Non-medical Case Management (Service Linkage)	Pg
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FY 2015 Houston EMA/HSDA Ryan White Part A Service Definition
Service Linkage at Testing Sites
(Revision Date: 03/03/14)

HRSA Service Category Title: **RWGA Only**	**Non-medical Case Management**
Local Service Category Title:	**A. Service Linkage targeted to Not-In-Care and Newly-Diagnosed PLWHA in the Houston EMA/HDSA** **Not-In-Care PLWHA** are individuals who know their HIV status but have not been actively engaged in outpatient primary medical care services for more than six (6) months. **Newly-Diagnosed** PLWHA are individuals who have learned their HIV status within the previous six months and are not currently receiving outpatient primary medical care or case management services as documented in the CPCDMS data system. **B.** ***Youth targeted Service Linkage, Care and Prevention:*** Service Linkage Services targeted to Youth (13 – 24 years of age), including a focus on not-in-care and newly-diagnosed Youth in the Houston EMA. *Not-In-Care PLWHA are Youth who know their HIV status but have not been actively engaged in outpatient primary medical care services in the previous six (6) months. *Newly-Diagnosed Youth are Youth who have learned their HIV status within the previous six months and are not currently receiving outpatient primary medical care or case management services as documented in the CPCDMS data system.
Budget Type: **RWGA Only**	Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	Early intervention services, including HIV testing and Comprehensive Risk Counseling Services (CRCS) must be supported via alternative funding (e.g. TDSHS, CDC) and may not be charged to this contract.
HRSA Service Category Definition: **RWGA Only**	***Case Management (non-Medical)*** includes the provision of 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 of medical treatments, as medical case management does. ***Early intervention services (EIS)*** include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose to extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.
Local Service Category Definition:	**A.** ***Service Linkage:*** Providing allowable Ryan White Program outreach and service linkage activities to newly-diagnosed and/or ***Not-In-Care*** PLWHA who know their status but are not currently enrolled

	in outpatient primary medical care with information, referrals and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPHS/RWGA policies. **B.** ***Youth targeted Service Linkage, Care and Prevention:*** Providing Ryan White Program appropriate outreach and service linkage activities to newly-diagnosed and/or not-in-care HIV-positive Youth who know their status but are not currently enrolled in outpatient primary medical care with information, referrals and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed; advocating on their behalf to decrease service gaps and remove barriers to services; helping Youth develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPHS/RWGA policies. Provide comprehensive medical case management to HIV-positive youth identified through outreach and in-reach activities.
Target Population (age, gender, geographic, race, ethnicity, etc.):	**A. Service Linkage:** Services will be available to eligible HIV-infected clients residing in the Houston EMA/HSDA with priority given to clients most in need. All clients who receive services will be served without regard to age, gender, race, color, religion, national origin, sexual orientation, or handicap. Services will target low income individuals with HIV/AIDS who demonstrate multiple medical, mental health, substance use/abuse and psychosocial needs including, but not limited to: mental health counseling, substance abuse treatment, primary medical care, specialized care, alternative treatment, medications, placement in a medical facility, emotional support, basic needs for food, clothing, and shelter, transportation, legal services and vocational services. Services will also target clients who cannot function in the community due to barriers which include, but are not limited to, mental illness and psychiatric disorders, drug addiction and substance abuse, extreme lack of knowledge regarding available services, inability to maintain financial independence, inability to complete necessary forms, inability to arrange and complete entitlement and medical appointments, homelessness, deteriorating medical condition, illiteracy, language/cultural barriers and/or the absence of speech, sight, hearing, or mobility. **Service Linkage** is intended to serve eligible clients in the Houston EMA/HSDA, especially those underserved or unserved population groups which include: African American, Hispanic/Latino, Women and Children, Veteran, Deaf/Hard of Hearing, Substance Abusers, Homeless and Gay/Lesbian/Transsexual. **B.** ***Youth targeted Service Linkage, Care and Prevention:*** Services will be available to eligible HIV-infected Youth (ages 13 – 24) residing

	in the Houston EMA/HSDA with priority given to clients most in need. All Youth who receive services will be served without regard to age (i.e. limited to those who are between 13- 24 years of age), gender, race, color, religion, national origin, sexual orientation, or handicap. Services will target low income Youth living with HIV/AIDS who demonstrate multiple medical, mental health, substance use/abuse and psychosocial needs including, but not limited to: mental health counseling, substance abuse treatment, primary medical care, specialized care, alternative treatment, medications, placement in a medical facility, emotional support, basic needs for food, clothing, and shelter, transportation, legal services and vocational services. Services will also target Youth who cannot function in the community due to barriers which include, but are not limited to, mental illness and psychiatric disorders, drug addiction and substance abuse, extreme lack of knowledge regarding available services, inability to maintain financial independence, inability to complete necessary forms, inability to arrange and complete entitlement and medical appointments, homelessness, deteriorating medical condition, illiteracy, language/cultural barriers and/or the absence of speech, sight, hearing, or mobility. ***Youth Targeted Service Linkage, Care and Prevention*** is intended to serve eligible youth in the Houston EMA/HSDA, especially those underserved or unserved population groups which include: African American, Hispanic/Latino, Substance Abusers, Homeless and Gay/Lesbian/Transsexual.
Services to be Provided:	**Goal (A): Service Linkage:** The expectation is that a single Service Linkage Worker Full Time Equivalent (FTE) targeting Not-In-Care and/or newly-diagnosed PLWHA can serve approximately 80 newly-diagnosed or not-in-care PLWH/A per year. The purpose of **Service Linkage** is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. **Service Linkage** is a working agreement between a client and a Service Linkage Worker (SLW) for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. The purpose of **Service Linkage** is to assist clients who do not require the intensity of *Clinical or Medical Case Management*, as determined by RWGA Quality Management guidelines. **Service Linkage** is both office- and field-based and **may include the issuance of bus pass vouchers and gas cards per published guidelines.** Service Linkage targeted to Not-In-Care and/or Newly-Diagnosed PLWHA extends the capability of existing programs with a documented track record of identifying Not-In-Care and/or newly-diagnosed PLWHA by providing “hands-on” outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services.

