it states that an active client mean successful contact initiated by a case manager, but often it is initiated by client contact. Possible area for clarification of meaning.	See #13	
18	p. 9	According to the case management standards, successful contact with clients is determined by the case manager attempting in contacting client. It does not state whether "successful contact" can be made from the client to the case manager. I think that in making clients self-sufficient, successful contact can be made from the client to the case manager. Would this mean that a client who calls the case manager in regards to medication, appointments, etc. would not be considered a successful contact? I do agree that it is the case manager's responsibility in contacting client, but in becoming self-sufficient, the client's attempt at contacted the case manager is considered successful.	See #13	

		With moving clients to Lost to follow-up, the definition states that client can be moved to LTF after "3 unsuccessful attempts to contact client in 3 months". Again, successful contact is defined as contact initiated by case manager. If a client responds to one of the 3 "successful attempts", would the case manager still proceed in the LTF process, as it would not be considered "successful"?		
19	p. 12 Description: procedures for establishing client case records and recording on-going activities (i.e. assessment, reassessment, service provision, problem logs).	Logs for the agency or the client?	For the client	
20	*p. 17 3. Case Conferencing* <u>Description</u>: process, documentation, and frequency of required case conferencing with a client's providers in order to facilitate care coordination.	Does this refer to all clients or only those requiring MCM?	MCM only	

21	*p. 17 3. Case Conferencing* Description: process, documentation, and frequency of required case conferencing with a client's providers in order to facilitate care coordination	Does this refer to the treating providers? How would a CM pull together all these providers on a consistent basis?	AAs need to work with agencies to help them coordinate with clinical care teams in their area for case conferencing. All providers should work together to discuss a process that makes sense for their area.	
22	p. 18 Guidance on what types of client behavior is serious enough to lead to suspension / termination of services	Does this need to include what is required to resume services?	We will discuss on call on what could be included for this.	
23	p. 19 *DSHS preferred* qualifications for a case manager: a degree in health, human	For those CM's that are currently providing this role is there a grandfather clause to allow them to continue or is there a requirement for them to obtain a degree over a given period of time to stay in that role?	This did not change from prior standards. AAs set the regional educational backgrounds. At the DSHS level, degrees are only preferred NOT required.	
24	p. 19 Minimum qualifications for case manager supervisors: degreed or licensed in	What is to occur to the current supervisors that do not meet this?	This has been a standard for several years. Let's discuss.	
25	p. 19	The new cm training requirements have changed and are given strict timeframes on	These have not changed. The 90 day timeframe is only suggested, the required time frame is 6 months.	

		training and supervision on pages 19 and 20. These are tight timeframes, especially the initial 90 days to complete initial training requirements		
26	p. 20 HIV Case Management 101: A Foundation Part Two	Is this offered online?	Yes – will update	
27	p. 20	What kind of documentation is required for continuing education for case managers? It does not specify.	That's up to an AA/agency level	
28	p. 23 Brief overview of status and needs regarding:	Routine health maintenance (PAP, well woman exams etc), Immunizations	This is more appropriate for assessment not intake.	
29	p. 23	On page 23, it states that if a client has not been active in 3 months, then they are due a brief intake. We have clients on 6 month follow-ups who do not need new assessments at 3 months. I could understand 6 months, but they move in and out of the service area. Just because they were in Midland for 3 months, then return, doesn't mean their needs have changed. It seems like a harsh requirement.	Will change to 6 months.	
30	p. 23	Page 23: first sentence of the paragraph, "When requesting services....., all new clients and returning clients who have not been active in case management services for more than three months must have an intake screening to determine eligibility and need for program services, including determining	See #29	

		if a client needs case management services" So....if a client has not been active for 3 months, and they contact us needing a service (MCM, clinic, etc.), we have to re-intake them? Then what is the point of the acuity/contact frequency categories that are more than 3 months? Only the highest acuities have more than 3 month contact frequency. So, everyone else gets at least 6 month case management contact, however after only 3 months, if we have not had an active case management service with a client, we have to re-intake them?		
31	p. 23	Page 23, Brief intake and Eligibility Determination- all new clients and returning clients who have not been active in case management services for more than three months must have *an intake screening* to determine eligibility and need for program services, including determining if a client needs case management services in order to access and maintain care. What about clients that have been re-certified within that year and/ or had an initial intake? Do we do another brief intake with them again, please clarify?	See #29	
	p. 24	Pg 24—In light of discussions about newly diagnosed/linkage to care, would recommend defining urgent need related to conditional eligibility. I'd recommend stating newly diagnosed, lost to care, etc.	Will discuss	
32	p. 24	This is an old complaint, but I wish to explore it again. On page 24, it states that we can provide services without proof of	Will discuss	

