Service Category Definition - DSHS State Services

Local Service Category:	**Non-Medical Case Management Targeting Substance Use Disorder**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum 10% of budget for Administrative Cost. Direct medical costs and Substance Abuse Treatment/Counseling cannot be billed under this contract.
DSHS Service Category Definition:	**Non-Medical Case Management (N-MCM)** model is responsive to the immediate needs of a person living with HIV (PLWH) and includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, entitlements, housing, and other needed services. **Non-Medical Case Management Services (N-MCM)** provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. N-MCM services may also include assisting eligible persons living with HIV (PLWH) to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication (e.g., face-to-face, phone contact, and any other forms of communication) as deemed appropriate by the Texas DSHS HIV Care Services Group Ryan White Part B program.
Local Service Category Definition:	***Non-Medical Case Management:*** The purpose of Non-Medical Case Management targeting Substance Use Disorders (SUD) is to assist PLWHs with the procurement of needed services so that the problems associated with living with HIV are mitigated. N-MCM targeting SUD is intended to serve eligible people living with HIV in the Houston EMA/HSDA who are also facing the challenges of substance use disorder. Non-Medical Case Management is a working agreement between a PLWH and a Non-Medical Case Manager for an indeterminate period, based on PLWH need, during which information, referrals and Non-Medical Case Management is provided on an as- needed basis and assists PLWHs who do not require the intensity of Medical Case Management. Non-Medical Case Management is both office-based and field based. N-MCMs are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWH may be identified, including substance use disorder treatment/counseling and/or recovery support personnel. Such incoming referral coordination includes meeting prospective PLWHs at the referring provider location in order to develop rapport with and ensuring sufficient support is available. Non-Medical Case Management also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those PLWHs who have not returned for scheduled appointments with the provider nor have provided updated information about their current Primary Medical Care provider (in the situation where PLWH may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Non-Medical Case Management extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWH who are not currently accessing primary medical care services.

Target Population (age, gender, geographic, race, ethnicity, etc.):	**Non-Medical Case Management targeting SUD** is intended to serve eligible people living with HIV in the Houston EMA/HSDA, especially those underserved or unserved population groups who are also facing the challenges of substance use disorder. The target populations should also include individuals who misuse prescription medication or who use illegal substances or recreational drugs and are also: – Transgender, – Men who have sex with men (MSM), – Women or – Incarcerated/recently released from incarceration.
Services to be Provided:	**Goals:** The primary goal for N-MCM targeting SUD is to improve the health status of PLWHs who use substances by promoting linkages between community-based substance use disorder treatment programs, health clinics and other social service providers. N-MCM targeting SUD shall have a planned and coordinated approach to ensure that PLWHs have access to all available health and social services necessary to obtain an optimum level of functioning. N-MCM targeting SUD shall focus on behavior change, risk and harm reduction, retention in HIV care, and lowering risk of HIV transmission. The expectation is that each Non-Medical Case Management Full Time Equivalent (FTE) targeting SUD can serve approximately 80 PLWHs per year. **Purpose:** To promote Human Immunodeficiency Virus (HIV) disease management and recovery from substance use disorder by providing comprehensive Non-Medical Case Management and support for PWLH who are also dealing with substance use disorder and providing support to their families and significant others. **N-MCM targeting SUD** assists PLWHs with the procurement of needed services so that the problems associated with living with HIV are mitigated. **N-MCM targeting SUD** is a working agreement between a person living with HIV and a Non-Medical Case Manager (N-MCM) for an indeterminate period, based on identified need, during which information, referrals and Non-Medical Case Management is provided on an as- needed basis. The purpose of **N-MCM targeting SUD** is to assist PLWHs who do not require the intensity of *Clinical or Medical Case Management*. **N-MCM targeting SUD** is community-based (i.e. both office- and field-based). This Non-Medical Case Management targets PLWHs who are also dealing with the challenges of substance use disorder. N-MCMs also provide "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Efforts may include coordination with other case management providers to ensure the specialized needs of PLWHs who are dealing with substance use disorder are thoroughly addressed. For this population, this is not a duplication of service but rather a set of agreed upon coordinated activities that clearly delineate the unique and separate roles of N-MCMs and medical case managers who work jointly and collaboratively with the PLWH's knowledge and consent to partialize and prioritize goals in order to effectively achieve those goals.

