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 15

OLD BUSINESS

None

DISCUSSION	
CONCLUSION	

NEW BUSINESS

WELCOME	**Teena Edwards, Facilitator**
	Process: Go down and list of general comments and discuss each one.

Texas HIV Case Management Standards

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/ITEM 2	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 3	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 4	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/ITEM 5	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 6	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 7	
DISCUSSION	
CONCLUSION	
FOLLOW-UP ACTIONS	
PERSON RESPONSIBLE	

TOPIC/ITEM 8	#33, page 31 Referral and follow-up for the client
DISCUSSION	It is somewhat confusing. referral need to be tracked in whatever primary client recording system that the agency currently uses. We don't want double entry in both the client's record and ARIES. Might be better to drop the "use of URS and chart

	and replace it with "primary client charting system." Concerned that requirement for ARIES use was being watered down. AAs can require ARIES entry for all of their agencies. DSHS just doesn't want to make this requirement statewide as many agencies, especially in the metro areas use another system. AAs should continue to require whatever system for charting is currently in place for their providers. It is not acceptable to allow the providers to change to another system at this time. Part A grantees agreed that it was best practice to monitor an element directly from the primary chart and not from another source. There was also discussion on what were the minimal data elements required to be entered into ARIES. DSHS will generate a list of those required elements within the next couple of months and once those elements are agreed upon by all, the standards and the monitoring tool can be strengthened to refer to those elements.
CONCLUSION	AAs may require document in ARIES for all of their providers. The AAs will monitor for this item in whatever the primary client recording system is; whether it is paper charts, electronic health record, ARIES, or another system. Emphasis will be on looking at the information in the primary client record and not solely using ARIES when another charting system is in place.
FOLLOW-UP ACTIONS	Wording changed to primary client recording system in Standards. Minimal elements required for ARIES input to be distributed
PERSON RESPONSIBLE	DSHS Staff

TOPIC/ITEM 9	#34, page 31 Case closure/graduation
DISCUSSION	It would be helpful to standardize wording used if a definition of inactive, discharged,

	violation of rules, and lost to follow up was defined by DSHS. DSHS can certainly define discharged and lost to follow up because those two terms are fairly standard. There was a discussion regarding whether the other two terms could be agreed upon at a state level or whether it would be best at a regional level. Part As currently have those defined at a region level, but they would be open to attempting to define for the state.
CONCLUSION	DSHS will send an email to all workgroup members asking for what they are currently using to define inactive and violation of rules. DSHS will also send out draft definition for discharged and loss to follow-up. Attempt will be made to seek consensus on defining these terms at the state level.
FOLLOW-UP ACTIONS	DSHS to send out request and definitions
PERSON RESPONSIBLE	Teena Edwards, DSHS

TOPIC/ITEM 10	#35, page 31 - 3 attempts to contact
DISCUSSION	These may need a time frame specified as to 3 attempts in a month or 6 weeks. DSHS offered to define the timeframe at 3 months. After monitoring this for a while we can reassess if this timeframe is realistic.
CONCLUSION	Three months seems realistic at this time.
FOLLOW-UP ACTIONS	Standards will be updated to include 3 months as the timeframe to make 3 attempts before discharge.
PERSON RESPONSIBLE	Ann Dills, DSHS

TOPIC/ITEM 11	#36, page 33 Case managers attempt to secure release of information (ROI)
DISCUSSION	At initial intake, releases should be obtained from the client for all providers that are known at that time. Any new

	provider that they are engaging with later on will require a ROI to be signed. These forms must be specific to the provider, the information requested, and have an end date or expiration date.
CONCLUSION	Wording in the standards was reviewed again and no changes recommended.
FOLLOW-UP ACTIONS	None
PERSON RESPONSIBLE	

TOPIC/ITEM 12	#37, page 37 Sample forms
DISCUSSION	It would be helpful if there was a medical adherence screening tool included in the standards. The Viral Suppression workgroup of the Texas HIV Syndicate will be working on this to identify reliable and valid tool for medical adherence to put into an online case management toolkit. All sample forms will eventually go into this toolkit and taken out of the Standards. Workgroup members would like to know what work is being done in the workgroups associated with the HIV Syndicate.
CONCLUSION	Another process is being used to identify a medical adherence screening tool
FOLLOW-UP ACTIONS	Information regarding the work being done by the workgroups in the HIV Syndicate will be sent to all standard workgroup members
PERSON RESPONSIBLE	Janina Vazquez, DSHS