		income, positivity, etc. in the 30 day grace period they come into care. If they end up not being HIV positive or never bring in the documents we need, we have wasted much needed resources only to discharge the client. Is this really the best utilization of dwindling budgets? Can you all ensure providers that this will not be held against us in an audit situation?		
33	p. 25	The populations are listed for those requiring case management at the time of intake. The case management standards state that a client who meets any of the criteria "must remain at the highest acuity level of medical case management for at least a 3 month period in order to address the immediate challenges associated with these issues". A client's acuity score does not always reflect the "highest acuity level". For example, a client who has been recently released from incarceration might not score at a high level of acuity due to the legal section not being a weighted section. So, what constitutes as "the highest acuity level of medical case management"? Would it be Level 3 and up, according to the "Suggested Acuity Levels and Frequency of Case Manager Initiated Contact"?	See #4	
34	p. 26 see XXX for SAMISS tool	Is this a link to an outside site or will there be an Appendix with forms attached?	A website will be created by the end of 2014 to house all forms	
35	p. 27	I like, on page 27, the clear cut steps if a client does not bring in requested documentation in the 30 day grace period.	Thank you	

36	p. 28 Acuity	On page 28, there are 5 levels of acuity. The document states that they are "suggested" acuity levels. Can agencies continue to use 4 levels?	Agencies can continue to use current systems in place as long as there is frequency of contact associated with the acuity levels.	
37	p. 32	I like the new Treatment Adherence section for MCMs very much.	Thank you	
38	p. 32 A core component of Medical Case Management services is to assist clients to achieve and maintain viral suppression.	This seems like something we should be concerned with regardless of a client's case management status. Even if they are not case managed, this seems like something that is important.	Agreed – the focus of this however is on CM standards, so that's what we're addressing.	
39	p. 32 MCM	Why is Viral Suppression and Treatment Adherence something that is ONLY a component of MCM? Is it not important for all clients, regardless of their Acuity and/or case management level to have viral suppression and treatment adherence addressed? If the answer is yes, it's important to all clients, then, per the new case management standards, they would have to receive Medical Case Management. In my opinion, viral suppression/treatment adherence should be addressed by both MCM and N-MCM clients and is appropriate to be addressed by both medical and non medical case managers.	Not all clients need case management to achieve viral suppression and treatment adherence. If they do need CM services to help achieve this, they should be receiving MCM services.	

40		I don't have issue with most of these; however, I think that expecting VL & CD4 discussion is appropriate for EVERY client encounter. There are times when dealing with a client, that we have other issues to deal with as well and, at least from the client's perspective, are more important than their VL & CD4. These issues are obviously going to impact their overall adherence and viral suppression but if I am focused on their VL & CD4 at EVERY encounter regardless of what other issues are impacting they, they are going to shut down and stop telling me about the real and every day issues/problems that are the real reasons for their treatment adherence issues. This is requirement will also have a HUGE impact on staff (especially MCM staff as they are the only ones per these standards who can address treatment adherence) and result in staff having less contact with client and spending less time with clients when they do have contact.	Will discuss	
41	p. 32	Page 32: MCM ONLY--Viral Suppression/Treatment Adherence *Is this new? I know we have always had treatment adherence as a category, but this talks about intervention plans. Will this be on the care plan, or will there be a separate "treatment adherence intervention plan" required?	Yes this is new, no you don't need a separate tx adherence plan. Treatment adherence should be incorporated into the client's overall care plan.	
42	p. 32 2) Making and keeping appointments; Overcoming	Need to include a number 3.	Thanks	

	barriers			
43		Can we PLEASE separate out discharging clients from graduating clients as we have been told over and over that it isn't the same? I believe a standalone graduation section would be helpful to all providers.	We can talk about providing more guidance on graduation, but we don't think it's necessary to create a completely separate section.	
44	p. 38 Referral and Follow-Up	How do referrals work for clients who are not in case management? Do they need to be documented? Followed up?	Any referral made by a RW agency should be followed up on. This conversation is about the CM standards, however, so that's the focus.	
45	p. 39	Page 39, Case Closure/Graduation: I do understand the process and like it but what does it mean by 3 attempts to contact client (via phone, *e-mail*, and /or written correspondence.) My understanding is we could not use email to contact client, due to confidentiality. We have not used email to try to contact client, but I do like the idea, much easier and faster.	Need appropriate ROI at start to allow this. Emails are okay as long as there is no public health information (PHI) in them and the client requests/agrees to email contact	
46	p. 40 reestablishment	Fix	Unclear - do we need to correct the spelling?	
47	p. 40	Page 40: Promising Practices, notice that case managers should utilize multiple methods of contact (phone, text, e-mail, and certified mail) when trying to re-engage a client, as appropriate. Again my understanding is not to use text from our personal cell phones and e-mails; I just want more clarification for our program	See #45 for emails. Text options are available via computer services so personal cell phones are not required to text. Again, this can occur with appropriate ROI and the client agrees/requests text communication.	
48	p. 40 Case Closure	It states that case managers should use multiple methods in contacting client. Phone, text, e-mail, and sending a certified letter are listed among methods. I am assuming the text and e-mail component of this promising	See #45	