	N-MCMs should provide activities that enhance the motivation of PLWHs on N-MCM's caseload to reduce their risks of overdose and how risk-reduction activities may be impacted by substance use and sexual behaviors. N-MCMs shall use motivational interviewing techniques and the Transtheoretical Model of Change, (DiClemente and Prochaska - Stages of Change). N-MCMs should promote and encourage entry into substance use disorder services and make referrals, if appropriate, for PLWHs who are in need of formal substance use disorder treatment or other recovery support services. However, N-MCMs shall ensure that PLWHs are not required to participate in substance use disorder treatment services as a condition for receiving services. For those PLWH in treatment, N-MCMs should address ongoing services and support for discharge, overdose prevention, and aftercare planning during and following substance use disorder treatment and medically-related hospitalizations. N-MCMs should ensure that appropriate harm- and risk-reduction information, methods and tools are used in their work with the PLWH. Information, methods and tools shall be based on the latest scientific research and best practices related to reducing sexual risk and HIV transmission risks. Methods and tools must include, but are not limited to, a variety of effective condoms and other safer sex tools as well as substance abuse risk-reduction tools, information, discussion and referral about Pre- Exposure Prophylactics (PrEP) for PLWH's sexual or drug using partners and overdose prevention. N-MCMs should make information and materials on overdose prevention available to appropriate PLWHs as a part of harm- and risk-reduction. Those PLWHs who choose to access primary medical care from a non-Ryan White source, including private physicians, may receive ongoing Non-Medical Case Management services from provider**.**
Service Unit Definition(s) **(TRG Only)**:	One unit of service is defined as 15 minutes of direct services or coordination of care on behalf of PLWH.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA Services*.
Client Eligibility:	PLWHs dealing with challenges of substance use/abuse and dependence. Resident of the Houston HSDA.
Agency Requirements **(TRG Only)**:	These services will comply with the TRG's published **Non-Medical Case Management Targeting Substance Use Disorder** Standards of Care and policies and procedures as published and/or revised, including linkage to the CPCDMS data system as well as DSHS Universal Standards and Non-Medical Case Management Standards of Care. **Non-Medical Case Management targeted SUD** must be planned and delivered in coordination with local HIV treatment/prevention/outreach programs to avoid duplication of services and be designed with quantified program reporting that will accommodate local effectiveness evaluation. Subrecipients must document established linkages with agencies that serve PLWH 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 primary care providers.
Staff Requirements:	Minimum Qualifications: **Non-Medical Case Management 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 services to PLWH 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 Non-Medical Case Management Workers must have a minimum of one (1) year work experience with PLWHA and/or substance use disorders. Supervision: The Non-Medical Case Management Worker must function within the clinical infrastructure of the applicant agency and receive ongoing supervision that meets or exceeds TRG's published **Non-Medical Case Management Targeting Substance Use Disorder** Standards of Care.
Special Requirements **(TRG Only)**:	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Universal Standards and non-Medical Case Management Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service. Contractor must be licensed in Texas to directly provide substance use treatment/counseling.

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 #2**	Date: **04/23/19**
Recommendations:	Financial Eligibility: No financial cap
1.	
2.	
3.	

NON-MEDICAL CM TARGETING SUD

Feedback from Providers and People Living With HIV (PLWH)

HISTORICAL OVERVIEW

- The case management positions have been funded for more than 20 years in the Houston/Galveston area.
- Three agencies were funded in the Houston area.
  - One “targeting” GLBT community.
  - One “targeting” mono-lingual/bilingual Spanish-speaking individuals.
  - One does not use funds for case management services.

