A Report on HIV Case Management Services

In Massachusetts

Prepared for the Massachusetts Department of Public Health

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EXECUTIVE SUMMARY

This assessment of HIV case management services in Massachusetts was conducted for the Massachusetts Department of Public Health's HIV/AIDS Bureau (DPH) and the Boston Public Health Commission's AIDS Program (BPHC) in the winter and spring of 2003. Some of the key issues of concern for DPH and the BPHC included:

- The variation in program models and case manager skill sets across the state.
- Client profiles and caseloads of different agencies.
- How case managers address mental health, substance use and abuse, harm reduction and risk reduction.
- How case managers work with clients to achieve independence.
- Training and supervision provided to case managers.
- Standards of care, data collection, and reporting issues.
- Changes to consider in the upcoming case management procurement.

Eleven agencies that receive Title I and/or DPH funds to provide HIV case management services participated in the assessment (50% of the case management programs funded by the HIV/AIDS Bureau). Programs were selected to ensure diverse case management models and geographical distribution. Interviews were conducted with one case management supervisor and two case managers at each of the 11 agencies, for a total of 33 interviews.

Key Findings

Models

All of the case management programs were social service models. Four employed a triage model, where individuals were referred to case management or other services/departments based on their needs as ascertained during an intake interview. Another four programs maintained all clients in case management for the duration of their affiliation with the organization. Three programs were health center or hospital-based programs, where case managers functioned as part of a clinical team. By default, some of these programs used a triage model due to the volume of clients. Six of the agencies, all located in major urban areas, reported that some of their clients received case management from other service providers.

Evolution of case management program over time

Program administrators/supervisors talked about the shift in case management from helping people die in comfort, and responding to the crisis of dying with AIDS, to the current situation where people are living longer. Case managers now need to be more knowledgeable about medical issues.

Case Manager Diversity and Skills

One of the greatest strengths of the case management programs was the cultural, linguistic and experiential diversity of the case management staff and supervisors. Over half had a primary language other than English, primarily Spanish. Several spoke Haitian Creole or Portuguese. Two thirds of the case managers had a bachelors or masters

degree, while the remaining one third had a high school diploma or some college. Almost one third had substance abuse counseling experience and several were licensed mental health counselors. Strict educational requirements for case managers, common in some states, often stand in the way of achieving the diversity found in Massachusetts. As long as the case managers receive clinical and administrative support and supervision from qualified individuals, as was the case in most of the programs we met with, they can continue to provide high quality services in a culturally relevant manner.

Client Profile and Caseloads
Case manager caseloads averaged 48 clients last year with a range of 20-255 clients per case manager. Case managers saw half of their clients on a weekly or monthly basis, and half of their clients less often than once/month. Nearly one quarter of all clients were only seen once/year. Clients seen frequently included people who were homeless, people with serious mental health issues, the unemployed, people coping with domestic violence, and/or people who were monolingual (Spanish, Creole, or Portuguese). Clients seen or spoken with less often required services described as "maintenance" services, such as helping with paperwork for medications, health insurance, and fuel assistance.

Approximately one-fourth of clients in case management services had a current or previous history of substance abuse, but this varied greatly by program. Case managers reported that approximately half of their clients had mental health issues, and almost half experienced serious medical problems such as Hepatitis C, cancer, diabetes, neuropathy or side effects of medications.

Mental health and substance abuse assessment, harm reduction and risk reduction
Four case managers used a standardized mental health screening tool, three used a formal risk assessment tool, and nine were able to provide specific examples of how they practiced harm reduction. Most case managers said mental health questions and substance use/abuse questions were part of their intake process, but they were not certain if this constituted a formal screening tool.

Most case managers discussed condom use with their clients and a few talked about using clean needles. However, many of the case managers reported that this was often a difficult subject, and in the interest of building a relationship with clients, the case managers let their clients bring up the subject rather than initiate discussion directly. Four of the case managers had little or no knowledge of harm reduction, and another nine demonstrated some knowledge of harm reduction, but did not provide concrete examples of how they implemented this approach.

Client discharge or empowerment
Three of the case managers reported a formal process to assess client independence, and five of the case managers reported that they closed any cases in the past year for reasons other than death or moving. The closing of case management cases occurred within agencies that had a client service alternative for individuals who did not need ongoing care. Most case managers indicated that they believed clients would need to access their services forever, and therefore they did not discharge anyone.