	In order to ensure linkage to an ongoing support system, eligible clients identified funded under this contract, including clients who may obtain their medical services through non-Ryan White-funded programs, must be transferred to a Ryan White-funded Primary Medical Care, Clinical Case Management or Service Linkage program within 90 days of initiation of services as documented in both ECLIPS and CPCDMS data systems. Those clients who choose to access primary medical care from a non-Ryan White source, including private physicians, may receive ongoing service linkage services from provider or must be transferred to a Clinical (CCM) or Primary Care/Medical Case Management site per client need and the preference of the client. **GOAL (B):** This effort will continue a program of ***Service Linkage, Care and Prevention to Engage HIV Seropositive Youth*** targeting youth (ages 13-24) with a focus on Youth of color. This service is designed to reach HIV seropositive youth of color not engaged in clinical care and to link them to appropriate clinical, supportive, and preventive services. The specific objectives are to: (1) conduct outreach (service linkage) to assist seropositive Youth learn their HIV status, (2) link HIV-infected Youth with primary care services, and (3) prevent transmission of HIV infection from targeted clients.
Service Unit Definition(s): **RWGA Only**	One unit of service is defined as 15 minutes of direct client services and allowable charges.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services.*
Client Eligibility:	Not-In-Care and/or newly-diagnosed HIV-infected individuals residing in the Houston EMA.
Agency Requirements:	**Service Linkage** services will comply with the HCPHS/RWGA published **Service Linkage** Standards of Care and policies and procedures as published and/or revised, including linkage to the CPCDMS data system. Agency must comply with all applicable City of Houston DHHS *ECLIPS* and RWGA/HCPHS *CPCDMS* business rules and policies & procedures. **Service Linkage** targeted to Not-In-Care and/or newly diagnosed PLWHA must be planned and delivered in coordination with local HIV prevention/outreach programs to avoid duplication of services and be designed with quantified program reporting that will accommodate local effectiveness evaluation. Contractor must document established linkages with agencies that serve HIV-infected clients or serve individuals who are members of high-risk population groups (e.g., men who have sex with men, injection drug users, sex-industry workers, youth who are sentenced under the juvenile justice system, inmates of state and local jails and prisons). Contractor must have formal collaborative, referral or Point of Entry (POE) agreements with Ryan White funded HIV/AIDS primary care providers.

Staff Requirements:	Service Linkage Workers must spend at least 42% (867 hours per FTE) of their time providing direct client services. Direct service linkage and case management services include any activities with a client (face-to-face or by telephone), communication with other service providers or significant others to access client services, monitoring client care, and accompanying clients to services. Indirect activities include travel to and from a client's residence or agency, staff meetings, supervision, community education, documentation, and computer input. Direct case management activities must be documented in the CPCDMS according to system business rules. *Must comply with applicable HCPHS/RWGA published Ryan White Part A/B Standards of Care:* Minimum Qualifications: **Service Linkage Workers** must have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWH/A may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Supervision: The Service Linkage Worker must function within the clinical infrastructure of the applicant agency and receive ongoing supervision that meets or exceeds HCPHS/RWGA published Ryan White Part A/B Standards of Care for Service Linkage.
Special Requirements: **RWGA Only**	Contractor must be have the capability to provide Public Health Follow-Up by qualified Disease Intervention Specialists (DIS) to locate, identify, inform and refer newly-diagnosed and not-in-care PLWHA to outpatient primary medical care services. Contractor must perform CPCDMS new client registrations and, for those newly-diagnosed or out-of-care clients referred to non-Ryan White primary care providers, registration updates per RWGA business rules for those needing ongoing service linkage services as well as those clients who may only need to establish system of care eligibility. This service category does not routinely distribute Bus Passes. However, if so directed by RWGA, Contractor must issue bus pass vouchers in accordance with HCPHS/RWGA policies and procedures.

FY 2020 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/19**
Recommendations:	Approved: Y:_____ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/06/19**
Recommendations:	Approved: Y:____ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup #1**	Date: **04/23/19**
Recommendations:	Financial Eligibility: No financial cap
1.	
2.	
3.	

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FY 2017 PERFORMANCE MEASURES HIGHLIGHTS

RYAN WHITE GRANT ADMINISTRATION

HARRIS COUNTY PUBLIC HEALTH (HCPH)

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Highlights from FY 2017 Performance Measures

Measures in this report are based on the 2017 Houston Ryan White Quality Management Plan, Appendix B. HIV Performance Measures.

Non-Medical Case Management / Service Linkage

- During FY 2017, 7,084 clients utilized Part A non-medical case management / service linkage. According to CPCDMS, 3,259 (46%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing non-medical case management.
- Among these clients, 372 (43%) clients utilized primary medical care for the first time after accessing service linkage for the first time.
- Among these clients, the median number of days between the first service linkage visit and the first primary medical care visit was 18 days during this time period.

Ryan White Part A
HIV Performance Measures
FY 2017 Report

Non-Medical Case Management / Service Linkage
All Providers

For FY 2017 (3/1/2017 to 2/28/2018), 7,084 clients utilized Part A non-medical case management.