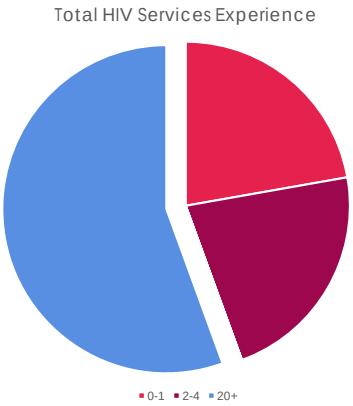
INTERVIEW PROCESS

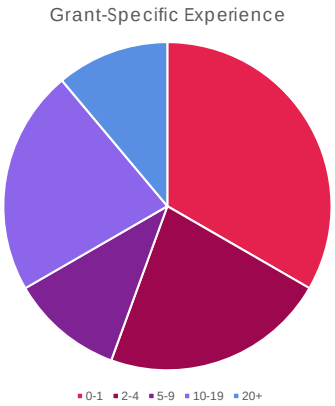
- TRG contacted the two Houston providers that were funded for case management services targeting substance use disorders.
- TRG conducted interviews with provider staff at both agencies.
  - 9 staff members interviewed including
    - Case managers (past and present),
    - Outreach workers,
    - Recovery coaches &
    - Supervisors.
- TRG conducted interviews with people living with HIV:
  - 4 people living with HIV interviewed.
  - Additional interviews are being scheduled.

PROVIDER INTERVIEWS

Conducted by Patrick L. Martin, Reachelian Ellison and Cynthia Aguries

EXPERIENCE OF PROVIDER STAFF



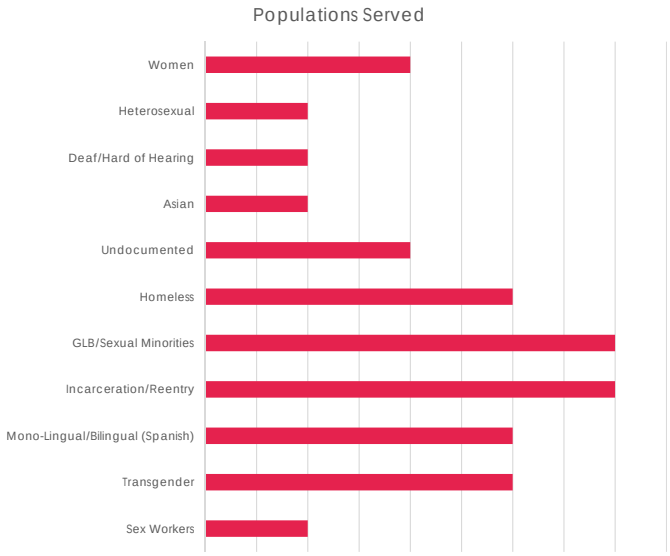


EXPERIENCE OF STAFF

- Trends:
  - None of the current case managers has specific licensure or certification.
  - Two of the case managers had more than twenty years experience serving people living with HIV.
  - The same case managers had 15-20 years serving PLWH who also have substance use disorders (SUD).
  - All case managers have access to clinical support from licensed staff.
  - Agency teams included:
    - Recovery coaches and/or
    - Licensed case managers.

SPECIAL POPULATIONS

- Not 'scientific" data. Instead the data is as reported by staff.
- Weighted by the number of case managers who identified the population.
- **Not based on the percentage of PLWH served/case management caseload**

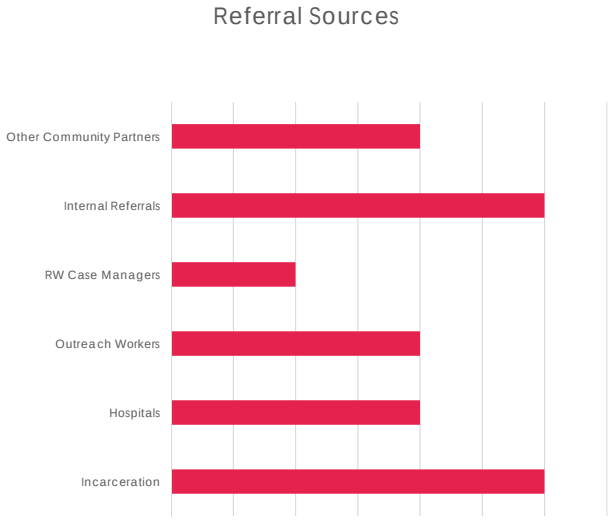


SPECIAL POPULATIONS

- Trends:
  - Incarcerated/Reentry, GLB(T)/Sexual Minorities, Monolingual/Bilingual (Spanish), and Homeless were all identified the most as populations being served.
- Interesting Discovery:
  - Though not a large percentage of the overall PLWH numbers served, every case manager interviewed stated that they had transgender PLWH on their caseload.
  - Though every case manager stated they have PLWH releasing from incarceration/history of incarceration on their caseload, one case manager works exclusively with individuals releasing from incarceration.