TOPIC/ITEM 13	Standards and Monitoring tool consistent with HRSA guidance for vigorous enrollment
DISCUSSION	Concern was expressed that the current standards and the monitoring tool are not consistent with HRSA's guidance on the role of the case manager being vigorously pursuing ACA. HRSA has opened up this guidance to 7-8 service categories and as such, is not specific to case management. Therefore DSHS feels that enrollment and pursuit of eligibility for ACA insurance can be accomplished using a variety of staff

	from case managers, to patient navigators, to eligibility workers. Therefore, the case management standards should not limit the ability of other types of workers to complete this task. DSHS is looking into revising the Payor of Last Resort policy to make sure that it matches HRSA guidance with inclusiveness of the insurance and ACA entitlement and benefits that a client may be eligible to obtain. Although a lot of case managers are performing this function, it is not occurring throughout the state. Some of the Part As are looking into the roles of Benefit Counselors.
CONCLUSION	Recommended that the AAs determine which staff in their region would be the best to perform the eligibility and benefit determination and require that level of staff to perform this duty.
FOLLOW-UP ACTIONS	More discussion at the next conference call if needed
PERSON RESPONSIBLE	

Case Management Monitoring Tool

TOPIC/ITEM 14	#1, item 7 Randomized sampling for supervisor review of charting
DISCUSSION	If a supervisors caseload is large, then yes, a randomized method for selecting the charts for review needs to be implemented. A randomized system needs to be put into place so that the supervisor will not be choosing the same charts over and over again and there won't be a preference shown on whose charts to audit.
CONCLUSION	AAs need a policy and procedure for their agencies regarding how supervisors are going to select charts for review.
FOLLOW-UP ACTIONS	AAs to implement
PERSON RESPONSIBLE	AAs

TOPIC/ITEM 15	#2, item 13 Double entry of information
DISCUSSION	Everyone agrees that double entry should not be required. Wording in the tool will reflect the changes in the standards -

	"primary client record system." With the understanding that the system implies use of whatever methods for charting care is currently in place. So paper charts, electronic health records, another method, or ARIES. or a combination. When the AA monitors the agency, they will audit the information in the primary client record.
CONCLUSION	Primary client record clarifies where the information should be found.
FOLLOW-UP ACTIONS	Wording will be changed to primary client record
PERSON RESPONSIBLE	Teena Edwards, DSHS

TOPIC/ITEM 16	#3 and #4, item 15 and item 17.
DISCUSSION	There is confusing over what it means to "appear to be complete." The wording of the items will be changed to "Agency has a policy and/or procedure for handling client grievances that is clients centered. and "Agency has a policy and/or procedure on conducting a client financial assessment that is client centered. Concern that there may be differences in interpretation and that this wording is still vague.
CONCLUSION	Client centered still may be too vague.
FOLLOW-UP ACTIONS	Lisa McKamie-Muttiah will send a draft of these items using another term for consideration
PERSON RESPONSIBLE	Lisa McKamie-Muttiah

TOPIC/ITEM 17	#5 and #6, item 19
DISCUSSION	There is confusing over what it means to "appear to be complete." The wording of the item will be changed to "Agency has a policy and/or procedure for creating a Care Plan and includes a process for monitoring changes and updates as needed.
CONCLUSION	Item is clear when the wording "appears to be complete." is dropped.
FOLLOW-UP ACTIONS	Changes will be made in the monitoring tool

PERSON RESPONSIBLE	Teena Edwards, DSHS

TOPIC/ITEM 18	#7, item 24 No ARIES documentation expectations stated.
DISCUSSION	As in the standards, we will change the wording to primary client record system. AAs can make the decision at the local level which system the providers must use for which information. This should help items 30 and 37 as well.
CONCLUSION	Change wording to primary client record system.
FOLLOW-UP ACTIONS	Wording will be changed in monitoring tool
PERSON RESPONSIBLE	Teena Edwards, DSHS

TOPIC/ITEM 19	#8, item 25 HIV proof
DISCUSSION	We all agree that HIV proof is only required on time. The item in question may be confusing since the other two bullets have time specified (every 6 months)
CONCLUSION	One time only will be added after Documentation of proof of HIV status.
FOLLOW-UP ACTIONS	Wording changed in monitoring tool
PERSON RESPONSIBLE	Teena Edwards, DSHS

