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FY 2020 Houston EMA Ryan White Part A/MAI Service Definition Service Linkage at Testing Sites	
HRSA Service Category Title: <b>RWGA Only</b>	<b>Non-medical Case Management</b>
Local Service Category Title:	<p><b>A. Service Linkage targeted to Not-In-Care and Newly-Diagnosed PLWHA in the Houston EMA/HDSA</b></p> <p><b>Not-In-Care PLWHA</b> 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.</p> <p><b>Newly-Diagnosed PLWHA</b> 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.</p> <p><b>B. Youth targeted Service Linkage, Care and Prevention:</b> 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.</p> <p>*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.</p> <p>*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.</p>
Budget Type: <b>RWGA Only</b>	Fee-for-Service
Budget Requirements or Restrictions: <b>RWGA Only</b>	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: <b>RWGA Only</b>	<p><b>Case Management (non-Medical)</b> 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.</p> <p><b>Early intervention services (EIS)</b> 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.</p>
Local Service Category Definition:	<b>A. Service Linkage:</b> Providing allowable Ryan White Program outreach and service linkage activities to newly-diagnosed and/or <b>Not-In-Care</b> PLWHA who know their status but are not currently enrolled

	<p>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.</p> <p><b>B. Youth targeted Service Linkage, Care and Prevention:</b> 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.</p>
<p>Target Population (age, gender, geographic, race, ethnicity, etc.):</p>	<p><b>A. Service Linkage:</b> 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.</p> <p><b>Service Linkage</b> 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.</p> <p><b>B. Youth targeted Service Linkage, Care and Prevention:</b> Services will be available to eligible HIV-infected Youth (ages 13 – 24) residing</p>

	<p>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.</p> <p><i>Youth Targeted Service Linkage, Care and Prevention</i> 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.</p>
Services to be Provided:	<p><b>Goal (A): Service Linkage:</b> 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 <u>newly-diagnosed or not-in-care</u> PLWH/A per year.</p> <p>The purpose of <b>Service Linkage</b> is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. <b>Service Linkage</b> 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 <b>Service Linkage</b> is to assist clients who do not require the intensity of <i>Clinical or Medical Case Management</i>, as determined by RWGA Quality Management guidelines. <b>Service Linkage</b> is both <u>office- and field-based</u> and <b>may include the issuance of bus pass vouchers and gas cards per published guidelines</b>. 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.</p>

	<p>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, <u>may receive ongoing service linkage services from provider</u> or must be transferred to a Clinical (CCM) or Primary Care/Medical Case Management site per client need and the preference of the client.</p> <p><b>GOAL (B):</b> This effort will continue a program of <i>Service Linkage, Care and Prevention to Engage HIV Seropositive Youth</i> 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.</p>
Service Unit Definition(s): <b>RWGA Only</b>	One unit of service is defined as 15 minutes of direct client services and allowable charges.
Financial Eligibility:	Refer to the RWPC's approved <i>Financial Eligibility for Houston EMA/HSDA Services</i> .
Client Eligibility:	Not-In-Care and/or newly-diagnosed HIV-infected individuals residing in the Houston EMA.
Agency Requirements:	<p><b>Service Linkage</b> services will comply with the HCPHS/RWGA published <b>Service Linkage</b> Standards of Care and policies and procedures as published and/or revised, including linkage to the CPCDMS data system.</p> <p><u>Agency must comply with all applicable City of Houston DHHS ECLIPS and RWGA/HCPHS CPCDMS business rules and policies &amp; procedures.</u></p> <p><b>Service Linkage</b> 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.</p>

<p>Staff Requirements:</p>	<p>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.</p> <p><i>Must comply with applicable HCPHS/RWGA published Ryan White Part A/B Standards of Care:</i></p> <p><u>Minimum Qualifications:</u>  <b>Service Linkage Workers</b> 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.</p> <p><u>Supervision:</u>  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.</p>
<p>Special Requirements:  <b>RWGA Only</b></p>	<p>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.</p> <p>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.</p>

***FY 2021 RWPC “How to Best Meet the Need” Decision Process***

<b>Step in Process: Council</b>		Date: <b>06/11/2020</b>
Recommendations:	Approved: Y: _____ No: _____ Approved With Changes: _____	If approved with changes list changes below:
1.		
2.		
3.		
<b>Step in Process: Steering Committee</b>		Date: <b>06/04/2020</b>
Recommendations:	Approved: Y: _____ No: _____ Approved With Changes: _____	If approved with changes list changes below:
1.		
2.		
3.		
<b>Step in Process: Quality Improvement Committee</b>		Date: <b>05/19/2020</b>
Recommendations:	Approved: Y: _____ No: _____ Approved With Changes: _____	If approved with changes list changes below:
1.		
2.		
3.		
<b>Step in Process: HTBMTN Workgroup #1</b>		Date: <b>04/21/2020</b>
Recommendations:	Financial Eligibility:	
1.		
2.		
3.		

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**FY 2018 PERFORMANCE MEASURES HIGHLIGHTS  
RYAN WHITE GRANT ADMINISTRATION  
HARRIS COUNTY PUBLIC HEALTH (HCPH)**

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*HCPH is the local public health agency for the Harris County, Texas jurisdiction. It provides a wide variety of public health activities and services aimed at improving the health and well-being of the Harris County community.*

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## **Highlights from FY 2018 Performance Measures**

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Measures in this report are based on the 2018/2019 Houston Ryan White Quality Management Plan, Appendix B. HIV Performance Measures.

### **Service Linkage (Non-Medical Case Management)**

- During FY 2018, 7,646 clients utilized Part A non-medical case management / service linkage. According to CPCDMS, 3,548 (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, 49% of clients utilized primary medical care for the first time after accessing service linkage for the first time.
- The median number of days between the first service linkage visit and the first primary medical care visit was 14 days during this time period.

Ryan White Part A  
HIV Performance Measures  
FY 2018 Report

**Service Linkage / Non-Medical Case Management**  
All Providers

For FY 2018 (3/1/2018 to 2/28/2019), 7,646 clients utilized Part A non-medical case management.

<b>HIV Performance Measures</b>	<b>FY 2017</b>	<b>FY 2018</b>	<b>Change</b>
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)	3,259 (46.0%)	3,548 (46.4%)	<b>0.4%</b>
60% of clients will access RW primary medical care for the first time after accessing service linkage for the first time	372 (44.4%)	459 (48.9%)	<b>4.5%</b>
Mean of less than 30 days between first ever service linkage visit and first ever primary medical care visit:			
Mean	40	27	<b>-32.5%</b>
Median	19	14	<b>-26.3%</b>
Mode	1	1	<b>0.0%</b>
60% of newly enrolled clients will have a medical visit in each of the four-month periods of the measurement year	119 (43.1%)	133 (47.7%)	<b>4.6%</b>



Harris County  
**Public Health**  
Building a Healthy Community

**Ryan White Part A  
Quality Management Program- Houston EMA  
Case Management Chart Review FY 18  
Ryan White Grant Administration  
CUMMULATIVE SUMMARY, DE-IDENTIFIED**

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## Overview

Each year, the Ryan White Grant Administration Quality Management team conducts chart review in order to continuously monitor case management services and understand how each agency implements workflows to meet quality standards for their funded service models. This process is a supplemental complement to the programmatic and fiscal audit of each program, as it helps to provide an overall picture of quality of care and monitor quality performance measures.

A total of 609 medical case management client records were reviewed across seven of the ten Ryan White-Part A funded agencies, including a non-primary care site that provides Clinical Case Management services. The dates of service under review were March 1, 2018- February 28, 2019. The chart review was conducted by the Project Coordinator for Quality Management Development, a Licensed Master Social Worker on the Ryan White Grant Administration team. The sample selection process and data collection tool are described in subsequent sections.

Case Management is defined by the Ryan White legislation as a, “range of client-centered services that link clients with health care, psychosocial, and other services,” including coordination and follow-up of medical treatment and “adherence counseling to ensure readiness for and adherence to HIV complex treatments.” Case Managers assist clients in navigating the complex health care system to ensure coordination of care for the unique needs of People Living With HIV. Continuous assessment of need and the development of individualized service plans are key components of case management. Due to their training and skill sets in social services, human development, psychology, social justice, and communication, Case Managers are uniquely positioned to serve clients who face environmental and life issues that can jeopardize their success in HIV treatment, namely, mental health and substance abuse, poverty and access to stable housing and transportation, and poor social support networks.

Ryan White Part-A funds three distinct models of case management: Medical Case Management, Non-Medical Case Management (or Service Linkage Work), and Clinical Case Management, which must be co-located in an agency that offers Mental Health treatment/counseling and/or Substance Abuse treatment. Some agencies are also funded for Outreach Services, which complement Case Management Services and are designed to locate and assist clients who are on the cusp of falling out of care in order to re-engage and retain them back into care.

While traditional, community-based case management models tend to provide intensive, individualized assistance to a limited and defined number of clients on a social worker’s “case load,” case management in this time and place resembles more of a “revolving door” model. This evolution is not unique to the Ryan White system of care. The National Association of Social Workers has identified this transformation of case management in the health care setting as a growing challenge for medical social workers<sup>1</sup>. Social workers have become sought out by health care institutions in order to add professionals to their practice who specialize in holistic, person-centered approaches. However, as the health care system itself changes, the role of a medical case managers has adapted to include the more administrative tasks that are necessary for managed care facilitates and reimbursement models to function.

In practical terms, this means that case managers are now more often performing tasks that registered nurses, benefits specialists, and medical assistants are equally skilled to perform, such as scheduling and reminders, basic health education, and insurance or coverage navigation. While it is clear that these are invaluable functions in the HIV treatment setting, it is a distinct shift away from the type of psychosocial work that social workers are trained to do, such as supportive counseling, task-centered motivational change, service planning and intensive follow-up, and accompaniment through the social services system. Unfortunately, as the HIV epidemic shifts to disproportionately impact low-income, marginalized communities with lower social capital and higher incidence of mental health concerns, this the exact type of professional help that is sorely underutilized in HIV care.

<sup>1</sup> National Association of Social Workers. (2016). *NASW Standards for Social Work Practice in Health Care Settings*.

While this description is certainly not true of all agencies or client records reviewed, the data presented in this year's chart review paints an overall picture of a case management system that is characterized by in-the-moment, on-demand requests, rather than ongoing contact at regular intervals. More than half of the clients in the sample (56%) had 3 or less interactions from a case manager within the review year and less than 11% of the medical case management clients received two "care plans" within the year. These findings are consistent with last year's review, in which the previous chart abstractor noted that, "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."

At the individual agency level, there are many noteworthy and innovative practices that were highlighted throughout the chart review process and quality management site interviews. For example, a lead case manager at one agency regularly conducts chart review on the next day's patients in order to brief and essentially "pre-round" with the medical provider on their patient list. Another agency engages clients in their own assessments by having the patient self-administer the form so that it may be used as a conversation starter and way to build rapport, rather than a "cold interview" technique. Yet another agency has adapted their physical clinic layout to utilize a "pod" model in which at least one medical case manager and one service linkage worker is assigned to a provider, which functionally and closely resembles a case load model. One agency has an entirely separate benefits department that handles eligibility and enrollment for coverage programs, freeing up that responsibility from the case management team. All of these practices highlight opportunities and strengths within our Ryan White system for case management to continue as a value-added service for People Living with HIV.

## The Tool

A copy of the Case Management Chart Review tool is available in the Appendix of this report.

