Frequently Asked Questions – Case Management		
Area	**Question**	**Answer**
Priority Populations for MCM services	The standards state that priority populations must be automatically enrolled in Medical Case Management (MCM) services. With limited funding for MCM services in our area, we're worried that we won't be able to provide this service to everybody that meets the criteria. Can we put clients on a wait list for MCM services, and provide Non-Medical Case Management (N-MCM) services until availability arises?	There should not be a wait list for case management services. If you have a wait list, please contact your Administrative Agency and/or DSHS Services Consultant for guidance. Agencies that have wait lists (or are worried they will need a wait list) for case management should look through their case management rosters to ensure that clients currently on case management caseloads actually need the service. Case management services should not be used as the sole access point to other agency services. Clients who do not need case management should be graduated from caseloads to allow for those clients who need case management to access it. Clients should receive the service needed – if the client needs coordination of medical care and treatment, they should be receiving MCM services, as HRSA does not allow N-MCM to coordinate medical care. If clients are being assigned to N-MCM because MCM caseloads are too big, agencies should make a concerted effort to ensure all clients receiving MCM services actually need it, and should make efforts to graduate clients as appropriate.
	One of the priority populations required to enter into MCM services at intake is the newly diagnosed. Not all clients who are newly diagnosed are in need. For instance, some clients with a new diagnosis are very capable of managing their HIV disease but may be in need other agency services. Do we have to enroll everybody that meets the priority population criteria into MCM services?	The criteria used to determine the priority populations was based on research and data identifying criteria that increased the risk of dropping out of care. Unless clients expressly do not want MCM services, they should be enrolled on a short-term basis to ensure access and maintenance in care. Case manager judgment and client autonomy are important factors to consider, and we don't want to create additional barriers to care and access. Case managers can, on a limited basis with supervisory consultation, override this if they have the rationale and the client agrees to it. The rationale behind the decision should be documented in case notes in

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		the client's primary record. This, however, should be done on a very exceptional basis.
Policies and Procedures	In the documentation section it requires a policy/procedure for supervisory review and sign off on client records. Due to the high client caseloads and limited managers, it is not feasible for managers to review and sign off on all assessments, reassessments, case closures. Is it allowable to count supervisory file reviews as the supervisory review?	It is up to the agency to determine their policy for supervisory review. DSHS requires that clients who graduate from case management services have supervisory approval. The agency is to determine the procedures and implement appropriately per their written policy.
Minimum required trainings	Could supervisory review and approval for trainings that are deemed equivalent to the core proficiencies suffice, or would each and every training off of the topic list need approval?	All trainings used for continuing education must be approved by the DSHS training specialist. There is a list of pre-approved trainings that includes any AETC training, and trainings developed by Gilead and ViiV (they receive pre-approval from DSHS). Training approval is easy and quick. You can e-mail HIVCMTraining@dshs.state.tx.us for approval.
Case Management Service flow chart	The chart provided, while helpful, does not seem to allow for determination of client need, as this is directive and not based on assessment. This chart seems appropriate as a general guide, but without an intake and the comprehensive assessment, staff cannot fully determine a client's need. Is this for guidance or is this the directive to fully follow the chart?	The chart is merely a tool to provide guidance and is not a directive. The directive is to follow the standards of care written in the document concerning intake and assessment to determine client appropriateness for services.
	The box on the left states case	The measure of "2 appointments in the last 12

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	managers should assess to see if their client is retained in care, and uses the measure of two appointments in the last 12 months to determine retention. This is different from the HIV/AIDS Bureau (HAB) measure that states retention in care is defined as "at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits". Which one should we use to determine retention in care?	months" is a simplified version of the HAB measure to help guide case managers and clients to determine the need for case management services. The amount of time between visits is still important to look at, and should be used to help determine need. If you want to measure retention in care for reporting purposes, please use the HAB measure.
Acuity	Please clarify if acuity or if MCM criteria standards drive the placement of a client into services. We do understand that acuity will determine frequency of contact; however, it is somewhat confusing as to how if supports client placement into services.	Acuity does not determine client placement into services. Clients are placed into services, an assessment is done, and based on the assessment acuity/frequency of contact is assigned. Clients meeting the criteria listed on pages 7 and 25 must be enrolled into MCM services with bi-weekly contact regardless of acuity.
Frequency of Contact	Is there a tool for program monitors to use to verify that frequency of contact has occurred and is appropriate?	Currently the only way to verify frequency of contact between case management staff and clients is to look at service utilization in the client's primary record (most likely ARIES). As we move forward, we will be working with Administrative Agencies and monitors to find the most effective tools to help monitor records. If you have suggestions for this, please contact your DSHS Services Consultant.
Discharge from case management	The directives listed about how to close cases involving non-compliance are helpful, however, does it allow for discharge with	If the client does not follow through it is not a successful contact and would not reset the process. This policy does allow for discharge with supervisory approval for the circumstance

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	supervisory approval when brief contact is made, but the client does not follow through? For example, the client agrees to an appointment or additional phone contact, but does not call or attend the meeting or respond to an additional CM phone call (essentially starting the process over again).	described. Supervisory approval and case manager judgment may override the discharge policy as long as there is appropriate documentation in the client's primary record.
Case management status	Do the designations listed (active, inactive, lost to follow, discharged, and graduate) correspond to the guidelines in ARIES?	The 'status' option currently in ARIES is regarding agency status not case management status. Currently there is no way to designate one of the above CM statuses in ARIES, but we are working to add this functionality.