TOPIC/ITEM 20	#9, item 30 No ARIES documentation
DISCUSSION	As in the standards, we will change the wording to primary client record system. AAs can make the decision at the local level which system the providers must use for which information.
CONCLUSION	Change wording to primary client record system.
FOLLOW-UP ACTIONS	Wording will be changed in monitoring tool
PERSON RESPONSIBLE	Teena Edwards, DSHS

TOPIC/ITEM 21	#10, item 36 Child abuse checklist
DISCUSSION	The checklist to use for the DSHS Child Abuse requirement is on the DSHS

	website and isn't in the case management standards. The case managers should be using this checklist for all appropriate clients
CONCLUSION	Checklist and associated requirements will be referenced in the Standards
FOLLOW-UP ACTIONS	Update Standards to include
PERSON RESPONSIBLE	Ann dills, DSHS

TOPIC/ITEM 22	#11, item 37
DISCUSSION	As in the standards, we will change the wording to primary client record system. AAs can make the decision at the local level which system the providers must use for which information.
CONCLUSION	Change wording to primary client record system.
FOLLOW-UP ACTIONS	Wording will be changed in monitoring tool
PERSON RESPONSIBLE	Teena Edwards, DSHS

TOPIC/ITEM 23	#12, item 38
DISCUSSION	This item is very difficult to follow. Unfortunately the wording follows HRSAs HAB measure. A concern was raised that new reviewers may have a difficult time following the item to determine if the item was met. DSHS volunteered to draft a diagram of the decisions to see if this helps clarify this measure.
CONCLUSION	A diagram might assist in the review of this item and will be placed as the last page of the monitoring tool
FOLLOW-UP ACTIONS	Draft diagram
PERSON RESPONSIBLE	Teena Edwards, DSHS

TOPIC/ITEM 24	#13, item #38 Inclusion of VL and CD4 counts
DISCUSSION	Question was raised on whether we wanted to include a question regarding VL and CD4 counts. These two items are HAB measures in the OAMC Standards.

	Discussed that the possible item was whether or not the case manager was a member of the medical care team and coordinated care with the providers and whether the case manager discussed VL and CD4 counts with the patients as part of medical adherence
CONCLUSION	Insert an item asking if documentation is present that the case manager consulted with the medical team and has talked with the patient about their viral load and CD4 counts. Take this item and combine with the HAB measure for medical visits to a provider and place under a separate category - Medical Care Coordination in the monitoring tool. A couple of changes will be made in the standards that targets the role on the medical care team of the case manager.
FOLLOW-UP ACTIONS	Add an additional category in the monitoring tool to encompass medical care team coordination and update standards
PERSON RESPONSIBLE	Ann Dills and Teena Edwards, DSHS

TOPIC/ITEM 25	#14, item 40 Reporting System and the client record.
DISCUSSION	As in the standards, we will change the wording to primary client record system. AAs can make the decision at the local level which system the providers must use for which information.
CONCLUSION	Change wording to primary client record system.
FOLLOW-UP ACTIONS	Wording will be changed in monitoring tool
PERSON RESPONSIBLE	Teena Edwards, DSHS

TOPIC/ITEM 26	#15, item 42 - Care plan updates
DISCUSSION	Under care planning, the care plan should be updated as life circumstances change, as goals are completed, etc. As care plans change, goals are achieved, we should see the acuity change as well.
CONCLUSION	The care plan will be updated as needed

	with changes in life circumstances and a formal review of the care plan will occur every six months.
FOLLOW-UP ACTIONS	Standards will be updated to include when the care plan and acuity will need to updated.
PERSON RESPONSIBLE	Ann Dills, DSHS

TOPIC/ITEM 27	#16, item 43 No documentation expectations
DISCUSSION	As in the standards, we will change the wording to primary client record system. AAs can make the decision at the local level which system the providers must use for which information.
CONCLUSION	Change wording to primary client record system.
FOLLOW-UP ACTIONS	Wording will be changed in monitoring tool
PERSON RESPONSIBLE	Teena Edwards, DSHS