The Case Management Chart Review tool is a pen and paper form designed to standardize data collection and analysis across agencies. The purpose of the tool is to capture information and quantify services that can present an overall picture of the quality of case management services provided within the Ryan White Part-A system of care. This way, strengths and areas of improvement can be identified and continuously monitored.

This tool has been developed with input from case management providers and previous chart abstractors and continues to be refined to prompt a more detailed chart review process. Since the tool and sample collection method continue to be revised each year, a retrospective comparison is not offered in this report, though previous reports are available upon request.

The coversheet of the chart abstraction tool captures basic information about the client, including their demographics, most recent appointments and lab results, and any documented psychological, medical, or social issues or conditions that would be documented in their medical record.

The content of the second sheet focuses on coordination of case management services. There is space for the chart abstractor to record what type of worker assisted the client (Medical Case Manager, Service Linkage Worker, Outreach Worker or Clinical Case Manager) and what types of services were provided. Any notes about case management closure are recorded, as well as any assessments or service plans or documented reasons for the absence of assessments or service plans.

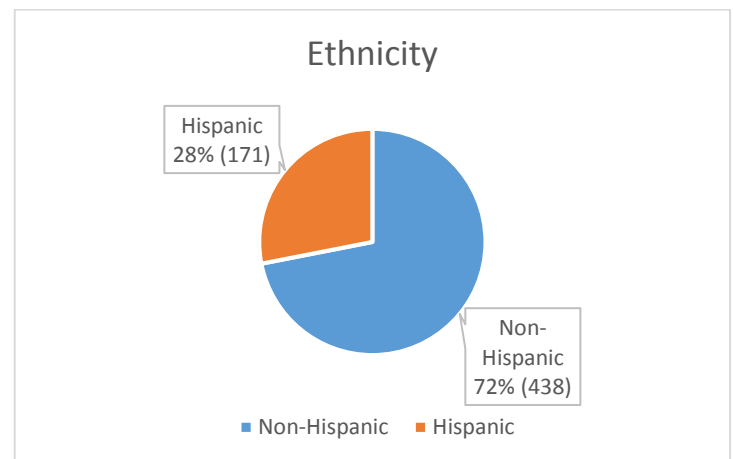
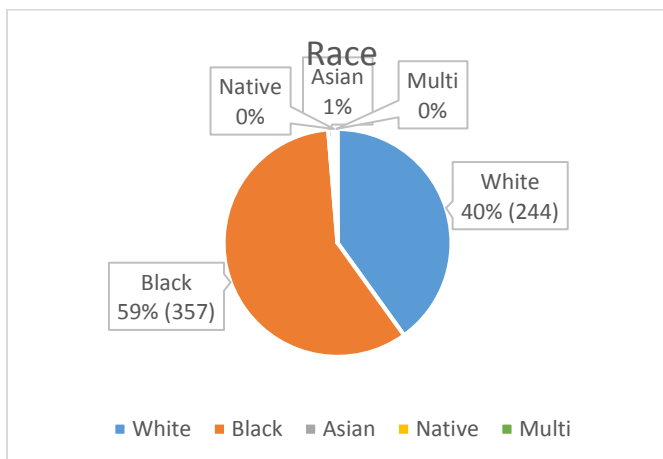
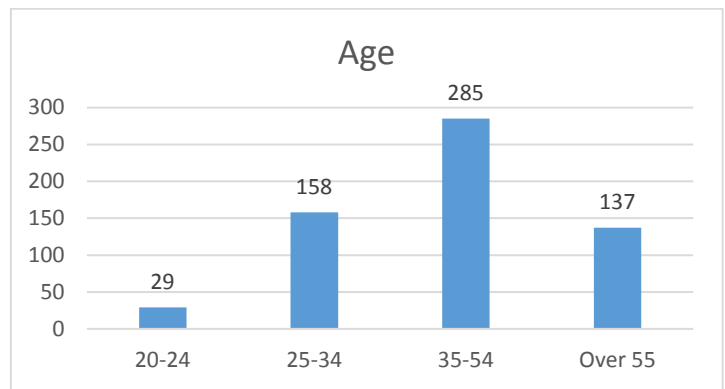
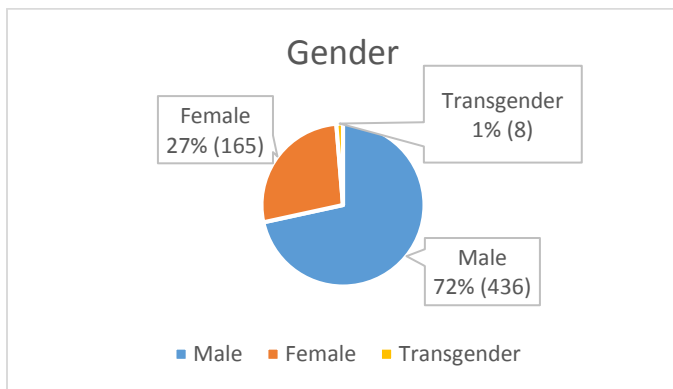
The chart abstraction tool was also reviewed by the Ryan White Grant Administration Quality Management team, the supervisors of the case management staff at each agency, and a Clinical Quality Improvement committee convened by Ryan White Grant Administration.

# The Sample

In order to conduct a thorough and comprehensive review, a total of 609 client records were reviewed across seven agencies for the 2018-2019 grant year. This included sixty (60) Clinical Case Management charts at a non-primary care site. In this Case Management Chart Review Report, any section that evaluated a primary care related measure excludes the sample of the non-primary care site. Minimum sample size was determined in accordance with *Center for Quality Improvement & Innovation* sample size calculator<sup>2</sup> based on the total eligible population that received case management services at each site.

Agency	A	B	C	D	E	F	G
# of Charts Reviewed	67	105	97	70	105	105	60
<b>TOTAL</b>	609 (549 excluding non-PCare site)						

For each agency, a randomized sample of clients who received a billable Ryan White- A service under at least one (1) of eleven (11) case management subcategory codes during the March 1, 2018- February 28, 2019 grant year was queried from the Centralized Patient Care Data Management System data base. The total eligible population from which the sample was drawn was a pool of 11,159 case management clients. The number of clients selected at each site is proportional to the number of case management clients served there. Each sample was determined to be comparable to the racial, ethnic, age, and gender demographics of each site’s overall case management patient population.



<sup>2</sup> New York Department of Health AIDS Institute. (2006). *HIVQUAL Workbook: Guide for quality improvement in HIV care*. NY: U.S. Department of Health and Human Services Health Resources and Services Administration HIV/AIDS Bureau.



Health insurance coverage type was also analyzed according to the client's registration. More than half of the sample (55%) was uninsured; 24% was enrolled in either Medicaid, Medicare, or some combination; 7% had a private or commercial plan; and an additional 14% had an unknown insurance coverage status.

## Cumulative Data Summaries

### APPOINTMENTS & ENCOUNTERS

The number of HIV-related primary care appointments and case management encounters in the given year were counted for each client.

### HIV-RELATED PRIMARY CARE APPOINTMENTS

For this measure, the number of face-to-face encounters for an HIV-related primary care appointment with a medical provider was counted. Any number of appointments above three per year was simply coded as 3 appointments. Any Viral Load/CD4 count lab test that accompanied the appointment was also recorded, which is shared on page 9.

# of appointments	A	B	C	D	E	F	TOTAL
0 appts.	6 (9%)	14 (13%)	15 (15%)	1 (1%)	11 (10%)	7 (7%)	54 (10%)
1 appts.	12 (18%)	13 (12%)	20 (21%)	12 (17%)	26 (25%)	24 (23%)	107 (19%)
2 appt.	23 (34%)	17 (16%)	21 (22%)	37 (53%)	44 (42%)	34 (32%)	176 (32%)
3 + appts.	26 (39%)	61 (58%)	41 (42%)	20 (29%)	24 (23%)	40 (38%)	212 (39%)
<b>TOTALS</b>	67 (100%)	105 (100%)	97 (100%)	70 (100%)	105 (100%)	105 (100%)	549 (100%)

The overall sample trends towards a higher number of primary care appointment in the year, with the majority of the case management review clients having at least 3 appointments in the year (39%), followed by 32% of the clients having 2 appointments in the year, 19% having 1 appointment, and 10% of the sample having had 0 appointments.

## CASE MANAGEMENT ENCOUNTERS

Frequency of case management encounters were also reviewed. The dates and types of the encounters (face-to-face vs. phone), as well as who provided the service (Clinical, Medical, Non-Medical Case Manager or Outreach Worker) and a general description of what was discussed during the encounter were also recorded.

The distribution of frequency of case management encounters could be described as an inverted bell curve, with most of the clients clustering either at the low end of one encounter (29%) within the year or more than 5 encounters (30%).

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*“Overall, the average number of case management encounters for the entire sample was five (5).”*

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# of CM encounters	A	B	C	D	E	F	G	TOTAL
1	1 (2%)	23 (21%)	20 (21%)	29 (41%)	53 (50%)	33 (31%)	15 (25%)	174 (29%)
2	2 (3%)	22 (21%)	10 (10%)	17 (24%)	22 (21%)	21 (20%)	3 (5%)	97 (16%)
3	3 (4%)	15 (14%)	13 (13%)	8 (11%)	8 (8%)	16 (15%)	4 (7%)	67 (11%)
4	3 (4%)	14 (13%)	13 (13%)	5 (7%)	5 (5%)	7 (7%)	1 (2%)	48 (8%)
5	3 (4%)	9 (9%)	9 (9%)	7 (10%)	7 (7%)	3 (3%)	4 (7%)	42 (7%)
Over 5	55 (82%)	22 (21%)	32 (33%)	4 (6%)	10 (10%)	25 (24%)	33 (55%)	181 (30%)
<b>TOTALS</b>	67 (100%)	105 (100%)	97 (100%)	70 (100%)	105 (100%)	105 (100%)	60 (100%)	609 (100%)
Range	1-51	1-15	1-17	1-6	1-24	1-25	1-82	1-82
Average	11.8	3.75	5	2.4	2.8	4	11	5

29% of the clients in the sample had just one case management encounter within the review year while another 30% had more than five, with the highest amount of encounters for one client being 82 within the grant year. Overall, the average number of encounters for the entire sample was five case management encounters. Neither race nor gender had a significant impact on the average number of encounters. The average number of encounters for clients who had contact with a Medical Case Manager was double that of those who did not have contact with a Medical Case Manager throughout the year, at six and three encounters, respectively. The agency with the highest average frequency of case management encounters averaged nearly one encounter per month, at 11.8.

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*The average number of encounters for clients who had contact with a Medical Case Manager was six, while the average for those who did not work with an MCM was three.*

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## VIRAL SUPPRESSION

Any results of HIV Viral Load + CD4 count laboratory tests that accompanied HIV-related primary care appointments were recorded as part of the case management chart abstraction. Up to three laboratory tests could be recorded. Lab results with an HIV viral load result of less than 200 copies per milliliter were considered to be virally suppressed.

Upon coding, clients who were suppressed for all of their recorded labs (whether they had one, two, or three tests done within the year), were coded as “Suppressed.” Clients who were unsuppressed (>200 copies/mL) for all of their labs were coded as “Unsuppressed.” Clients who had more than one laboratory test done and were suppressed for at least one and unsuppressed for at least one were coded as “Mixed Status,” and clients who had no laboratory tests done within the entire year were coded as “Unknown.”

Therefore, it is important to note that the “VL Suppression Rate” is presented in two different ways in the chart below. The top rate, in blue, is the more conservative analysis of the percentage of clients who were coded as “Suppressed.” In other words, it is the percentage of clients within the sample who were suppressed for *all* of their recorded labs during the year, which could be loosely interpreted as “durably suppressed.” The second VL Suppression Rate offered in red is the more standardly used HRSA HAB Performance Measure<sup>3</sup> of having the *most recent* laboratory result on file under 200 copies/mL.