REFERRAL SOURCES

- Not 'scientific" data. Instead the data is as reported by staff.
- Weighted by the number of case managers who identified the referral source.

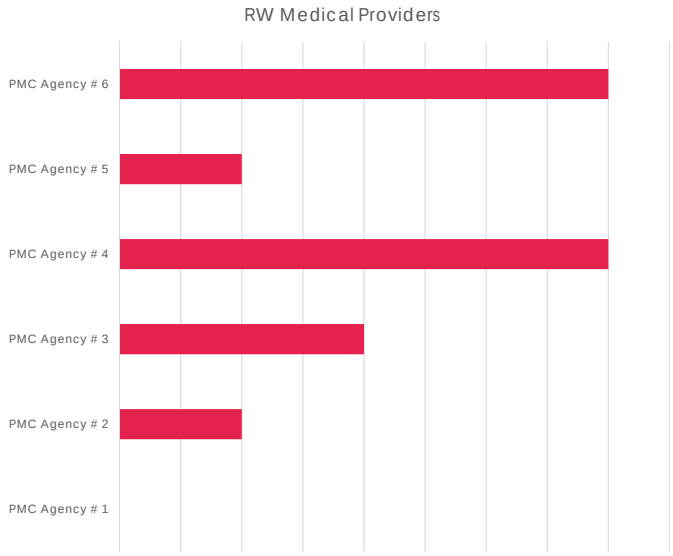


REFERRAL SOURCES

- Trends:
  - Largest number of referrals comes from correctional facilities and internal referrals.
- Interesting Discovery:
  - Referrals from Medical Providers to SUD Case Managers
    - PLWH with Substance Use Disorders
    - PLWH who needed more intense "interactions"

REFERRALS TO MEDICAL CARE

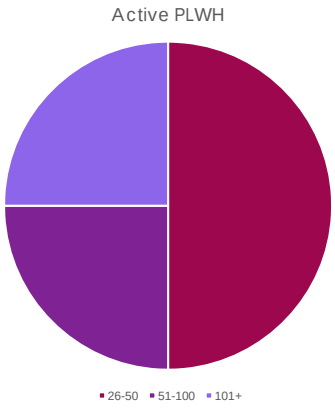
- All case managers reported referring PLWH into medical care as part of their service delivery.
- Not 'scientific" data. Instead the data is as reported by staff.
- Weighted by the number of case managers who identified the agencies.

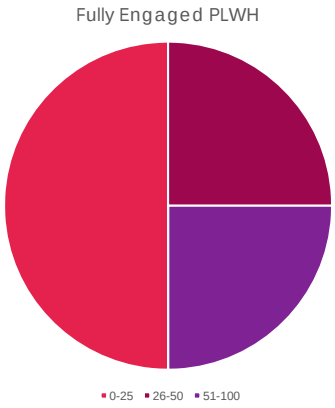


REFERRALS FROM MEDICAL CARE

- Trends:
  - Several RW Medical Providers have established relationships with these positions. This relationship included:
    - Interdisciplinary case review
      - Interaction with Medical Case Managers and Intake Workers
      - Monthly meeting to discuss cases

CASELOAD





CASELOAD

- Trends:
  - Caseload expressed into two ways.
    - Active: Interactions occurring but not fully-engaged in the program.
    - Full-Engaged: Interactions follow the traditional model of case management.
  - PLWH engaging multiple times with program as they were focused on sobriety.