HIV Performance Measures	FY 2016	FY 2017	Change
A minimum of 70% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing non-medical case management (service linkage)	3,072 (45.0%)	3,259 (46.0%)	**1.0%**
Percentage of clients who utilized primary medical care for the first time after accessing service linkage for the first time	508 (52.5%)	372 (42.9%)	**-9.6%**
Number of days between first ever service linkage visit and first ever primary medical care visit:			
Mean	36	35	**-2.8%**
Median	21	18	**-14.3%**
Mode	14	1	**-92.9%**
60% of newly-enrolled clients will have a medical visit in each of the four-month periods of the measurement year	132 (46.3%)	119 (43.1%)	**-3.2%**

Case Management Chart Review Cumulative De-identified Report

2017-2018

Anne Russey, MEd, LPC-Supervisor

Independent Contractor

This reports summarizes the data collected from the 2017-2018 chart review of non-medical and medical case management services. Site visits and remote reviews occurred during October and November of 2018.

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Overview

A total of 312 medical case management and non-medical case management (or service linkage) client charts were reviewed. The dates of service included in the review period were March 1, 2017 - February 28, 2018, with the exception of AIDS Healthcare Foundation, the newest addition to Harris County Ryan White Part A services, whose dates of service under review were May 1, 2018-October 29, 2018. Progress notes, brief assessments, comprehensive assessments, supporting documents in any format available (electronic, hard copy, scanned documents) were reviewed as provided by each site. The sample selection was provided to this contractor by RWGA staff and included clients whom received services under each of the service category types identified above.

This contractor proposed changes to the Chart Review Tool following the 2016-2017 review, but the proposed changes were not considered by the required parties in time to implement any significant changes for this 2017-2018 review. Carin Martin of RWGA did however, approve use of an addendum page that was added to this year's review. This writer also utilized the notes section of the tool to track a number of co-occurring medical conditions to begin to gather data on other conditions that may influence or impact health outcomes of people living with HIV in the Harris County EMA.

Case management is defined by the Harris County RWGA Standards of Care as "services in HIV care [that] facilitate client access to health care services, assist clients to navigate through the wide array of health care programs and ensure coordination of services to meet the unique needs of People Living with HIV (PLWH)." Case managers serving in the agency and clinic settings are helping clients navigate very complex and fragmented systems at agency, local, state and federal levels that sometimes feel like they're working against the very clients they were designed to serve, treat and protect.

If we consider conditions outside of an HIV+ diagnosis, such as active mental health and substance use disorders, unstable or insufficient housing, employment, income or transportation, poor support networks, lack of health insurance, barriers to medication among many other psychical and psychosocial factors contribute to lower retention in care and viral load suppression rates and increased risk and rates of new HIV transmissions, it is clear that case management has the potential to affect and in many cases improve health outcomes for the clients it serves. Licensed case managers are uniquely positioned by their education and training to assist clients struggling with complex mental health and substance use issues.

One can see threads of the old models of case management running through the 312 charts reviewed, with a very small handful of examples of a client quickly completing an assessment and service plan followed by intensive and frequent contact from a non-medical or medical case manager who documents in progress notes as obstacles and barriers are overcome, goals are accomplished and needs are met in their and 6 months later in their re-assessment and service plan review before eventually being discharged. This contractor wants to be clear that those appear to be the exception and not the norm. The majority of charts reviewed (44%) did not have a brief or comprehensive assessment completed at all. Only 152 clients (48%) had 3 or more phone or in person encounters with a case manager during the review year. This The Ryan White Standards of Care seem to presume much more intense and frequent contact between case manager and client than is actually happening in practice. Due presumably to increased demand for services and volume of clients served by each site, case management services seem to be delivered mostly on demand based on the needs of the individual clients in front of the case manager at the moment in which the provider, client or someone else requests help. Gone are the days of a case manager having a small manageable case load that allows for

close monitoring, following up on service plan goals and referrals, and regular discharges from services when goals are met and services are "complete"- unless the system somehow evolves and changes too.

Cumulative Data Summaries

Brief Assessments

# clients with brief assessment in review period 3/1/17-2/28/18	Site						
	A	B	C	D	E	F	Total
0	7	0	15	56	34	13	125
	39%	0%	31%	55%	42%	25%	40%
1	4	0	24	41	25	10	104
	22%	0%	50%	40%	31%	20%	33%
2	0	0	1	3	1	0	5
	0%	0%	2%	3%	1%	0%	2%
Not applicable	7	12	8	2	21	28	78
	39%	100%	17%	2%	26%	55%	25%
Total	18	12	48	102	81	51	312
	100%	100%	100%	100%	100%	100%	100%

40% of the 312 charts reviewed in the review period 3/1/17-2/28/18 did not have a brief assessment completed. 25% of the 312 charts reviewed were not required to have a brief assessment completed due to no contact with a non-medical case manager. When there was contact with a non-medical case manager noted, reasons for lack of brief assessments varied but often included client showing up unannounced and/or having a very short period of time to spend with SLW or sometimes frequent phone call contacts rather than in office visits and thus time and attention was spent on meeting client's immediate need and helping overcome a specific barrier rather than on completion of the brief assessment. Client crises especially around medication access clearly take priority (as they should) over completion of the brief assessment. 33% of the 312 charts reviewed had one brief assessment completed and 2% had two completed. The majority of the brief assessments reviewed identified only one or two needs such as transportation, vision, dental and/or other specialty care or supportive service need and noted appropriate referrals were made. In the rare cases more complicated needs were identified there was generally documentation of referral to medical case management noted.