VL Status	A	B	C	D	E	F	TOTAL
VL Suppression Rate	69%	55%	55%	66%	59%	64%	60%
	73%	59%	60%	67%	60%	64%	63%
Suppressed	46 (69%)	58 (55%)	53 (55%)	46 (66%)	62 (59%)	67 (64%)	332 (60%)
Mixed Status	8 (12%)	17 (16%)	12 (12%)	11 (16%)	9 (9%)	11 (10%)	68 (12%)
Unknown	5 (7%)	17 (16%)	19 (20%)	2 (3%)	15 (14%)	7 (7%)	65 (12%)
Unsuppressed	8 (12%)	13 (12%)	13 (13%)	11 (16%)	19 (18%)	20 (19%)	84 (15%)
NO INTERVENTION	6 (9%)	16 (15%)	10 (10%)	1 (1%)	11 (10%)	4 (4%)	48 (9%)
<b>TOTALS</b>	67 (100%)	105 (100%)	97 (100%)	70 (100%)	105 (100%)	105 (100%)	549 (100%)

Across all primary care sites, the case management clients reviewed for these samples had a viral load suppression rate between 60–63%, depending on which estimate is used. In contrast, this result is much lower than what is typical for the Ryan White Part A Houston Primary Care Chart review, which has hovered around 85% for the past several years. This difference may be due to a number of factors, most likely of which is the difference in characteristics of the two reviews’ samples. The Primary Care chart review sample is collected from a pool of clients who are considered *in care*, or have at least two medical appointments with a provider with prescribing privileges in the review year. Additionally, “fluctuating viral load” is one of the eligibility criteria for medical case management, so clients who have challenges maintaining a suppressed viral load are more likely to be seen by case management and be included in this sample.

Of particular interest in this review was the role of case management staff when a client received an unsuppressed laboratory result. For clients who were coded as “Unsuppressed,” “Mixed Status,” or “Unknown,” the overall narrative of the client record was also reviewed to understand whether intervention from case management would have been appropriate and whether a CM staff did intervene to better coordinate care, encourage retention, or provide education on medication adherence. Overall, less than 10% of the sample (9%) was unsuppressed at some point during the review year *and* did not receive case management intervention when it would have been appropriate.

<sup>3</sup> Health Resources and Services Administration HIV/AIDS Bureau. (2019, December). Performance Measure Portfolio. Retrieved from <https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio>

## CARE STATUS

The chart abstractor also documented any circumstances in the record for which a client was new, lost, returning to care, or some combination of those care statuses. A client was considered “New to Care,” if they were receiving services for the first time at that particular agency (so not necessarily new to HIV treatment or the Houston Ryan White system of care). “Lost to Care” was defined as not being seen for an HIV-related primary care appointment within the last six months and not having a future appointment scheduled, even beyond the review year. “Re-engaged in Care” was defined as any client who was previously lost to care, either during or before the review year, and later attended an HIV-related primary care appointment.

Care Status	A	B	C	D	E	F	TOTAL
New to Care	6 (9%)	23 (22%)	5 (5%)	13 (19%)	6 (6%)	3 (3%)	56 (10%)
Lost to Care	6 (9%)	11 (10.5%)	12 (12%)	3 (4%)	9 (9%)	9 (9%)	50 (9%)
Re-engaged in Care	3 (4.5%)	6 (6%)	12 (12%)	2 (3%)	15 (14%)	14 (13%)	52 (10%)
New + Later Lost	3 (4.5%)	4 (4%)	0 (0%)	1 (1%)	0 (0%)	0 (0%)	8 (1%)
Re-engaged + Lost	0 (0%)	9 (8.5%)	5 (5%)	1 (1%)	2 (2%)	1 (1%)	18 (3%)
Coordination of Care	94% (17 of 18)	70% (37 of 53)	65% (22 of 34)	85% (17 of 20)	94% (30 of 32)	78% (21 of 27)	78% (144 of 184)
N/A	49 (73%)	52 (49%)	63 (65%)	50 (71%)	73 (69%)	78 (74%)	365 (67%)
<b>TOTALS</b>	<b>67</b>	<b>105</b>	<b>97</b>	<b>70</b>	<b>105</b>	<b>105</b>	<b>549</b>

Overall, 10% of the sample was considered New to Care, 9% was Lost to Care, and 10% was Re-engaged in Care. An additional 1% initiated services and were later lost, and 3% returned to care and were then later lost to care again within the same year. Notably, two agencies had a higher than average percentage of New to Care clients within their sample, with 22% of Agency B clients and 19% Agency D clients being new.

When a client’s attendance met one of the above care statuses, their medical record was reviewed to understand if case management or other staff was involved in coordinating their care. Activities that counted as “Coordination of Care” were any actions that welcomed the client into or back into care or attempted to retain them in care, such as: reminder phone calls, follow-up calls, attendance or introduction at the first appointment, or home visits. For agencies funded for Outreach Services, several progress notes appeared for clients who were lost or re-engaged in care. In the future, a more focused chart review sample of Outreach services may help to shed light on the benefits of this service category.

Every agency reviewed had policies and procedures in place for retention in care, as evidenced by both materials submitted as part of the Quality Management site visit and the percentage of New, Lost, and Re-engaged clients who received some type of retention in care service or service attempt. 78% of the clients within the sample who would have been subject to Coordination of Care services were contacted or assisted by staff in an effort to retain them in care. Some agencies had remarkably high Coordination of Care rates, at 94%.

## COMORBIDITIES

In an effort to understand and document common comorbidities within the Houston Ryan White system of care, co-occurring conditions were recorded, including mental health and substance abuse issues, other medical conditions, and social conditions. This inventorying of co-morbidities may prove particularly helpful for selecting future training topics for case management staff.

### MENTAL HEALTH & SUBSTANCE ABUSE (history or active)

Any diagnosis of a mental health disorder (MH) or substance abuse issue (SA) was recorded in the chart review tool, including a history of mental illness or substance abuse. All Electronic Medical Records include some variation of a “Problem List” template. This list was often a good source of information for MH and SA diagnoses, but providers sometimes also documented diagnoses or known histories of illness within progress notes without updating the Problem List. Clients sometimes also self-reported that they had been diagnosed with one of the below conditions by a previous medical provider. Any indication of the presence of mental illness or substance abuse, regardless of where the information was housed within the medical record, was recorded on the chart abstraction tool. Clients could also have or have had more than one of the MH or SA issues. Any conditions other than alcohol abuse, other substance abuse, depression, bipolar disorder, anxiety, or schizophrenia were recorded as “Other.” The most common types of conditions that became coded as “Other” were Post-Traumatic Stress Disorder and Adjustment Disorder.

	A	B	C	D	E	F	G	TOTAL
<b>% of sample w/ MH or SA issue</b>	<b>51%</b>	<b>45%</b>	<b>49%</b>	<b>39%</b>	<b>53%</b>	<b>61%</b>	<b>80%</b>	53% (323 of 609)
<b>Alcohol abuse/dependence</b>	9 (13%)	8 (8%)	7 (7%)	1 (1%)	4 (4%)	9 (9%)	6 (10%)	44 (7%)
<b>Other Substance Abuse/Dependence</b>	7 (10%)	15 (14%)	19 (20%)	11 (16%)	38 (36%)	27 (26%)	13 (22%)	130 (21%)
<b>Depression</b>	15 (22%)	34 (32%)	24 (25%)	9 (13%)	22 (21%)	41 (39%)	12 (20%)	157 (26%)
<b>Bipolar Disorder</b>	6 (9%)	10 (10%)	7 (7%)	6 (9%)	6 (6%)	5 (5%)	9 (15%)	49 (8%)
<b>Anxiety</b>	13 (19%)	11 (10%)	17 (18%)	5 (7%)	5 (5%)	15 (14%)	6 (10%)	72 (12%)
<b>Schizophrenia</b>	3 (4%)	2 (2%)	1 (1%)	0 (0%)	7 (7%)	1 (1%)	2 (3%)	16 (3%)
<b>Other</b>	12 (18%)	16 (15%)	27 (28%)	6 (9%)	9 (9%)	16 (15%)	32 (53%)	118 (19%)
<b>TOTALS</b>	<b>67</b>	<b>105</b>	<b>97</b>	<b>70</b>	<b>105</b>	<b>105</b>	<b>60</b>	<b>609</b>

Overall, 53% of the sample had either an active diagnosis or history of a mental health or substance abuse issue documented somewhere within their medical record. This is inclusive of the Clinical Case Management site, for which diagnosis with or clinical indication of a MH or SA issue is an eligibility criteria.

## MENTAL HEALTH & SUBSTANCE ABUSE REFERRALS

For clients with an *active* diagnosis of a mental health or substance abuse issue, the chart abstractor recorded if they were referred or already engaged in MH/SA services. This measure was *not* inclusive of clients who had a previous history of symptoms or whose recovery treatment was considered long complete. Because of this, the percentage in the top row of the previous chart and the percentage of clients considered “N/A” for a MH/SA referral do not equal 100%.

Received MH Referral?	A	B	C	D	E	F	G	TOTAL
N/A	39 (58%)	64 (61%)	54 (56%)	46 (66%)	68 (65%)	50 (48%)	7 (12%)	328 (54%)
Yes	25 (37%)	28 (27%)	38 (39%)	24 (34%)	35 (33%)	52 (50%)	53 (88%)	255 (42%)
No	3 (5%)	13 (12%)	5 (5%)	0 (0%)	2 (2%)	3 (3%)	0 (0%)	26 (4%)
<b>TOTALS</b>	67 (100%)	105 (100%)	97 (100%)	70 (100%)	105 (100%)	105 (100%)	60 (100%)	609 (100%)

Overall, 54% of the sample would not have been appropriate for a MH or SA referral based on the information available in their medical record. An additional 42% either did receive a referral or were already engaged in treatment and 4% did not receive a referral. This means that 91% of the sample (or 255 out of 281 individuals) who should have received a referral did receive one, according to their medical chart.

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*91% of the sample with active MH or SA symptoms was either referred for further counseling or treatment or already engaged in services.*

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## MEDICAL CONDITIONS

Medical conditions other than HIV were also recorded in an effort to understand what co-occurring conditions may be considered commonly managed alongside HIV within the case management population. Sexually Transmitted Infections and Hypertension were common, at 31% and 23% prevalence within the sample, respectively. Insomnia was the most common co-occurring condition that was coded in the “Other” category.

	A	B	C	D	E	F	TOTAL
<b>Opportunistic Infection</b>	2 (3%)	2 (2%)	2 (2%)	1 (1%)	4 (4%)	3 (3%)	14 (3%)
<b>STI</b>	11 (16%)	38 (36%)	37 (38%)	28 (40%)	23 (22%)	32 (30%)	169 (31%)
<b>Diabetes</b>	11 (16%)	12 (11%)	4 (4%)	4 (6%)	20 (19%)	8 (8%)	59 (11%)
<b>Cancer</b>	0 (0%)	0 (0%)	0 (0%)	0 (0%)	4 (4%)	1 (1%)	5 (1%)
<b>Hepatitis</b>	4 (6%)	24 (23%)	6 (6%)	4 (6%)	17 (16%)	7 (7%)	62 (11%)
<b>Hypertension</b>	12 (18%)	18 (17%)	25 (26%)	13 (19%)	28 (27%)	29 (28%)	125 (23%)
<b>Other</b>	14 (21%)	15 (14%)	15 (15%)	18 (26%)	21 (20%)	6 (6%)	89 (16%)
<b>TOTALS</b>	67	105	97	70	105	105	549



## SOCIAL CONDITIONS

Any indication within the medical record that a client had experienced homelessness/housing-related issues, pregnancy/pregnancy-related issues, a release from jail or prison, or intimate partner violence at any point within the review year was recorded in the chart abstraction tool. Homelessness and housing issues were the most commonly identified “Social Condition” within the sample. 4% of the sample reported experiencing some other type of social issue, the most common of which being a disclosed history of childhood sexual abuse.