KEY ACTIVITIES

- CMs expressed "hands on" approach that included the following activities:
  - Understanding the challenges of SUD
  - Coaching PLWH
  - Long-term support through changes in circumstances
  - Challenge of IDs
  - Transportation
  - Empowering PLWH in accessing systems:
    - Transgender
    - Undocumented
    - Recently Released
  - SUD Treatment
    - Knowing Treatment Resources and
    - Matching Program to PLWH

KEY ACTIVITIES

- CMs expressed "hands on" approach that included the following activities:
  - Community based interactions
  - Relapse Prevention
  - Eligibility Process:
    - Preparation for the process and
    - Navigation through the process
  - Application for THMP
  - Food/Hygiene
  - Accessing Other Resources:
    - Support Groups
    - Faith-Based
    - AA/NA/CA

PLWH INTERVIEWS

Conducted by Reachelian Ellison

PLWH INTERVIEWS

- *Important Note: PLWH are not forced to disclose any information. Some participants are more comfortable sharing details. Therefore, this details may not be consistent from participant to participant.*
- Participant #1: Newly diagnosed – while in jail.
- Participant #2: Diagnosed in 2004. Has accessed the program multiple times.
- Participant #3: History of homelessness.
- Participant #4: Currently homeless. Dealing with recent diagnosis of diabetes.

WHAT ARE YOUR GOALS?

- When asked "What do you want from this program?"
  - Stability and follow-up
  - Assistance is obtaining long-term goals
  - Motivation and empowerment
  - Learning a new skill
    - Administrative
    - Carpentry
    - Basic computer skills

PROGRAM PERFORMANCE

- When asked "How has this program helped you?"
  - "Talk" and encouragement
  - Food programs
  - Visits in jail
- When asked "What can be done to improve the program?"
  - More programs to help
    - Connections to reenter the workforce with a "bad background (list of places that will hire or train me)"
    - Vouchers for food, clothes and resources
    - A list of services/where I can get help with a "bad background (drug history or incarceration)"

MISSED APPOINTMENTS?

- When asked "Why Do You Miss Appointments?"
  - Lack of transportation
    - Bus fare
    - Gas
  - I forget/Short-term memory loss
    - Texts
    - Morning reminders
    - Day before reminders
  - Personal Issues
  - Depression
  - PTSD

QUESTIONS?

November 21, 2018

Dear Colleague:

As Assistant Secretary for Mental Health and Substance Use, I urge the public health and substance use treatment communities to focus on the synergistic epidemics of substance use disorder, human immunodeficiency virus (HIV) and viral hepatitis. To protect the health of our nation, we must leverage every available resource to prevent, detect, and treat these frequently co-occurring conditions. With effective implementation of evidence-based screening tools, preventive interventions, clinical treatments, and recovery supports we will improve health outcomes, prevent spread of infection, and reduce mortality in vulnerable populations.

Because drug use may weaken the immune system and lead to risky behaviors such as needle sharing and unsafe sex, people who use drugs – including injection drugs – have a greater likelihood of contracting HIV, hepatitis, and other infectious diseases.[1, 2] In June 2018, the CDC issued a Public Health Alert regarding more than 2,500 new hepatitis A (HAV) infections across multiple states.[3] Over two-thirds of these infections were among individuals who use illicit drugs or were homeless. Similarly, acute hepatitis C virus (HCV) infection increased 3.5-fold from 2010 through 2016. Researchers believe the increase in acute HCV cases reflects rising rates of injection-drug use.[4] Almost two-thirds of persons diagnosed with acute HCV infection in the U.S. are people who inject drugs (PWID). Even acute hepatitis B infections showed sharp increases between 2006 to 2013 in states greatly affected by the opioid epidemic (Kentucky, Tennessee, and West Virginia).[5]

If we thoughtfully address the HIV, hepatitis and substance use disorder epidemics, we may alleviate disease burden and excess mortality for all three conditions. For example, treatment of opioid use disorder with buprenorphine increases uptake of antiretroviral treatment for HIV infection. Once stabilized, patients are more likely to begin a course of treatment for HCV