		practice is for larger Ryan White providers, as we do not have a means of contacting clients via text message. With e-mail, what are the guidelines in attempting to contact client via e-mail? If clients have given permission to contact via e-mail, is it recommended as a means of secondary contact for client? This refers to HB300.		
49	General	More guidance on Non Case Managed clients, for example what are the minimum requirements?	This conversation is solely about the CM standards. Minimum requirements for non case managed clients are based on the services they are receiving – see service specific standards of care	
50	General	I understand that the standards are written from the perspective of a much larger viewpoint than mine; however, they are written in such a way that a small agency such as mine, with a client service staff of only two, will have extreme difficulty in meeting the standards. The standards could also be such that it results in the agency not being able to provide quality care to clients because of lack of staff and monetary resources. The needs of smaller agencies should be considered as well as the needs and make up of larger agencies.		
51	General	In summary, it seems to me the new standards are so focused on clients receiving MCM services that they will result in the exact the opposite of what the initial statement of intent defines.		
52	General	It seems that this is all very obviously geared toward larger providers. All of the guidelines about 3-6 month reassessments, re-intakes,		

		and just the general overall requirements are great in theory. However, with the few staff members that we have, it does not seem possible to do all of this end of the work, without our actual services to clients being affected. I know some providers have case managers that are specially designated to do intakes and reassessments only, and in those agencies, I can see how this format and these requirements make more sense. I just feel like the actual client care part of our jobs gets a little lost in all of the formalities, when the same rules are applied across the board, regardless of agency size and configuration. While I believe standards are necessary and we all need guidelines, I believe there should be different standards for rural and smaller providers. From what I can tell, everything else makes sense and does not seem much different. Overall, there seems to be more clarification, so that is good. Aside from the questions above that I would like further interpretation/clarification on, that's all I have for now.		
53	General	As an individual, I think some parts of the CM standards are largely geared to a much larger RW provider than what we are, such as in terms of employees, the place/or city in Texas, and the number of the special population we serve. Just to let you know, I remember sitting down with a group from other RW providers across the state at Ann Dills presentation Case Management		

		101 at the State conference, and I ask them about their initial intake process. The initial intake was discussed at the presentation, and most of the MCM in my group told me when they see the client to do their assessments and care plans, they already have done their initial intake with someone else from their agency. They don't see the clients until they have done their initial intake; and some of the clients are ask to fill out their own initial intake paperwork, only if they have cognitive understanding and there is no Language barrier.		
54	General	If a client is identified as needing medical case management (either short-term or long-term), then their primary assistance is supposed to come from a medical case manager. According to the case management standards, the role of the non-medical case manager is for referrals and follow up, ensuring that the needed services were received and to evaluate if there are other services needed for client. Medical case managers assist clients with following treatment plan and coordination of services for client. Although all case managers should be well versed in medical information regarding HIV and STDs, does this mean that all medical questions and concerns need to be referred to a medical case manager? For example, I completed an initial intake with a client and determined medical case management is needed for client. I would have, initially, stated that client needs short-term medical case management, but in	If a client has been identified as needing MCM services, and he has questions related to MCM, then the staff providing MCM should be who the client coordinates with. Medical care and coordination is the responsibility of the MCM as per HRSA standards.	

		reality, he needs long-term medical case management. At the beginning of client's initial intake, it was not made known to me that client will need further, ongoing medical case management services. Client calls often with primarily medical and mental health concerns. Are these questions technically supposed to directed to a medical case manager, as client has been assigned medical case management? And is it then, up to the medical case manager to re-address client's needs and coordinate services from there? If client is assigned to medical case management, the primary way that medical case managers can re-address client's needs will be when client is seen in TAC clinic, every 3-6 months. This works well except when a client does not attend their scheduled appointment, and therefore misses the 3-6 month window period. I would say that the role of the non-medical case manager should also be to discuss adherence, medication regimen, mental health, etc. with client. I do not think this should be primarily the responsibility of the medical case manager.		