Comprehensive Assessments

# clients with comprehensive assessment in review period 3/1/17-2/28/18	Site						
	A	B	C	D	E	F	Total
0	8	0	28	15	21	23	95
	44%	0%	58%	15%	26%	45%	30%
1	10	12	5	7	21	13	68
	56%	100%	10%	7%	26%	25%	22%
2	0	0	0	3	1	1	5
	0%	0%	0%	3%	1%	2%	2%
Not applicable	0	0	15	77	38	14	144
	0%	0%	31%	75%	47%	27%	46%
Total	18	12	48	102	81	51	312
	100%	100%	100%	100%	100%	100%	100%

30% of the 312 charts reviewed in the review period 3/1/17-2/28/18 did not have a comprehensive assessment completed. 46% of the 312 charts reviewed were not required to have a comprehensive assessment completed due to no contact with a medical case manager. When there was contact with a medical case manager, reasons for lack of comprehensive assessments varied but often included client showing up unannounced and/or having a very short period of time to spend with MCM or sometimes frequent phone call contacts rather than in office visits and thus time and attention was spent on meeting client's immediate need and helping overcome a specific barrier rather than on completion of the comprehensive assessment. Client crises especially around medication access clearly take priority (as they should) over completion of the comprehensive assessment. In some cases there was documentation of justification for delay of completion of comprehensive assessment noted in the progress notes of the client's chart. 22% of the 312 charts reviewed had one comprehensive assessment completed and 2% had two completed.

Assessment Needs

Need identified on assessment	Total	
Transportation	74	43%
Mental Health	62	36%
OAMC	55	32%
Insurance	51	29%
Dental	49	28%
Treatment Adherence	42	24%
Vision	42	24%
Housing	33	19%
HIV Education	29	17%
Self Efficacy	29	17%
Substance Abuse	25	14%
Income	24	14%
Basic	23	13%
Support	23	13%
HIV Related Legal	19	11%
Culural	17	10%
Food	10	6%
General Education	9	5%
Emergency Financial	6	3%
Translation	3	2%
Kids/Child Care	1	1%
Benefits	0	0%

Of the 175 comprehensive, brief and brief-transportation assessments reviewed in detail, the most common need identified in 43% of the charts was transportation. The following came in as the four next most commonly identified needs: mental health (36%), outpatient ambulatory medical care (32%), insurance (29%) and dental (28%). At sites where dental and vision services were readily available, it seemed those needs almost always made it to the service plan. Needs besides transportation may be under represented due to the standard of care requirement of an assessment being on file in order to provide a bus pass. In the cases where an assessment is needed to provide a bus pass, transportation is the focus of the time and the encounter and other needs may be deferred or ignored until subsequent or return encounters. Other needs such as barriers to medication or primary care were addressed in progress notes rather than on the service plan(s). It seemed that more important than the identified need making it to the service plan, was whether or not a client received information, referral or assistance accessing services or support to help them meet their need. Information, referrals and assistance to overcome obstacles or barriers and the outcomes of those efforts was typically documented in detail in progress note encounters or consultation/coordination encounters with other providers rather than in the assessment or service plan.

Service Plans

# clients with service plan in review period 3/1/17-2/28/18	Site						
	A	B	C	D	E	F	Total
0	10	5	28	14	23	23	103
	56%	42%	58%	14%	28%	45%	33%
1	7	7	5	4	19	13	55
	39%	58%	10%	4%	23%	25%	18%
2	1	0	0	6	1	1	9
	6%	0%	0%	6%	1%	2%	3%
Not applicable	0	0	15	78	38	14	145
	0%	0%	31%	76%	47%	27%	46%
Total	18	12	48	102	81	51	312
	100%	100%	100%	100%	100%	100%	100%

33% of the 312 charts reviewed in the review period 3/1/17-2/28/18 did not have a service plan completed. 46% of the 312 charts reviewed were not required to have a comprehensive assessment completed due to no contact with a medical case manager. When there was contact with a medical case manager, reasons for lack of service plans varied but as service plans are generally completed following a comprehensive assessment it makes sense that the number of clients missing both an assessment and a service plan would be similar and due to similar obstacles. In follow up to the 2016-2017 review where Agency A and Agency C had some issues with incomplete scanned documents/missing service plans where one was noted, this was not a problem in this year's review. In almost every case if there was a note indicating a service plan was completed, it was readily available in the chart for all sites.

Encounters

# of progress notes during review period	Site						
	A	B	C	D	E	F	Total
1 or more	18	12	48	102	80	51	311
2 or more	18	5	31	69	56	36	215
3 or more	18	2	25	48	36	23	152
4 or more	16	1	15	34	26	15	107
5 or more	14	0	11	19	21	11	76

It seems worth noting that less than half of the clients receiving services during the review period had 3 or more contacts with a case manager during the one year review period. The Ryan White Standards of Care requirements seem to presume much more frequent contacts between case manager and client during a one year period that would allow for more intense case management and follow up. It should come as no surprise that if contact is limited to 1, 2 or 3 instances that opportunities to complete assessments and service plans and subsequent reviews and follow ups are extremely limited if not non-existent.