[1] https://www.cdc.gov/hiv/group/hiv-idu.html
[2] Paintsil E, He H, Peters C, Lindenbach BD, Heimer R: Survival of hepatitis C virus in syringes: implication for transmission among injection drug users. J Infect Dis. 2010 202(7):984-90.
[3] https://emergency.cdc.gov/han/han00412.asp
[4] Zibbell JE, Asher AK, Patel RC, Kupronis B, et al. Increases in acute hepatitis C virus infection related to a growing opioid epidemic and associated injection drug use, United States, 2004 to 2014. Am J Public Health. 2018;108(2):175-181.
5 https://www.hhs.gov/hepatitis/learn-about-viral-hepatitis/data-and-trends/index.html

coinfection. Failure to treat individuals with opioid use disorder and HIV/HCV co-infection has serious consequences including end-stage liver disease, liver cancer, or related mortality.[6]

The risk of HIV and viral hepatitis transmission is lower when people who are infected know their status and receive education and treatment. The U.S. Preventive Services Task Force (USPSTF) recommends screening for HIV, HBV, and HCV for all adults at high risk, including PWID but, unfortunately, as many as 1 in 7 people with HIV and more than half of people with HBV and HCV are unaware of their status.[7,8,9] Since 2012, there have been more deaths due to hepatitis C than all 60 major infectious diseases combined.[10] And, in 2015, the rapid outbreak of HIV and HCV in Scott County, Indiana demonstrated how a lack of medical care capacity and substance use disorder (SUD) prevention and treatment resources can accelerate the devastating spread of disease.[11]

In most cases, private insurance and Medicare/Medicaid are required to cover preventative services with a grade A or B recommendation by the USPSTF. Thus, hepatitis A and B vaccination and HIV, HBV and HCV testing are available without a deductible or co-pay for most Americans.[12] Furthermore, Medicaid provides flexibility for states to improve care coordination and treatment for individuals living with SUD and those with HIV. SUD treatment providers without onsite rapid testing, vaccination, or prophylaxis prescribing, must form close partnerships with public health and/or primary care partners such as Federally Qualified Health Centers to which patients may be referred for these services to ensure receipt of necessary and ongoing care for health conditions including HIV and viral hepatitis.[13] In addition, peer navigators help increase access to care, treatment adherence, and viral suppression. Follow up and coordination with public health partners is essential.

SUD providers can help people with the epidemic conditions of substance use disorder, HIV, and viral hepatitis by focusing on the following goals:

1. **Reduce and eliminate alcohol and drug use**
2. **Provide evidence-based treatment for substance use disorders**
3. **Assist patients to get tested for HIV and viral hepatitis**
4. **Educate about prevention of substance use disorders and infectious diseases**
5. **Assure that those with substance use disorder(s) and/or infectious diseases get treatment**
6. **Provide post-exposure prophylaxis where clinically indicated**
7. **Encourage patients to practice safer sex every time**

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[6] https://www.drugabuse.gov/publications/drugfacts/drug-use-viral-infections-hiv-hepatitis

[7] https://www.cdc.gov/hiv/pdf/library/factsheets/cdc-hiv-care-continuum.pdf

[8] https://www.hhs.gov/hepatitis/learn-about-viral-hepatitis/data-and-trends/index.html

[9] https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/hepatitis-c-screening

[10] https://www.drugabuse.gov/publications/drugfacts/drug-use-viral-infections-hiv-hepatitis

[11] Peters PJ, Pontones P, Hoover KW, et al. HIV infection linked to injection use of oxymorphone in Indiana, 2014-2015. N Engl J Med. 2016;375(3):229-39.

[12] The White House. *National HIV/AIDS Strategy for the United States: Updated to 2020.*; 2015.

[13] Aletraris L, Roman PM. Provision of onsite HIV Services in Substance Use Disorder Treatment Programs: A Longitudinal Analysis. *J Subst Abuse Treat.* 2015;57:1-8. doi:10.1016/j.jsat.2015.04.005.

Along every step of the continuum, we each have a chance to reduce disease and improve health. Thank you for the work you do to save lives and improve the health of the American people.

Sincerely,

Elinore F. McCance-Katz, M.D., Ph.D.
Assistant Secretary for Mental Health
and Substance Use