	A	B	C	D	E	F	G	TOTAL
Homelessness or housing-related issues	4 (6%)	11 (10%)	9 (9%)	11 (16%)	8 (8%)	11 (10%)	6 (10%)	60 (10%)
Pregnancy or pregnancy-related issues	2 (3%)	0 (0%)	1 (1%)	0 (0%)	1 (1%)	0 (0%)	0 (0%)	4 (1%)
Recently released	0 (0%)	5 (5%)	2 (2%)	5 (7%)	5 (5%)	6 (6%)	5 (8%)	28 (5%)
Intimate Partner Violence	3 (4%)	2 (2%)	0 (0%)	2 (3%)	2 (2%)	3 (3%)	2 (3%)	14 (2%)
Other	3 (4%)	2 (2%)	3 (3%)	3 (4%)	5 (5%)	7 (7%)	2 (3%)	25 (4%)
<b>TOTALS</b>	<b>67</b>	<b>105</b>	<b>97</b>	<b>70</b>	<b>105</b>	<b>105</b>	<b>60</b>	<b>609</b>

## CASE MANAGEMENT ROLE DELEGATION

One area of interest for the Ryan White Grant Administration Quality Management team is to quantify and better help address the workflow and role delegation of medical case management and non-medical case management staff within the Ryan White system of care. According to the service category definitions and funding structure, care should be taken to ensure that clients are assigned to work with case management staff according to their level of need.

Individuals who have higher, more intensive levels of need that interfere with their ability to stay successful in HIV treatment should be assigned to work with a licensed social worker for medical case management services. Individuals who have lower, more intermittent need that could be assisted through straight forward referral and follow-up (versus ongoing management) are more appropriate for non-medical case management services by Service Linkage Workers. Client needs and acuity levels should be assessed at intake and monitored throughout regular periods in the year to continuously evaluate what services and staff would be the best “fit” for a client’s individual needs. In this way, resources can be appropriately allocated within the system of care and clients can be assigned to work with someone who can best meet their needs.

For these reasons, the chart abstractor documented what type of case manager each client worked with (a Medical Case Manager or Service Linkage Worker) and whether that client met the specified eligibility criteria for medical case management. It was also not uncommon for clients to work with both a Medical Case Manager *and* Service Linkage Worker within the same year, either because their level of need changed or to ensure that a client’s issues were addressed in a timely manner, regardless of whether the most appropriate staff member was available in the clinic.

	A	B	C	D	E	F	TOTAL
<b>Worked with MCM</b>	51 (76%)	67 (64%)	70 (72%)	34 (49%)	16 (15%)	47 (45%)	285 (52%)
<i>Met criteria for MCM</i>	37 (73%)	34 (51%)	68 (97%)	30 (88%)	16 (100%)	44 (94%)	229 (80%)
<b>Worked primarily with SLW</b>	17 (25%)	48 (46%)	62 (64%)	40 (57%)	96 (91%)	59 (56%)	322 (59%)
<i>Met criteria for MCM</i>	3 (18%)	11 (23%)	8 (13%)	7 (18%)	16 (18%)	11 (19%)	56 (17%)
<b>TOTALS</b>	67	105	97	70	105	105	549

52% of the sample worked with a Medical Case Manager (licensed social worker) at any point within the review year and 80% of those clearly met the eligibility criteria for medical case management. An additional 7% of the sample was marked as “unknown” for whether they met the medical case management eligibility criteria, as a way for the chart abstractor to acknowledge that there may be more detail to the client’s case than the information available in the medical record.

59% of the sample *primarily* worked with a Service Linkage Worker (SLW) within the review year, meaning that they either only worked with an SLW, or all of their interactions except for one were with an SLW. Of those, 17% had some information available in their medical record indicating that they technically met the criteria for medical case management and may have been considered more appropriate to work with a licensed social worker.

## COMPREHENSIVE ASSESSMENTS

A cornerstone of service provision within case management is the opportunity for the client to be formally assessed at touchpoints throughout the year for their needs, treatment goals, and action steps for how they will work with the case manager or care team to achieve their treatment goals. Agencies need to use an approved assessment tool and service plan, which may either be the sample tools available through Ryan White Grant Administration or a pre-approved tool of the agency's choosing.

The Ryan White Part-A Standards for medical case management state that a comprehensive assessment should be completed with the client at intake and that they should be re-assessed at least every six months for as long as they are receiving medical case management services. A more formal, comprehensive assessment should be used at intake and annually, and a brief reassessment tool is sufficient at the 6-month mark. In other words, the ideal standard is that every client who receives case management services for an entire year should have at least two comprehensive assessments on file. A service plan should accompany each comprehensive assessment to outline the detailed plan of how the identified needs will be addressed with the client.

# of Comp. Assessments	A	B	C	D	E	F	G	TOTAL
0	18 (27%)	28 (27%)	23 (24%)	2 (3%)	10 (10%)	7 (7%)	13 (22%)	101 (17%)
1	27 (40%)	34 (32%)	14 (14%)	31 (44%)	3 (3%)	38 (36%)	15 (25%)	162 (27%)
2	6 (9%)	2 (2%)	0 (0%)	1 (1%)	1 (1%)	2 (2%)	4 (7%)	16 (3%)
N/A	16 (24%)	41 (39%)	60 (62%)	36 (51%)	91 (87%)	58 (55%)	28 (47%)	330 (54%)
Completion Rate	<b>97%</b>	<b>70%</b>	<b>46%</b>	<b>100%</b>	<b>93%</b>	<b>91%</b>	<b>91%</b>	94% (570 out of 609)
<b>TOTALS</b>	<b>67</b>	<b>105</b>	<b>97</b>	<b>70</b>	<b>105</b>	<b>105</b>	<b>60</b>	<b>609</b>

The date of each assessment was recorded in the chart abstraction tool. The client was considered "N/A" for a comprehensive assessment if they did not work with a medical case manager throughout the year. As outlined in the previous section, 48% of the sample did not work with a Medical Case Manager within the year. An additional 6% were served by a Medical Case Manager for a one-time, immediate need which was justified by staffing needs, most often an ADAP application or re-certification issue. 17% of the sample received zero comprehensive assessments, 27% received one, and 3% received two.

Completion Rate for this analysis was defined as the percentage of eligible medical case management clients who were assessed *at least once* throughout the year *or* had a documented reason for why they did not receive a comprehensive assessment (most often this was because the client declined or because they were no longer receiving medical case management services), *or*, they had evidence of an assessment just outside of the chart review dates. By this calculation, 94% of clients who should have received an assessment within the year did indeed receive one.

## SERVICE PLANS

As mentioned, each comprehensive assessment should be accompanied by a service plan, otherwise known as a care plan, to outline what action will be taken to address the needs that are identified on the comprehensive assessment. A service plan can be thought of as an informal, working contract between client and social worker of who will be accountable for which actions in order for the client to meet their determined treatment goals. As with the comprehensive assessment, the date of each completed service plan was recorded in the chart abstraction tool, along with any documented justification for why a service plan was missing if it should have been completed.

# of Service Plans	A	B	C	D	E	F	G	TOTAL
0	25 (37%)	32 (30%)	32 (33%)	4 (6%)	10 (10%)	7 (7%)	20 (33%)	130 (22%)
1	22 (33%)	30 (29%)	5 (5%)	29 (41%)	3 (3%)	38 (36%)	11 (18%)	138 (23%)
2	4 (6%)	2 (2%)	0 (0%)	1 (1%)	1 (1%)	2 (2%)	1 (2%)	11 (2%)
N/A	16 (24%)	41 (39%)	60 (62%)	36 (61%)	91 (87%)	58 (55%)	28 (47%)	330 (54%)
Completion Rate	<b>73%</b>	<b>64%</b>	<b>22%</b>	<b>94%</b>	<b>93%</b>	<b>91%</b>	<b>72%</b>	<b>87%</b> (527 out of 609) <b>11%</b> (29 out of 279)
<b>TOTALS</b>	67 (100%)	105 (100%)	97 (100%)	70 (100%)	105 (100%)	105 (100%)	60 (100%)	609 (100%)

It is notable that less service plans are completed than comprehensive assessments, even though the two processes are intended to occur together, one right after the other. One common reason for this, as documented frequently in the client medical records, is that clients would often decline to continue on to complete the service plan, given the amount of time they had already spent in the clinic for the lengthy comprehensive assessment interview, in addition to whatever medical appointment they may have attended on that day.

Completion rates were calculated in two different ways. The first calculation, in blue, is the more liberal analysis that is consistent with the manner used to calculate the completion rate for comprehensive assessment. It is the percentage of eligible clients who received *at least one* service plan throughout the year *or* had a documented reason for why they did not complete the service plan *or* they had evidence of a completed service plan just outside of the review dates. By this calculation, 87% of clients who should have received a service plan within the year did indeed receive one.

The second, more conservative measurement in red is the more universally accepted standard for care planning in Ryan White Case Management Services, consistent with the HAB HRSA Performance Measure for Case Management<sup>4</sup>. This is the number of clients who were receiving case management services within the year and received at least two service plans within the year, excluding those had a documented reason for not completing a second care plan, such as only being enrolled in case management for only some of the year.

<sup>4</sup> Health Resources and Services Administration HIV/AIDS Bureau. (2019, December). Performance Measure Portfolio: MCM Measures. Retrieved from <https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/mcmmeasures.pdf>

## BRIEF ASSESSMENTS

Like Medical Case Management, Non-Medical Case Management is guided by a continuous process of ongoing assessment, service provision, and evaluation. Clients should be assessed at intake using a Ryan White Grant Administration approved brief assessment form and should be reassessed at six month intervals if they are still being serviced by a Non-Medical Case Manager.

# of Brief Assessments	A	B	C	D	E	F	TOTAL
0	7 (10%)	6 (6%)	15 (15%)	2 (2%)	16 (15%)	14 (13%)	60 (11%)
1	10 (15%)	28 (27%)	37 (38%)	37 (53%)	49 (47%)	41 (39%)	202 (37%)
2	0 (0%)	1 (1%)	0 (0%)	1 (1%)	5 (5%)	4 (4%)	11 (2%)
N/A	50 (75%)	70 (67%)	45 (46%)	30 (43%)	35 (33%)	46 (44%)	276 (50%)
Completion rate	<b>94%</b>	<b>97%</b>	<b>77%</b>	<b>98%</b>	<b>86%</b>	<b>97%</b>	<b>91%</b> (248 out of 273)
TOTALS	67 (100%)	105 (100%)	97 (100%)	70 (100%)	105 (100%)	105 (100%)	549 (100%)

Dates of any brief assessments were recorded, along with any justification of why an assessment was not completed if one would have been expected. 50% of the sample would not been applicable for a brief assessment, as they did not receive services from a Non-Medical Case Manager. 11% of the sample received zero brief assessments, 37% received one, and 2% received two.

Completion rates represent the percentage of eligible clients who received *at least one* assessment within the review year *or* had a documented reason as to why one was not completed *or* had evidence of a completed assessment just outside of the review period.