Assessment Summary

# clients with brief, comprehensive, both or no assessment in review period 3/1/17-2/28/18	Site						
	A	B	C	D	E	F	Total
Brief	0	0	24	35	25	10	94
	0%	0%	50%	34%	31%	20%	30%
Comprehensive	6	12	4	9	23	14	68
	33%	100%	8%	9%	28%	27%	22%
Both	4	0	1	8	0	0	13
	22%	0%	2%	8%	0%	0%	4%
None	8	0	19	50	33	27	137
	44%	0%	40%	49%	41%	53%	44%
Total	18	12	48	102	81	51	312
	100%	100%	100%	100%	100%	100%	100%

#** and Type of Assessment Reviewed	Site						
	A	B	C	D	E	F	Total
Brief	0	0	25	2	26	10	63
Brief-Transportation	0	0	0	40	0	0	40
Comprehensive	10	12	4	10	22	13	71
Total	10	12	29	52	48	23	174

** Tool did not allow for review of more than one assessment per chart

In summary, 44% of the 312 charts reviewed did not have any assessment completed. 22% had only comprehensive plan completed, 30% had only a brief assessment completed and only 4% had both a comprehensive and brief assessment completed. It should be noted that according to the standards of care, a brief assessment is not required in the event a non-medical case manager provides only basic referral or assistance, thus in cases where there was only contact from a non-medical case manager it may be appropriate that no assessment was completed.

174 assessments (brief, brief-transportation and comprehensive) were reviewed. Brief assessments were not required to have a service plan, and the service plans accompanying comprehensive assessments were often incongruent with the needs identified in the assessment. There were several instances where a need was identified but a note was added to indicate the client was declining to address the need as part of their service plan. Agency D was the only site who documented a separate type of brief assessment being used for clients in need of a Ryan White funded Metro bus pass. Agency B did not have a non-medical case manager on staff during the review period, thus all encounters reviewed were MCM encounters.

Lost to Care Status

Lost to Care Status	Site						
	A	B	C	D	E	F	Total
LTC Prior to Episode	1	0	3	10	3	3	20
	6%	0%	6%	10%	4%	6%	6%
LTC During Episode	1	0	1	14	7	1	24
	6%	0%	2%	14%	9%	2%	8%
Not LTC	16	12	44	78	71	47	268
	89%	100%	92%	76%	88%	92%	86%
Total	18	12	48	102	81	51	312
	100%	100%	100%	100%	100%	100%	100%

6% of charts reviewed indicated the client was lost to care prior to the review period. 8% of charts reviewed indicated the client was lost to acre during the review period. The remaining 86% of charts did not indicate a client was lost to care. In several cases efforts were noted to re-engage a client to care, including calling the last known number and even field visits to a client's last known address, sometimes successfully resulting in re-engaging a client to care and sometimes not. The 14% lost to care rate is likely lower than what actually occurs in the EMA as this sample only included clients who had a billable service encounter (meaning actual contact with a client- not efforts to retain or re-engage a client that did not result in contact) during the review period. If a client had billable contact with a non-medical or medical case manager during the review period it makes sense that they would most likely not be lost to care.

This reviewer utilized progress notes to identify clients who appeared to have been lost to care prior to or during the episode of care taking place during the review period. The tool did not allow for differentiation between prior to and during the review period so the reviewer utilized margin space of the tool to indicate if a client was lost prior to the review period. In the event the client was lost prior to the review (often indicated by a progress note stating the client attended a "RTC" or "return to care" appointment), the interventions taken to re-engage the client were often unclear.

It is notable that during this review period several sites utilized non-medical case managers (SLWs) dedicated specifically to the task of retaining or returning clients to care. It is the understanding of this reviewer that in future years the retention in care work will be funded and performed separate from non-medical case management under an Outreach service category so it may not be relevant to a qualitative review of this nature at that point.

Viral Load Suppression

Viral Load Suppression Information	Site						
	A	B	C	D	E	F	Total
Viral Load < 20	8	2	17	61	30	15	133
	44%	17%	35%	60%	37%	29%	43%
Viral Load not suppressed, but evidence	9	10	21	29	47	31	147
	50%	83%	44%	28%	58%	61%	47%
Viral Load not suppressed and no evidence of	0	0	0	5	0	1	6
	0%	0%	0%	5%	0%	2%	2%
No Viral Load data	1	0	10	7	4	4	26
	6%	0%	21%	7%	5%	8%	8%
Total	18	12	48	102	81	51	312
	100%	100%	100%	100%	100%	100%	100%

Of the 312 charts reviewed, 43% had evidence (lab results) of an undetectable viral load <20 copies per ml. 47% had evidence of at least one lab test during the review period that the viral load rose above 20 copies per ml, but also had evidence (progress notes) of an intervention or contact by a non-medical or medical case manager after or around the time of the lab test result. There were many cases where a client had a detectable viral load at one point in the review period, but later another result indicating their viral load was later suppressed. This positive change may correlate with the social service interventions they received (likely help accessing medication, overcoming barriers to primary care, referrals to mental health and substance use treatment, etc.) but further evaluation and adaptation of the tool would be needed to assess more closely. 2% of the charts reviewed had evidence of a detectable viral load at least once during the review period but no evidence of an intervention, contact or follow up after a viral load was detected. 8% of the charts did not have any lab tests/results in the chart- usually the case of a patient who was documented to be in primary care elsewhere but accessing non-medical case management services to access a specialty service like dental or vision care or a social service referral (housing, etc.).

It makes sense that of this sample of clients accessing non-medical and medical case management support that there would be a high percentage of individuals with an unsuppressed viral load due to the nature of support services. Considering the eligibility requirements in Standards of Care, to access non-medical and medical case management services, the clients accessing the service categories under review are likely experiencing risk factors that predispose them to having an increased viral load to begin with.