TOPIC/ITEM 28	#17 and #18, item 47 Care plans in ARIES
DISCUSSION	The requirement to print out care plans and have the client sign them goes back at least 10 years. Concern was voiced however that ARIES only allows one to screen print, and case managers aren't doing this because they feel this looks unprofessional. Care plans start being more effective and more useful to the client if they are specific to their needs. Lubbock is currently using a form that follows the care plan as it lists the problem statement, goals, etc. and has a signature page.
CONCLUSION	Maybe case managers will use a generic form that outlines the requirements in the care plan that clients can sign
FOLLOW-UP ACTIONS	Draft a generic care plan and send out for comment
PERSON RESPONSIBLE	Ann Dills, DSHS

TOPIC/ITEM 29	#19, item 52 Duplication of charting

DISCUSSION	As in the standards, we will change the wording to primary client record system. AAs can make the decision at the local level which system the providers must use for which information.
CONCLUSION	Change wording to primary client record system.
FOLLOW-UP ACTIONS	Wording will be changed in monitoring tool
PERSON RESPONSIBLE	Teena Edwards, DSHS

TOPIC/ITEM 30	#20, item 54 Frequency of contact based on acuity
DISCUSSION	Originally the standards stated that setting the frequency of contact based on acuity would be determined at the regional level. In some regions, this has occurred while in others they were waiting for DSHS to make that determination
CONCLUSION	Frequency of contact based on acuity will be set by DSHS as a statewide standard
FOLLOW-UP ACTIONS	Draft of an acuity scale will be sent to the stakeholders and will be included in the Standards
PERSON RESPONSIBLE	Ann Dills, DSHS

TOPIC/ITEM 31	#21, item 58-61 No documentation standards
DISCUSSION	As in the standards, we will change the wording to primary client record system. AAs can make the decision at the local level which system the providers must use for which information.
CONCLUSION	Change wording to primary client record system.
FOLLOW-UP ACTIONS	Wording will be changed in monitoring tool
PERSON RESPONSIBLE	Teena Edwards, DSHS

TOPIC/ITEM 32	#22, 23, and 24 items 63, 66, and 67 Documentation implies paper charts
DISCUSSION	As in the standards, we will change the wording to primary client record system. AAs can make the decision at the local

	level which system the providers must use for which information.
CONCLUSION	Change wording to primary client record system.
FOLLOW-UP ACTIONS	Wording will be changed in monitoring tool
PERSON RESPONSIBLE	Teena Edwards, DSHS

TOPIC/ITEM 33	# 25, item 67 Referrals
DISCUSSION	There is no place put referral denials. AAs have asked for a drop down under the referral tracking to document these. Since ARIES does not track referrals very easily referral denials can be charted in the case notes of the primary clients record.
CONCLUSION	Chart referral denials in the client's case notes
FOLLOW-UP ACTIONS	None at this time
PERSON RESPONSIBLE	

TOPIC/ITEM 34	#26, item 70 3 attempts
DISCUSSION	We discussed this under the standards and DSHS will add the 3-month timeframe to the standards as well as the monitoring tool
CONCLUSION	3-months will be the timeframe to complete at least 3 attempts to reach and re-engage client into care.
FOLLOW-UP ACTIONS	Standards and the monitoring tool will be updated to include 3 month timeframe
PERSON RESPONSIBLE	Ann Dills and Teena Edwards, DSHS

TOPIC/ITEM 35	Conference call on General Comments on the Case Management Standards
DISCUSSION	DSHS response to the general comments submitted on the case management standards will be sent out at the end of this week with a conference call scheduled for Tuesday, July 22 from 9:30 - 11:00 am to begin discussion

CONCLUSION	Schedule meetings as needed to discuss general items
FOLLOW-UP ACTIONS	Conference call scheduled
PERSON RESPONSIBLE	Teena Edwards, DSHS

Meeting Attendance

Teena Edwards	DSHS HIV Care Services Group
Janina Vazquez	DSHS HIV Care Services Group
Ann Dills	DSHS HIV Care Services Group
Shaina Johnson	DSHS HIV Care Services Group
Samantha Barriento	DSHS HIV Care Services Group
Michelle Berkoff	DSHS HIV Care Services Group
Jamie Schield	Planning Coordinator, North Central Texas Planning Council
Margie Drake	Manager, Tarrant County HIV Part A and B
Lisa Muttiah	Quality Assurance Coordinator, 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
Kristi Hanle	BVCOG HIV Program Director, Part B
Jessica Pierce	BVCOG Planner, Part B
Laura Castro	Bexar County Planning Council Liaison Part A