## ASSESSED NEEDS

All data from assessment tools was captured in the chart review tool. A total of 173 Comprehensive Assessments and 211 Brief Assessments were reviewed and recorded in order to quantify the frequency of needs. The count recorded is a raw count of how many times a need was recorded, encompassing both comprehensive and brief assessments and including clients who may have had the same need identified more than once at different points in time.

The top five most frequently assessed needs were: 1) Medical/Clinical, 2) Dental Care, 3) Vision Care, 4) Transportation, and 5) Mental Health. It should be noted, however, that there are no universal standards or instructions across case management systems on how to use these tools or how these needs are defined. For example, it was much more common for “Dental Care” to be identified as a need at agencies who had dental care co-located or easily available within their organization. Anecdotally, some case managers reported that they automatically checked “Medical/Clinical” as a need, regardless of whether or not the client needed assistance accessing medical care, because it was their understanding that this section *always* needed to be checked in order to justify billing for medical case management services. Therefore, this compilation of comprehensive and brief assessments should not be considered representative of *true need* within the HIV community in Houston, but rather, as representative of issues that case managers are discussing with clients.

Need identified on assessment	Count	Percentage %
<b>Medical/Clinical</b>	141	37%
<b>Dental Care</b>	123	32%
<b>Vision Care</b>	108	28%
<b>Transportation</b>	99	26%
<b>Mental Health</b>	95	25%
<b>Insurance Benefits</b>	85	22%
<b>Medication Adherence</b>	79	21%
<b>Housing/Living Situation</b>	66	17%
<b>Substance/Alcohol Use</b>	65	17%
<b>HIV Education/Prevention</b>	50	13%
<b>Support System</b>	34	9%
<b>Employment/Income</b>	34	9%
<b>HIV-Related Legal</b>	31	8%
<b>Self-Efficacy</b>	30	8%
<b>Basic Necessities/Life Skills</b>	29	8%
<b>Nutrition/Food Pantry</b>	22	6%
<b>Family Planning/Safer Sex</b>	15	4%
<b>Financial Assistance</b>	14	4%
<b>Abuse History</b>	12	3%
<b>Cultural/Linguistic</b>	9	2%
<b>General Education/Vocation</b>	9	2%
<b>Vaccination</b>	8	2%
<b>Hearing Care</b>	8	2%
<b>Home Care Needs</b>	5	1%
<b>Client Strengths</b>	4	1%
<b>Child Care/Guardianship</b>	2	1%
<b>Other</b>	2	1%
<i>Out of 384 assessments</i>		

## Conclusion

The 2018-2019 Case Management chart review highlighted many trends about the case management client population, strengths in case management performance, and areas identified for future attention and improvement.

Overall, we continue to learn more about the needs of this patient population by expanding the sample size of the review and adding new elements to the chart abstraction tool. The top three most common co-occurring conditions were: Sexually Transmitted Infections (31%), Depression (26%), and Hypertension (23%). Diabetes was also relatively common (11%) and it has been suggested that providing overview information on nutrition counseling and diabetes management may be a useful topic for future frontline case management trainings. In addition, 53% of the overall sample had a history or active diagnosis of a mental health or substance abuse issue. 10% of the sample was homeless or unstably housed. The prevalence of these complex co-morbidities further emphasizes the unique benefit that case managers contribute to the HIV treatment setting.

There were also many areas of high performance displayed in this chart review. Most (39%) of the clients in the sample had at least three HIV-related primary care appointments within the review year. While the measurement for Viral Load Suppression changed from last year's chart review, there was a marked improvement in overall VL suppression from 43% to this year's 60%. Case Management staff demonstrated a high level of coordination of care in many areas. For example, 91% of those with active mental health or substance abuse symptoms either received a referral for further treatment or counseling or were already engaged in services. 78% of the clients who were New, Lost, or Returning to Care (or some combination) received coordination of care activities from case management in an effort to retain them in care. And finally, when a client was found to be virally unsuppressed through a laboratory test, case management staff were often involved to follow-up with clients and provide medication adherence counseling. Less than 10% of sample was found to be virally unsuppressed at some time throughout the year and did not receive attention and intervention from case management staff.

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### *Case Management staff demonstrated high levels of coordination of care:*

- 91% MH and SA referral rate*
  - 78% of New, Lost, or Returning to Care clients were assisted by CM*
  - <10% of sample was unsuppressed without intervention*
- 

The review also highlighted that there are still many opportunities for refinement in case management workflow and service provision. Termination planning and review for case closure were inconsistently practiced across agencies. The discrepancy between the completion rate for one assessment versus two assessments per year is striking. This indicates that, as a case management system, we are good at initiating services, but need to dedicate much more attention to following clients throughout their care. It is quite possible that the 11% performance rate of 2 care plans within a year for medical case management clients is artificially low if many of those clients could be considered "closed" for case management and excluded from the calculation. However, without proper case closure documentation in the medical chart and, worse, without communication to the client to follow-up with them or manage service expectations, those cases are considered "open" for all intents and purposes.

This lack of follow-through is further evidenced in the frequency of contact with a case manager. More than half (56%) of the sample had three or fewer interactions with the case manager. If the ideal standard is for a client to be formally assessed at least twice throughout the year to discuss their history, present concerns, barriers, and goals, with follow-through in between those formal sit-downs to work through the issues identified in the care plan, it leaves room to wonder how clients can be adequately served. Further training and capacity building in the areas of assessment and interview techniques, as well as continuing to refine case management role delegation, may help improve quality in these areas.

# Appendix (Case Management Chart Review Tool)

CASE MANAGEMENT CHART REVIEW TOOL

Chart Review Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Agency:  AHF  AH  Ave360  HHS  Legacy  SHF

Review Period:  
3/1/20\_\_ - 2/28/20\_\_

**CLIENT INFORMATION**

---

Pt. ID # \_\_\_\_\_ Race: \_\_\_\_\_

Client Case Status:  Open/Active  Closed  Unk. Gender: \_\_\_\_\_

Last OAMC Appts:	Virally Suppressed?	← If No, linked to CM?
1.	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk.	
2.	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk.	
3.	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk.	
<input type="checkbox"/> No appts. during review period		

Last CMngmt. Contact:	Type (F2F/PC/Consult.) + short description	Signed/Dated/Clear?
1.		
2.		
3.		
4.		
5.		

During the review period, was the client:  New to care  Lost to care  Re-engaged in care  NA  
 If yes.... was there documentation of coordination of care or contact attempts?  Y  N  NA

Does the client have an active diagnosis of the following diagnoses? (Check ALL that apply)

- Alcohol abuse/dependence
- Other substance abuse/dependence: \_\_\_\_\_
- Depression
- Bipolar disorders
- Anxiety disorders
- Schizophrenia
- Other: \_\_\_\_\_

Was the client referred or already engaged with MH/SA services?  
 N/A  Yes  No

Does the client have any co-morbidity?

- Opportunistic Infection
- Sexually Transmitted Infections (STIs) : \_\_\_\_\_
- Diabetes
- Cancer
- Hepatitis
- Hypertension
- Other: \_\_\_\_\_

Was the client reported to have any of the following conditions?

- Homelessness
- Pregnancy (or other pregnancy-related conditions)
- Recently released
- IPV



**INSURANCE, BENEFITS, AND INCOME INFORMATION**

Health Insurance:  Uninsured  Medicaid \_\_\_\_\_  Medicare \_\_\_\_\_  Commercial \_\_\_\_\_  
 VA  Other? \_\_\_\_\_

Spouse/partner:	Children:	Other Dependents:	TOTAL HOUSEHOLD SIZE 1 2 3 4 5 6 7 8 9 10 Unk
Client Income \$:	Spouse Income \$:	Other Income \$:	TOTAL HOUSEHOLD INCOME \$:

Did the client lose insurance or coverage during the review period?  Y  N  Unk.   
 If so, were they provided with information/education or assistance?  Y  N  NA

**CASE MANAGEMENT SERVICES**

What types of services were provided by a Medical Case Manager (MCM)? <input type="checkbox"/> NA (Client not assisted by MCM) <input type="checkbox"/> Comprehensive assessment <input type="checkbox"/> Service Plan <input type="checkbox"/> Medication adherence counseling <input type="checkbox"/> Coordination of medical care <input type="checkbox"/> Transportation <input type="checkbox"/> ADAP/medication assistance <input type="checkbox"/> Eligibility <input type="checkbox"/> Community resource/benefits brokerage <input type="checkbox"/> Other _____ Did client meet criteria for MCM? Y <input type="checkbox"/> N <input type="checkbox"/> Unk. <input type="checkbox"/>	What types of services were provided by a Service Linkage Worker (SLW)? <input type="checkbox"/> NA (Client not assisted by SLW) <input type="checkbox"/> Brief assessment <input type="checkbox"/> SLW referred client to OAMC <input type="checkbox"/> OAMC visit scheduled by SLW <input type="checkbox"/> SLW accompanied client to OAMC <input type="checkbox"/> SLW called client to remind about OAMC visit <input type="checkbox"/> Client did not keep OAMC appt. and SLW contacted them <input type="checkbox"/> ADAP/medication assistance <input type="checkbox"/> Transportation voucher <input type="checkbox"/> Eligibility Were any of the above services provided by an Outreach Worker? Y <input type="checkbox"/> N <input type="checkbox"/> Unk. <input type="checkbox"/>	Was the client referred for Clinical Case Management services in the review period? <input type="checkbox"/> No- not applicable <input type="checkbox"/> No- applicable, but no referral documented <input type="checkbox"/> Yes- and there is evidence of coordination of services <input type="checkbox"/> Yes- and there is <u>no</u> evidence of coordination of services <input type="checkbox"/> Yes- but client refused services or is already engaged in treatment
--	---	---

Was the case discharged/closed for CM during the review period? Y  N  NA  Unk.   
 If yes..... Client met agency criteria for closure? Y  N  NA  Unk.   
 Client completed treatment program (CCM) Y  N  NA  Unk.   
 Date and reason noted? Y  N  NA  Unk.   
 Summary of services received? Y  N  NA  Unk.   
 Referrals noted? Y  N  NA  Unk.   
 Instructions given to client at discharge? Y  N  NA  Unk.