Co-occurring Conditions

Co-occurring Condition	Site	
	Total	% of Total
No Substance Use/MH dx	196	63%
Depression dx	73	23%
STD Dx	70	22%
Hypertension	69	22%
Other Substance Use	44	14%
Anxiety dx	39	13%
Diabetes II	32	10%
Other Mental Health dx	27	9%
Bipolar dx	25	8%
Homelessness noted	16	5%
Hep C	16	5%
Alcohol use disorder	13	4%
Cancer/Leukemia	5	2%
Pregnancy during episode	3	1%

Of the 312 charts reviewed 63% indicated no substance use or mental health diagnosis or problem. Progress notes and the problem lists/dashboards in the EHRs were utilized to identify co-occurring conditions. The most common mental health diagnosis or problem indicated was a depressive disorder at 23%. 22% of the charts reviewed indicated an STD/STI diagnosis. Anecdotally syphilis was identified frequently, however the review tool did not easily allow for documentation of specific STI/STD diagnoses and thus it is impossible to know for sure. This could be worth future consideration and may indicate additional training needs for support service staff who may be instrumental in helping clients access medication and treatment for various co-occurring conditions that ultimately affect the client's health outcomes.

Hypertension and Diabetes II were also noted by this reviewer as common co-occurring conditions. In many cases where a client had seemingly well managed HIV care, they were struggling with hypertension or diabetes and would likely benefit from additional support around those co-occurring conditions. This would likely require additional training and access to information and resources for the support staff tasked with helping a client navigate those conditions.

"Other Substance Use" (frequently methamphetamine, crack and marijuana) was noted in 14% of the charts. Again, the review tool did not allow for indication of specific substances being used besides alcohol so specific data is not available about the other substances being used.

Conclusion

The HIV care systems clients and providers must navigate in order to access and provide care is complex and at times burdensome. It is clear that non-medical and medical case managers play an important and useful role in helping clients overcome barriers to support services and primary care. Both non-medical and medical case managers appear to spend much of their time helping clients with eligibility and paperwork requirements mandated by the local, state and federal programs under which client's are served in order to access basic needs like medications, housing, transportation, primary and specialty medical care including dental and vision services and mental health or substance use treatment. The ways in which the most complex cases are funneled to the licensed medical case managers should continue to be evaluated and perhaps re-worked in some cases to ensure licensed medical case managers are being appropriately utilized to serve the most at risk and vulnerable clients who will benefit from the highest level of case management support available. Alternatively, consideration should be given to suggestions put forth by case management providers during the prior year's chart review process that may allow for billing simple information and referral encounters by licensed staff at a lower rate to give the sites flexibility in how they utilize available staff in their existing agency systems while still honoring and fulfilling their contract agreements and the standards of care.

Appendix

Review Tool

MCM and SLW Chart Review Tool

Services received
3/1/13-2/28/14

/___/___/201___/ **Client Case Status:** ☐ Open/Active ☐ Closed ☐ Unk

Brief Assessment Date 1:		**Brief Assessment Date 2:**	
Comp Assessment Date 1:		**Comp Assessment Date 2:**	
Service Plan Date 1:		**Service Plan Date 2:**	
Case Closure Date:			
Last OAMC Date:			
Last MCM Date:			

HIV/AIDS STAGE OF ILLNESS UPDATE, AND BEHAVIORAL HEALTH CONDITIONS

1. Most current documented HIV stage? ☐ HIV+, not AIDS ☐ AIDS ☐ HIV+/Status Unk
2. Was the client identified as needing MH/SA therapy/counseling? ☐ Yes ☐ No ☐ NA ☐ Unk
3. Does the client have an active diagnosis of the following diagnoses? (Check ALL That Apply)
   - ☐ Alcohol abuse/dependence
   - ☐ Other substance abuse/substance dependence
   - ☐ Depression
   - ☐ Bipolar disorder
   - ☐ Anxiety disorders
   - ☐ Other mental disorders ______________________
4. Was the client reported to have any of these conditions? (Check ALL That Apply)
   - ☐ Sexually transmitted infections (STIs)
   - ☐ Pregnancy
   - ☐ Homeless

SERVICE LINKAGE

5. How was the client assisted by a SLW in the observation period
   - ☐ **NA (Client not assisted by SLW)**
   - ☐ Brief assessment
   - ☐ SLW referred client to OAMC
   - ☐ OAMC visit scheduled by SLW
   - ☐ SLW accompanied the client to OAMC visit
   - ☐ SLW called client to remind about the OAMC visit
   - ☐ Client did not keep OAMC appointment and SLW contacted the client
   - ☐ Other SLW activity: ______________________

LOST TO CARE AND COORDINATION ACTIVITIES

6. Was the client lost to OAMC care? ☐ Yes ☐ No ☐ NA
7. Was there acknowledgement in the chart that the client was lost to OAMC care? ☐ Yes ☐ No ☐ NA
8. What activities did the **MCM** undertake because the client was lost to care? (Check all that apply)
   - ☐ **NA (Client not lost to care)**
   - ☐ No activities documented to contact client lost to care
   - ☐ Letter to client's last known address
   - ☐ Telephone call to client's last known telephone number
   - ☐ Telephone call to client's emergency contact person
   - ☐ Referral to outreach program: ______________________
9. Did the MCM receive information from the program about the client's status? ☐ Yes ☐ No ☐ NA
   a. Client status? ______________________

10. Was there evidence of coordination of services between MCM, clinician, and support service providers in the chart?
    - ☐ Yes, there is coordination of services
    - ☐ There is no evidence of coordination of services
    - ☐ Client refusal documented in client's records
    a. Evidence: ____________________

NEEDS REQUIRING COMPREHENSIVE CASE MANAGEMENT

CPCDMS Insurance Status: Uninsured

11. **Insurance, Benefits, and FPL**

Health Insurer	Coverage?	Disability/Survivor Benefits
Medicaid	Full? Managed Care? Share of Cost? Medically Needy? QMB?	SSA Old Age (≥ 65 Years)
Medicare	Part A? Part B? Part D?	SSA SSI
Commercial Name?		SSA SSDI
VA		Survivor Benefits (Widow, Widower, Child)
Other Insurers Name?		Commercial Disability/Worker's Comp