**ASSESSMENTS & SERVICE PLANS**

Brief Assess. Date 1:	Brief Assess. Date 2:	If no assessment or plan: <input type="checkbox"/> evidence of one just outside of review period <input type="checkbox"/> reason documented <input type="checkbox"/> enough info to complete		
Comp. Assess. Date 1:	Comp. Assess. Date 2:	<input type="checkbox"/> evidence of one just outside of review period <input type="checkbox"/> reason documented <input type="checkbox"/> enough info to complete		
Service Plan Date 1:	Service Plan Date 2:	<input type="checkbox"/> evidence of one just outside of review period <input type="checkbox"/> reason documented <input type="checkbox"/> enough info to complete		

COMPLETED ASSESSMENTS

Domain	MOST RECENT ASSESSMENT			NEXT MOST RECENT ASSESSMENT		
	TYPE (circle one)	Comprehensive	Brief	TYPE (circle one)	Comprehensive	Brief
	Assessed?	Need Identified?	Accounted for in Service Plan?	Assessed?	Need Identified?	Accounted for in Service Plan?
Medical/Clinical						
Vaccination						
Nutrition/Food Pantry						
Dental Care						
Vision Care						
Hearing Care						
Home Care Needs						
Basic Necessities/Life Skills						
Mental Health						
Substance/Alcohol Use						
Abuse History						
Housing/Living Situation						
Support System						
Child Care/Guardianship						
Insurance Benefits						
Transportation						
HIV-Related Legal						
Cultural/Linguistic						
Self-Efficacy						
HIV Education/Prevention						
Family Planning/Safer Sex						
Employment/Income						
General Education/Vocation						
Financial Assistance						
Medication Adherence						
Client Strengths						
Other						

**Linkage to Care for Newly Enrolled Clients  
Performance Improvement Activity (PIA)  
For Case Management Supervisors  
2018-2019 (and beyond)**

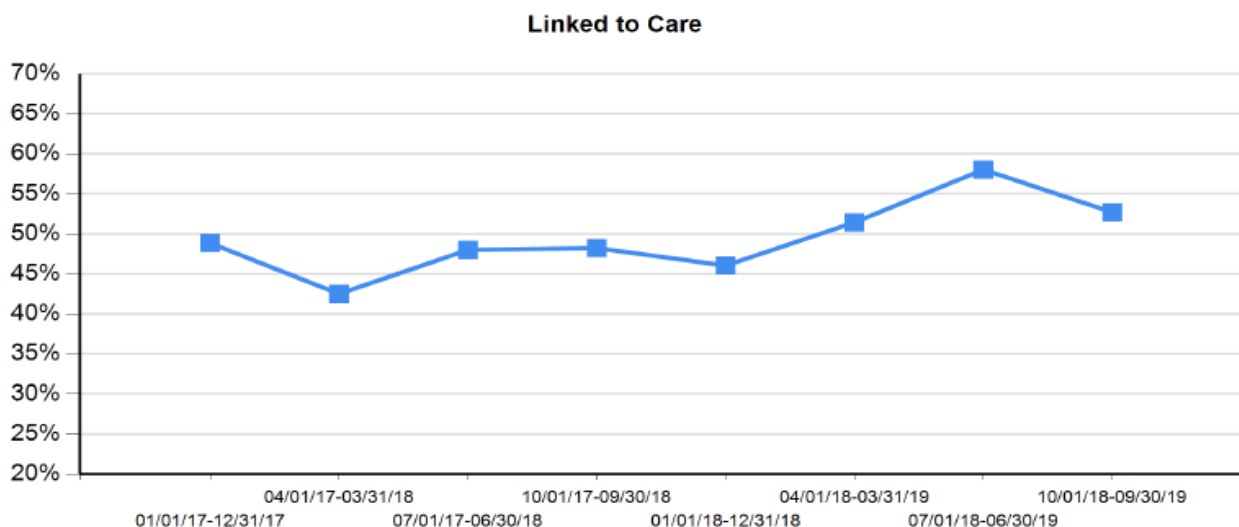
**Key Highlights**

- ❖ Following clients through their first year of care in a new clinic may be considered an effective intervention for HIV treatment outcomes.
- ❖ Clinic workflows should be optimized to ensure a patient-centered experience and effective treatment monitoring. It was surprising to find that many patients were not automatically prompted to schedule a follow-up visit, or asked for their input on what dates and times would work best for them, or that many did not have a recent (within 6 months) CD4 and VL lab on file.
- ❖ While HIV treatment management is down trending towards two primary care appointments per year, the findings from this activity suggest that new clients (without distinguishing between newly diagnosed, new to treatment, or just new to your clinic) may still benefit from having appointments scheduled every 3 months.

**Project Description**

Linkage to Care (L2C) is one important indicator used to predict treatment outcomes for new patients in HIV management. L2C performance measures vary across local and regional jurisdictions. The HRSA HAB Performance Measure Portfolio includes a Systems-Level Linkage to HIV Medical Care measure that is defined as the percentage of patients who attend a routine HIV medical care visit within 1 month of diagnosis. The Houston Ryan White Part A system includes three different Linked to Care measures for monitoring as part of Clinical Quality Improvement activities, one of which provided the basis for this Case Management Performance Improvement Activity.

This “Linked to Care 1” measurement monitors the number of newly enrolled uninsured clients who had at least one medical visit in each of the 4-month periods of the measurement year. This measure has hovered around 50% for the last couple years.



Deeper analysis was desired to better understand patients' experience in their first year of care as newly enrolled clients, particularly given that the Ryan White case management service models include Service Linkage Workers and intensive Medical Case Management aimed at new patients. By engaging Case Management (CM) Supervisors to prompt their staff to take a close look at newly enrolled clients, the intent of this PIA was to improve L2C performance.

For the purposes of this activity, new clients were defined as:

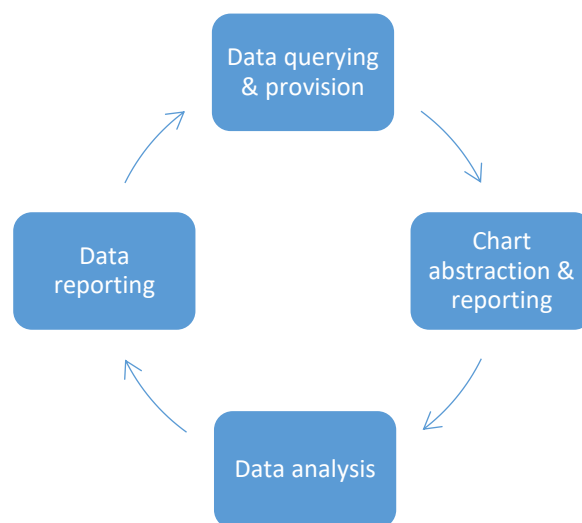
- Newly enrolled clients during the specified three-month period with at least one medical visit
- Excluding those who are insured and who are virally suppressed (<200 copies/ml)

With this definition in mind, it is important to understand that this activity is not necessarily aimed at understanding newly diagnosed patients or even new-to-treatment patients, though these populations may be captured in the data sets.

Each phase of the PIA is designed to repeat three times for a total of four quarters of data reporting. These four "cohorts," as they are referred to, are data sets for clients who were considered newly enrolled for the following time frames:

- Quarter/Cohort 1: March-May 2018
- Quarter/Cohort 2: June-August 2018
- Quarter/Cohort 3: September-November 2018
- Quarter/Cohort 4: December 2018-February 2019

Each quarter, the CPCDMS data base was queried by the Ryan White Grant Administration epidemiologist to provide a client list for CM Supervisors of their newly enrolled clients for that 3-month period. Supervisors were then instructed to conduct a chart review for each client on their list to complete each relevant data field. Results were then returned to RWGA Quality Management staff for analysis, after which the results were compiled and reported out to each agency for reflection and discussion, before repeating.



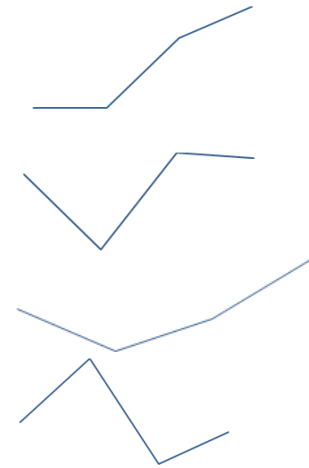
## Phase 1 of PIA: Quarterly Linkage to Care

The first phase of the L2C PIA aimed to monitor performance of case managers for successful linkage to care of newly enrolled clients seeking HIV primary care treatment. For this phase of the activity, successful "linkage" was defined as the presence of an initial HIV-related primary care appointment during the specified time range, followed by attendance at a follow-up appointment during the next 3-month period.

Each quarter, CM Supervisors were provided a list of new clients who enrolled during the specified time frame. They were instructed to return the list in the following quarter, reviewing the patient chart to determine: 1) whether they were scheduled for a "next" primary care appointment in a following quarter, 2) whether they attended that next appointment, 3) whether they were enrolled or receiving case management services, 4) and whether they were virally suppressed. This activity was repeated for four quarters to measure trends and improvement.

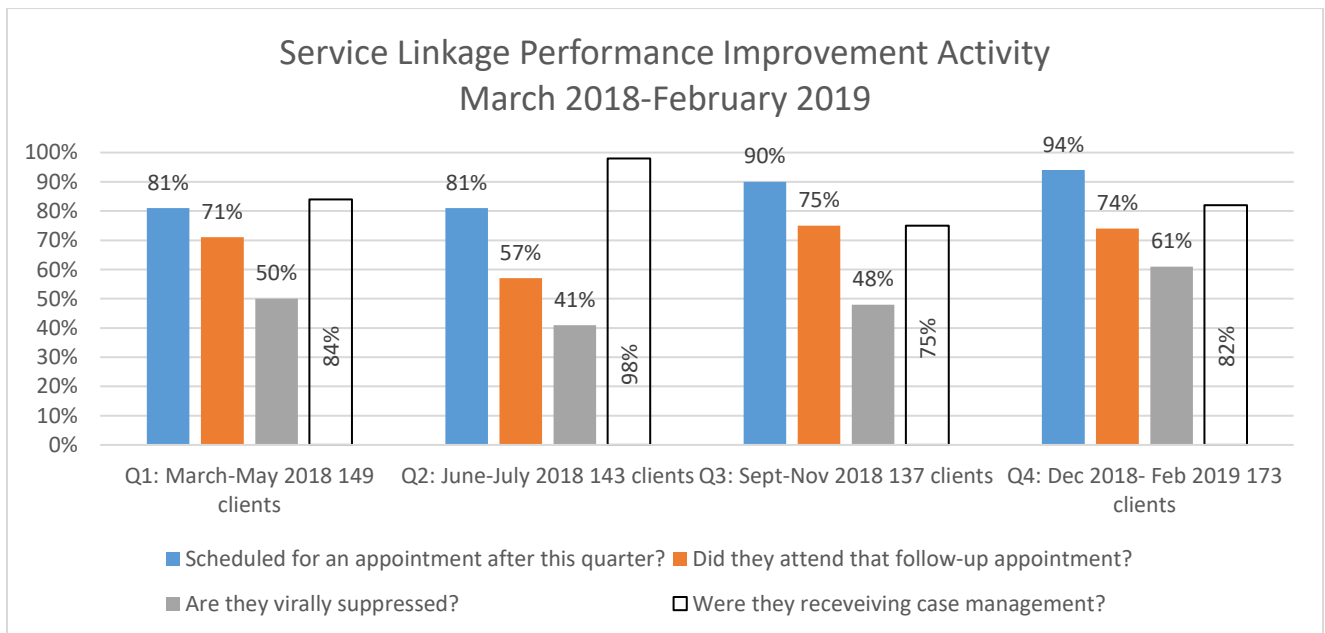
	Q1: March-May 2018 149 clients	Q2: June-July 2018 143 clients	Q3: Sept-Nov 2018 137 clients	Q4: Dec 2018- Feb 2019 173 clients
Scheduled for an appointment in the next quarter?	81%	81%	90%	94%
Did they attend that follow-up appointment?	71%	57%	75%	74%
Are they virally suppressed?	50%	41%	48%	61%
Are they receiving case management?	84%	98%	75%	82%

Linear progression



While performance did not improve linearly throughout this project phase, performance certainly had a marked improvement from the first quarter to the last. For example, 81% of clients from the first cohort at the beginning of the study were scheduled for a follow-up appointment. By the last quarter, 94% of the final cohort had been scheduled for a follow-up appointment. Similarly, viral load suppression increased from 50% to 61%.

These findings suggest that by virtue of providing focused attention to newly enrolled clients and assigning responsibility to particular staff to query patient health and attendance records and follow-up, outcomes can improve.



## Phase 2 of PIA: Retrospective “Second Look” Cohort Study

Following the completion of the first performance monitoring phase of the PIA for Year 1, the second year of the PIA initiated a retrospective cohort study. This phase of the PIA is currently ongoing, with two cohorts worth of data available. The purpose of this phase is to take a “second look” at each original cohort, one year later, to further understand what their first year in care has been like.

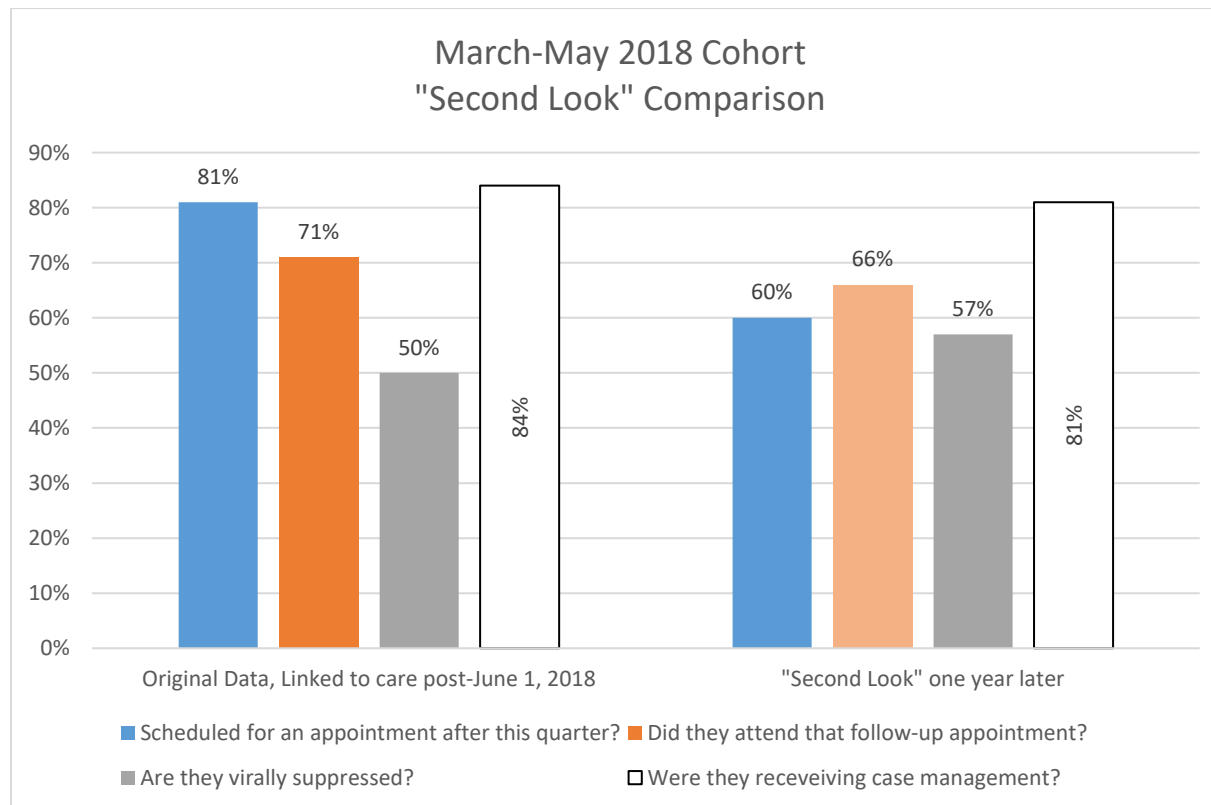
CM Supervisors were prompted to conduct a chart review for each of the clients on their original cohort list, identifying the following items: 1) Did the client have an HIV primary care appointment scheduled in each of the following quarters of their last year in care? 2) Have they been scheduled for a post-last quarter appointment, indicating they would be successfully “linked” to a second year of treatment in that facility? 3) When was their last laboratory CD4 and VL test performed and were they virally suppressed at that point in time? And finally, 4) were they enrolled in case management services during the year and, if so, how many case management encounters did they have?

For the purposes of this phase of the activity, attendance at a follow-up appointment from the first point in time will be compared to presence of lab work in the last 6 months.

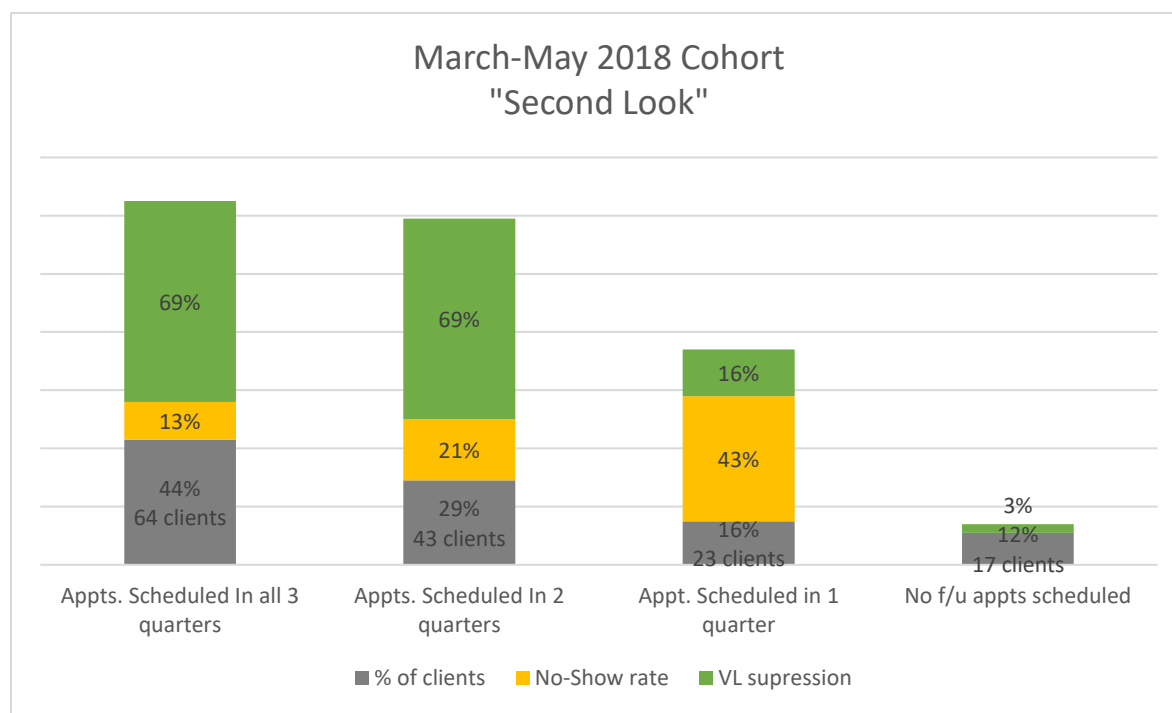
As with Phase 1, Phase 2 is expected to take one year to complete. To date, two cohorts have been re-examined for their second look.

### Cohort 1: March-May 2018

The following comparison is of the March-May 2018 Cohorts June 2018 data and their June 2019 status. Data was returned for 147 of the original 149 clients.



By June 2019, 60% of the original cohort had been scheduled for an appointment sometime after June 1<sup>st</sup>, 2019, indicating they were still engaged in care. 66% have had lab work completed in the last 6 months. 57% were known to be virally suppressed in the last 6 months. 81% had received case management services over the last year, with an average of 5 encounters.



Client outcomes were also examined to understand whether the number of scheduled appointments in the year had an impact on viral load suppression. 44% of clients were scheduled for an HIV primary care appointment in each of the following three quarters examined, while 29% had an appointment scheduled in two of the quarters, 16% with an appointment in just 1 quarter, and 12% with no follow-up appointments scheduled. It is of note that of the 17 clients who were not followed-up with at all, 1 appeared to have established care at a different Ryan White clinic, 1 was deceased, 1 was no longer in CPCDMS, and 14 had no further appointments in the RW-A system.

Clients who were scheduled for either three or two appointments had the same VL suppression rate at 69%, while clients with two appointments scheduled had a 43% suppression rate.

No-show rates were also examined. Clients with 3 follow-up appointments (one in each of the next quarters) had a 13% no-show rate and clients with 2 scheduled appointments had a 21% no-show rate. 43% of clients who were scheduled for one appointment did not attend that appointment.

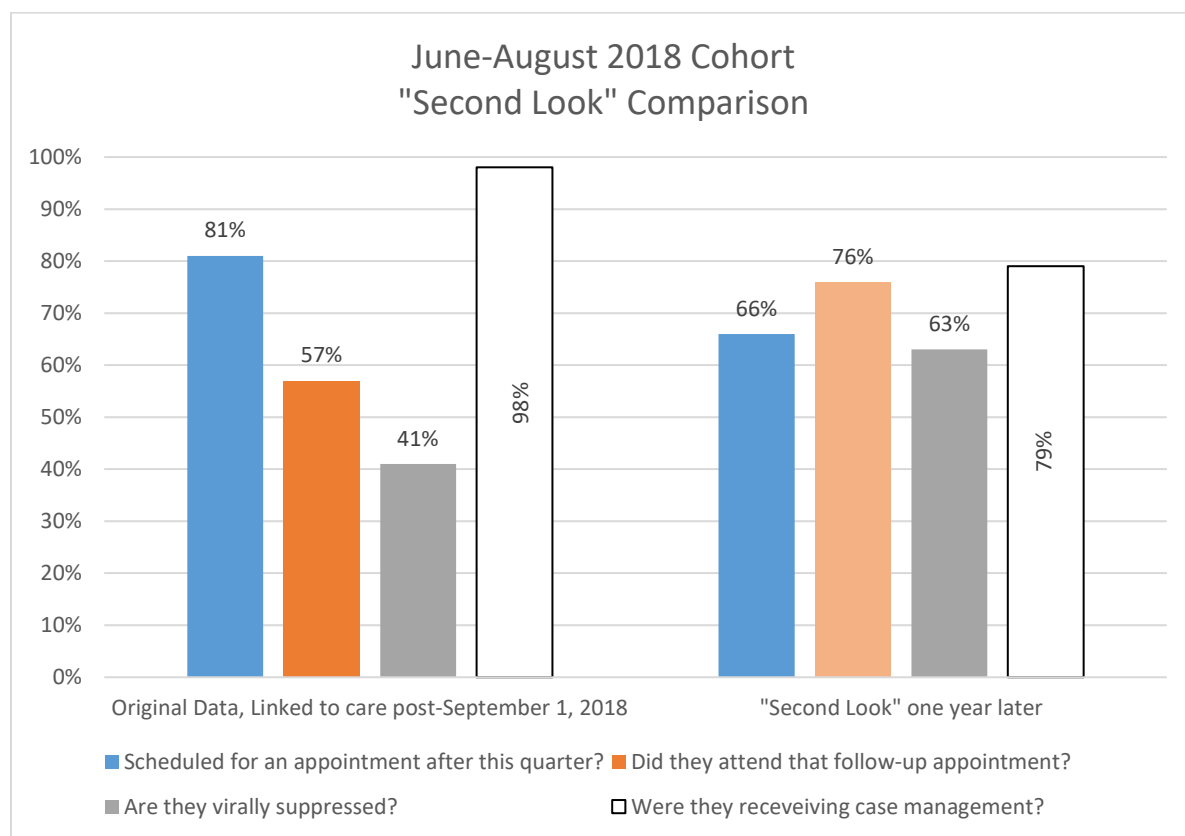
While these findings suggest that scheduling two appointments per year may be sufficient for clients to achieve the ultimate indicator of viral load suppression, even in their first year of care, more analysis was needed to understand the impact of no-show and cancellation rates.