Client	Spouse/partner	Client's children	Client's Mother	Client's father	Client's sisters	Client's brothers	Other		HOUSEHOLD SIZE
1	1	1 2 3 4 5 6 7 8	1	1	1 2 3	1 2 3	1 2 3	→	1 2 3 4 5 6 7 8 9 10 UNK

Client 1	$	Other Member1	$	Total Income:
Client 2	$	Other Member2	$	$
Spouse	$	Other Income	$	

CLINICAL CASE MANAGEMENT

12. Was the client referred for **clinical case management** services in the review period?
    ☐ Yes ☐ No ☐ Unk
    If YES, was there evidence of coordination of services between primary care provider and clinical case management at least every three months in the client's chart?
    - ☐ Yes, there is coordination of services
    - ☐ There is no evidence of coordination of services
    - ☐ Client refusal documented in client's record
    - ☐ NA, client not referred to clinical case management services

CASE DISCHARGE/TERMINATION/CLOSURE

13. Was case discharged/closed case during the review period? ☐1. Yes ☐ 0. No ☐ 8. NA ☐ 9. Unk

Case Closure	Closure 1	Closure 2	Closure 3
Client met agency criteria for closure?	Y N Unk NA	Y N Unk NA	Y N Unk NA
Date of closure noted?	Y N Unk NA	Y N Unk NA	Y N Unk NA
Summary of services received noted?	Y N Unk NA	Y N Unk NA	Y N Unk NA
Referrals noted?	Y N Unk NA	Y N Unk NA	Y N Unk NA
Instructions given to client at discharge noted?	Y N Unk NA	Y N Unk NA	Y N Unk NA
Reason for closure			
All goals met / no needs	Y N Unk NA	Y N Unk NA	Y N Unk NA
Client continues no show, lack of follow-up	Y N Unk NA	Y N Unk NA	Y N Unk NA
Client refused service	Y N Unk NA	Y N Unk NA	Y N Unk NA
Client died	Y N Unk NA	Y N Unk NA	Y N Unk NA
Client lost to care	Y N Unk NA	Y N Unk NA	Y N Unk NA
Client moves out of service area	Y N Unk NA	Y N Unk NA	Y N Unk NA
Client incarcerated	Y N Unk NA	Y N Unk NA	Y N Unk NA
Unk, unclear, contradictory documentation	Y N Unk NA	Y N Unk NA	Y N Unk NA

14. If an assessment was completed, were the following components assessed, addressed in the service plan, and addressed by referrals?

Worker Completing Assessment:	Assessment		Service Plan		Referral		Follow-up to Achieve Goal Documented?
	Domain Assessed?	Need Identified?	Resources Identified?	Timelines?	Referral Made?	Follow-up to Referral?	
Basic Necessities							
Benefits							
Children/Dependents							
Cultural/Linguistic							
Dental Care							
Emergency Financial Assistance							
Family Planning/Safer Sex							
Food/Nutrition							
General Education, Vocation, Literacy							
Health Insurance							
Health Insurance Premium Assistance							
Hearing Care							
HIV Ed/Prevention							
HIV Medications							
Housing Services							
Income							
Legal							
Mental Health Treatment							
Outpatient Ambulatory Medical Care							
Self-Efficacy							
Substance Abuse Treatment							
Support System							
Translation Services							
Transportation							
Treatment Adherence							
Vision Care Other:							

Addendum:

15. Viral load suppressed during review period?

- Yes
- No, intervention/follow up/linkage by SLW/MCM documented
- No, ***no documentation*** of intervention/follow up/linkage by SLW/MCM
- Unknown; no lab results containing VL information documented during review period

16. Was there a primary care visit within review period?

- Yes
- No

17. If no to 16, was there documentation by SLW/MCM to link client back to care?

- Yes
- No
- Not applicable (client moved out of EMA, client deceased, client refused service, etc.)

18. If any conditions applicable under 3 or 4, was there an attempt to link client to SLW/MCM care?

- Yes
- No, client was virally suppressed
- No, client had viral load and no linkage attempts documented

19. Progress notes: Were the five most recent progress notes (involving face to face or phone contact) in the review period dated, signed, indicative of the type of service delivered, the nature and extent of the service and the next steps or future plans?

F2F/PC date	Dated		Signed		Type of service noted?		Nature and extent of service noted?		Next steps or future plans noted?		Progress notes clear and concise?	
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N

Patient Navigation Intervention

Highlights from the Special Projects of National Significance (SPNS) Program

This fact sheet contains highlights from the Virginia Department of Health's *Patient Navigation* Intervention, focused on using patient navigation in linking newly diagnosed persons to care within 30 days of diagnosis. This intervention also targets those who have fallen out of care, who have never received care, or are at risk of being lost-to-care.

Setting: Central and Southwest Regions of Virginia

Target Population: Newly diagnosed PLWH; PLWH who have fallen out of care, have never received care, or are at risk of being lost to care

Theoretical Basis: Collaborative Learning Model

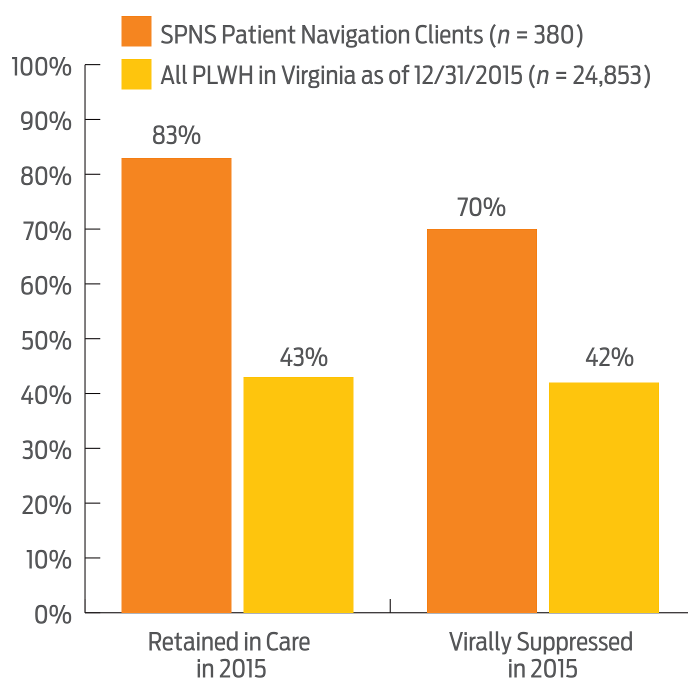
Background

Following a diagnosis of HIV, linking people living with HIV (PLWH) to HIV services is the next step on the HIV care continuum. Early initiation of HIV treatment is associated with improved outcomes along the HIV care continuum. Lower CD4 T cell counts at the time of treatment initiation is associated with shorter life expectancy and a lower likelihood of full rebound of CD4 counts.[1,2] Thus, linkage to care soon after diagnosis can be an important strategy for supporting PLWH. HHS guidelines indicate that all PLWH should be initiated in treatment, and as early as possible. Patient navigation support for PLWH has been demonstrated to improve efficiency and effectiveness of linkage to care interventions.[3] The Virginia Department of Health sought to promote timely linkage to and retention in care through the guidance and support of health workers known as Patient Navigators.

Unmet Needs

Underserved populations, including many racial, ethnic, and sexual minorities, face numerous structural, financial, and cultural barriers that impede their linkage to and engagement in care.[4] As such, addressing these key areas by increasing social support services; integrating one-stop-shop care delivery; removing structural barriers; providing financial support services; and using peer navigators or care coordinators, can help improve linkage to care for PLWH.

HIV Care Outcomes Among VDH SPNS Patient Navigation Clients Served 9/1/2013–8/31/2015



U.S. Department of Health and Human Services
Health Resources and Services Administration
HIV/AIDS Bureau
September 2018

Intervention Objectives

The objectives of the *Patient Navigation* Intervention were to create more timely and effective linkages to and retention in medical care for PLWH through the guidance and support of Patient Navigators.

Key Considerations for Replication

- **Engage potential partners and stakeholders** early in the planning process, and include diverse planning partners (e.g., service providers, community members, PLWH)
- **Research the availability of similar interventions** in the local area to avoid duplication or confusion and identify opportunities for partnerships and coordination
- **Develop a clear and comprehensive protocol** for Patient Navigators to follow
- **Client encounters should take place routinely** (more frequently at the start of navigation), be face-to-face whenever possible, and documented by the Patient Navigator
- **PLWH may enter the intervention at varying stages of the HIV care continuum,** and may need to re-engage with the intervention at some point
- **Navigators and PLWH work collaboratively** to develop a linkage-to-care plan; clients should be informed during intake that the transitioning out (once appropriate) will take place
- **Linkage to non-HIV-related services** (e.g., mental health, housing, transportation, education) can be facilitated by the Patient Navigator

Intervention Staff Requirements

To replicate the Virginia Department of Health's Patient Navigation intervention, the following positions and capacity are necessary.

- **Patient Navigators**—must possess specific knowledge and skills including being able to solve problems creatively and effectively; direct clients to community resources/information; and build working relationships. **Programs may be able to rely on community health workers or other staff dedicated to linkage-to-care efforts if a patient navigator is not available.*
- **Patient Navigator Supervisors**—A variety of staff serve to manage/supervise Patient Navigators including administrative staff, nurse managers, and physicians.

RESOURCES

This fact sheet is part of the ***Improving Health Outcomes: Moving Patients Along the HIV Care Continuum and Beyond*** resources from the Integrating HIV Innovative Practices (IHIP) project.

- **SPNS Initiative: Systems Linkages and Access to Care, 2011–2016: https://hab.hrsa.gov/about-ryan-white-hivaids-program/spns-systems-linkages-and-access**
- **VDH Active Referral Intervention Case Study: http://careacttarget.org/ihip**

Notes

[1] Althoff KN, Gange SJ, Klein MB, et al. Late presentation for human immunodeficiency virus care in the United States and Canada. Clin Infect Dis. Jun 1 2010;50(11):1512–1520. http://www.ncbi.nlm.nih.gov/pubmed/20415573.

[2] Moore RD, Keruly JC. CD4+ cell count 6 years after commencement of highly active antiretroviral therapy in persons with sustained virologic suppression. Clin Infect Dis. 2007;44(3):441–446. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=17205456.

[3] Okeke NL, Ostermann J, Thielman NM. Enhancing linkage and retention in HIV care: a review of interventions for highly resourced and resource-poor settings. Curr HIV/AIDS Rep. 2014;11(4):376–392. https://www.ncbi.nlm.nih.gov/pubmed/25323298

[4] CDC. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas, 2014. *HIV Surveillance Supplemental Report* 2016;21(No.4), Table 5a. www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-21-4.pdf Accessed September 16, 2016.

This publication lists non-federal resources in order to provide additional information to consumers. The views and content in these resources have not been formally approved by the U.S. Department of Health and Human Services (HHS) or the Health Resources and Services Administration (HRSA).