	Number/Percentage	VL Suppression Rate
<b>3 appointments attended</b>	44 (30%)	84%
<b>2 appointments attended</b>	45 (31%)	87%
<b>1 appointment attended</b>	30 (20%)	23%
<b>0 appointments attended</b>	28 (19%)	12%

When actual number of appointments attended was analyzed, clients who attended 2 appointments had the highest viral load suppression rate at 87%, followed closely by patients who attended 3 appointments at 84%. There are likely many confounding variables and factors that would influence why patients with less appointments achieve viral load suppression (slightly) more often. For example, long-term survivors who have a wealth of experience in managing their care may be more likely to opt for fewer appointments. Providers may make the decision to schedule and encourage more appointments to monitor patients who are having trouble with treatment adherence.

### **Cohort 2: June-August 2018**

Most recently, this activity was repeated for Cohort 2, the June-August 2018 set of clients. Data was returned for 131 of the original 143 clients.



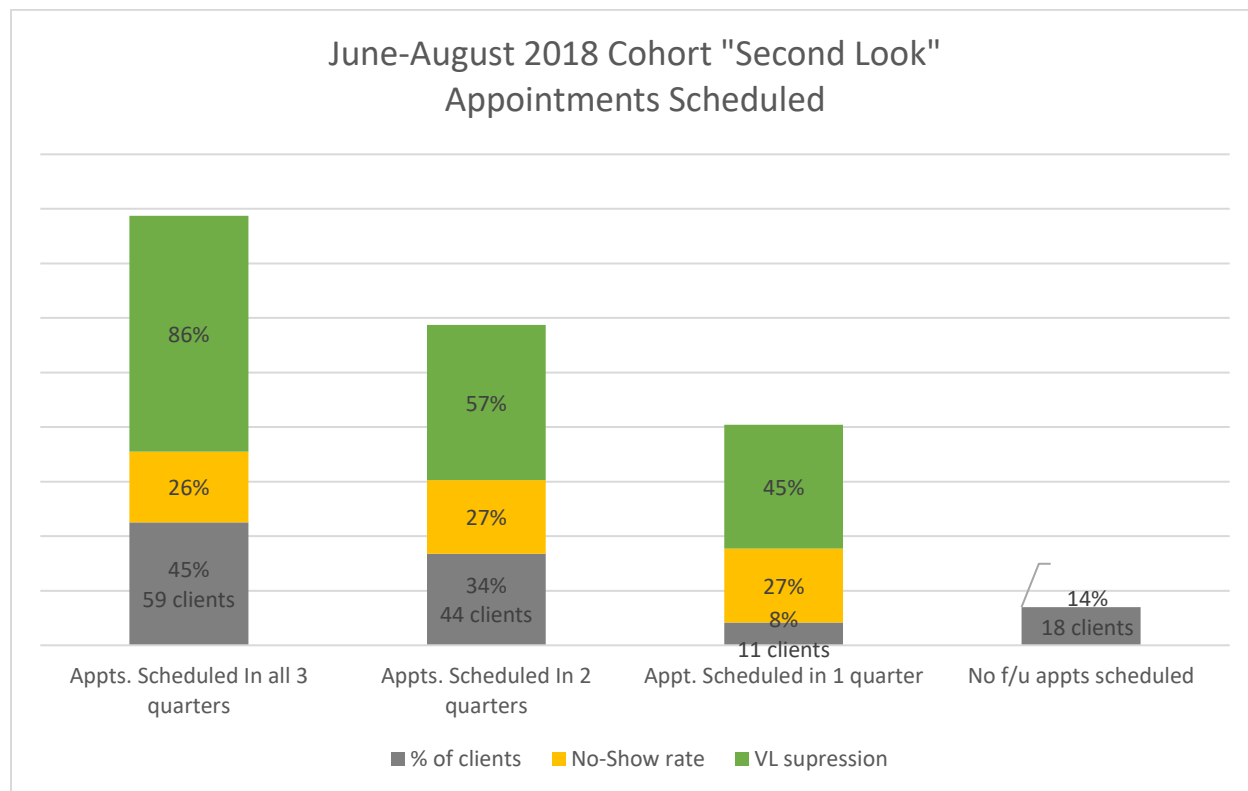
By October 2019, 66% of the original cohort had been scheduled for an appointment sometime after September 1<sup>st</sup>, 2019. 76% have had lab work completed in the last 6 months. 63% were known to be virally suppressed in the last 6 months. This marks an improvement on all clinical measures from the first cohort.

79% had received case management services over the last year, with an average of 5 encounters. It is also noteworthy that the less appointments a patient was scheduled for, the more number of case



management encounters they averaged. This suggests that case management staff may have been attempting to engage and retain clients who were less likely to be successfully linked to care.

Just like the first cohort, clients outcomes were analyzed based on number of scheduled appointments. The results were dissimilar to the first cohort.



45% of clients were scheduled for a primary care appointment in each of the three quarters examined, while 34% had an appointment scheduled in two of the quarters, 8% with an appointment in just 1 quarter, and 14% with no follow-up appointments scheduled.

Unlike the first cohort, clients scheduled for three additional appointments had the highest VL suppression rate at 86%, while clients with two appointments scheduled had a 57% suppression rate.

No-show rates were similar across groups, with about a quarter of appointments resulting in “no-show” or cancellations, regardless of how many they were scheduled.

When clients from this cohort were analyzed by number of appointments actually attended, the effect of appointment frequency was even more pronounced. Clients who attended all three follow-up appointments achieved a 93% VL suppressions rate, followed by clients attending 2 appointments at 74%.

	Number/Percentage	VL Suppression Rate
<b>3 appointments attended</b>	42 (32%)	93%
<b>2 appointments attended</b>	35 (27%)	74%
<b>1 appointment attended</b>	23 (18%)	52%
<b>0 appointments attended</b>	31 (24%)	16%

## Conclusions

While this PIA is only 1.5 years of the way completed through its projected 2 years of study, there have been a few key findings thus far.

First, the theory that continuous monitoring of newly enrolled clients would improve treatment outcomes seems to have been correct, as is consistent with quality improvement and management frameworks. While performance improvement for the first phase of the PIA was not linear, performance did improve from the first cohort to the last. Anecdotally, the CM supervisors have reported that providing a list of new clients for review each quarter is a helpful activity. As a result, RWGA has continued to provide these cohort lists at the agencies' request even though that phase of the PIA has concluded.

Second, this quarterly prompt to conduct a focused chart review has revealed that many clinic practices that were assumed to be occurring as part of routine HIV care were indeed not. For example, the CM Supervisors were surprised to learn that only 81% of clients in the first cohort had been scheduled for a follow-up appointment, a process which should be automatic and consistent. This revelation may have been what prompted the continuous improvement for this measure; scheduling for a follow-up appointment was the only measurement that had a clear linear progression towards improvement. In addition, participating in this activity highlighted a gap in clinic workflow in the way of laboratory testing, which is a cornerstone of HIV treatment and management. It was not uncommon for clients to be missing a recent (within the last 6 months) CD4 and VL lab result, even if they had been regularly attending face-to-face provider appointments. Clinics tend to have a different workflow for scheduling provider and lab appointments. Further study, possibly including internal environmental walk-through audits, should be conducted to optimize a patient-centered experience and to understand why so many clients do not regularly have HIV labs conducted.

Finally, the results of this PIA suggest that scheduling HIV-related primary care appointments every three months may be optimal as compared to the down trending preference for 2-3 appointments per year, particularly for new clients. While the second phase of this activity is still ongoing, results from the first two retrospective cohort studies suggest that not only are 3 follow-up appointments correlated with higher viral load suppressions rates, but scheduling patients for an appointment every quarter can help to ensure that they make it to at least a few appointments each year, given the cancellation and no-show occurrence.

# The Community Health Worker Role on the HIV Care Continuum

**A** Community Health Worker (CHW) is a member of the health care workforce who reduces the burden and stress of large caseloads and enhances traditional Ryan White HIV/AIDS Program care teams. This fact sheet is an introduction to CHWs. It defines CHW, lists other titles by which CHWs are referred, describes how CHWs enhance HIV care teams, and identifies the roles CHWs perform.

## CHW Defined

As defined by the American Public Health Association, a "CHW is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities, such as outreach, community education, informal counseling, social support, and advocacy."<sup>1</sup>

## CHWs Are Also Known As . . .

CHWs are known by a variety of titles. Some of the most common are:

- Peer Educators
- Outreach Workers
- Patient/Peer Navigators
- Peer Counselors
- Health System Navigators
- Linkage to Care Coordinators

## How CHWs Enhance HIV Care Teams

CHWs enhance HIV care teams by working in partnership with case managers, nurses, doctors, social workers, and other service providers to address the medical, social, and economic needs of people living with HIV (PLWH). CHWs are often referred to as a bridge between the client, the community where the client lives and medical clinics or community-based organizations. As such their work is bi-directional. CHWs have a role in improving the health of clients and their communities and they also influence the program and the clinical setting in which they function. CHWs unique ability to connect with the community can have an impact on all aspects of the *Triple Aim*: "improving client experience, improving health care, and lowering cost."<sup>2</sup>

**Within HIV care, CHWs are a bridge between HIV clinics and support service agencies and health care organizations.**



## CHW Roles

The *Community Health Worker Core Consensus Project* (C3) developed 10 core CHW roles. Although these roles are not HIV-specific, they can be used to develop tasks and responsibilities for CHWs on your HIV care team.

The following table lists the CHW roles developed by C3 and provides an example of how each role is performed in one or more stages of the HIV Care Continuum.

CHW Role <sup>3</sup>	How the Role is Performed Across the HIV Care Continuum
1. Cultural Mediation Between Individuals, Communities and Health and Social Systems	Support and increase linkage to and retention in care and adherence to treatment by educating clients about treatment and the appropriate use of services
2. Providing Culturally Appropriate Health Education and Information	Improve adherence to treatment by providing structured educational sessions on topics such as HIV, viral life cycle, treatment, and side effects
3. Care Coordination, Case Management, and System Navigation	Support retention in care by assisting clients with referrals for transportation, housing, behavioral health treatment, and other support services
4. Providing Coaching and Social Support	Support retention in care and treatment adherence by providing emotional support to clients
5. Advocating for Individuals and Communities	Support the entire HIV Care Continuum by serving on Ryan White Planning Councils
6. Building Individual and Community Capacity	Support retention in care and reduce barriers by collaborating with medical, behavioral health, and social services providers
7. Providing Direct Service	Support treatment adherence by picking up prescriptions for clients and educating them on the medication and its side effects
8. Implementing Individual and Community Assessments	Support linkage to and retention in care by working with case managers to assess clients' needs and develop care plans
9. Conducting Outreach	Support linkage to and retention in care by re-engaging clients lost to follow-up
10. Participating in Evaluation and Research	Document activities in electronic health records

## References

<sup>1</sup>American Public Health Association. n.d. Community Health Workers. Available at: <https://www.apha.org/apha-communities/member-sections/community-health-workers>

<sup>2</sup>Berwick DM, Nolan TW, and Whittington, J. (2008) The Triple Aim: Care, Health Cost. *Health Affairs*. 27(3):759-769

<sup>3</sup>Amended from Rosenthal EL, Rush CH, and Allen CG. (2016) Understanding Scope and Competencies. A Contemporary Look at the United States Community Health Workers Field. Progress Report of the Community Health Worker (CHW) Core Consensus Project. Building National Consensus on CHW Core Roles, Skills, and Qualities. Available at: <http://www.chwcentral.org/understanding-scope-and-competencies-contemporary-look-united-states-community-health-worker-field>