Case Manager training and supervision
Most of the case managers attended the DPH weeklong case management training. Over half of the case managers received training in the DPH Standards of Care, harm reduction, risk assessment, Hepatitis C, substance abuse, and diversity. Just under half of case managers attended a training related to mental health. Case managers identified several content areas in which they did not feel sufficiently educated and would like additional training. These included: mental health; substance use and abuse; Hepatitis C; updates on HIV medications; assisting clients in coping with medication side effects; managing medical complications such as diabetes and high blood pressure; self-care, coping strategies, and grieving; and changes in benefits and eligibility for public programs, particularly MassHealth.

Nearly all of the case managers received administrative supervision, and eighteen received clinical supervision. Administrative supervision was variable across agencies, with some supervisors demonstrating superior skills and others having minimal knowledge of the program. Most case managers felt that the clinical supervision they received was very important and helpful. Where clinical supervision was not available or poorly received, case managers had little understanding of the role of clinical supervision.

Standards of care, data collection, and reporting
All of the case managers were familiar with the DPH standards of care, and most of the agencies were working hard to implement the standards and develop systems to track implementation. This was most evident in programs with strong administrative supervisors. Only two of the eleven case management programs reported caseloads to us that were consistent with caseloads reported to DPH and/or the BPHC. Case managers reported that they spent nearly half of their time on activities that did not involve direct client contact. Administrative paperwork was the most time-consuming job function, requiring on average 6.3 hours/week, or 16% of a 40 hour week.

Recommendations
- Implement triage or leveling models of case management.
- Define levels of care, and for Level 1 clients, change the Standards of Care related to minimum contacts and full reassessment to more appropriately reflect the newly defined level.
- Clarify expectations about the case manager's role in mental health and substance abuse assessment, risk reduction counseling and harm reduction, and provide necessary training and technical assistance to implement this role.
- Provide targeted training for administrative supervisors.
- Expand case manager training to encompass the areas in which they have identified needs.
- Empowerment and independence – this requires further thought and work to understand the barriers for case managers and develop the tools, guidelines and training to implement a paradigm shift.
- Purchasing strategies – cost reimbursement rewards the filling of vacancies regardless of caseload size or needs, and unit rates reward caseload sizes regardless of needs or

staffing capacity. Neither is perfect, but you need one or another as a base. In addition, consider differential rates for Level 1 and Level 2 clients, and incentive or special payments for assessments, reassessments, and empowerment/independence for clients who move from Level 2 to Level 1.

INTRODUCTION

The HIV/AIDS Bureau at the Massachusetts Department of Public Health requested this assessment of HIV case management services in Massachusetts to help the Bureau prepare for the re-procurement of HIV case management services across the Commonwealth. The assessment was conducted in the winter and spring of 2003 by the Health and Disability Working Group of the Boston University School of Public Health in collaboration with both DPH and the Boston Public Health Commission's AIDS Program. The BPHC, as the administrator of the Ryan White Care Act Title I program in the Boston Eligible Metropolitan Area, also funds HIV case management services across the Commonwealth. Thus, many of the programs included in this assessment receive HIV case management funding from both sources.

Some of the key issues of concern for DPH and the BPHC included:

- What is the variation in program models across the state?
- What kinds of services do case managers refer people to, and what takes most of their time?
- Do case managers have similar skill sets, education, or background?
- How are the issues of mental health, substance use and abuse, harm reduction, and risk reduction addressed?
- What are the client profiles of different agencies, and has this changed over time?
- Are case managers prepared or trained to address the diversity of client needs?
- Do programs and individuals understand, and do they implement the case management Standards of Care?
- Do case managers discharge clients, or work with them to achieve independence?
- What kind of supervision, both administrative and clinical, do case managers receive, and is it useful?

- What changes should DPH consider, as it moves toward re-procurement, regarding models, standards, payment strategies, and joint purchasing strategies with BPHC?

The following report describes the methods for conducting this assessment, the findings, a discussion of key points, and recommendations for consideration in the procurement process, as well as recommendations regarding ongoing program monitoring and case management training.

METHODS

Eleven agencies that receive Title I and/or Title II funds to provide case management services to HIV-infected individuals in Massachusetts were selected by DPH and the BPHC to participate in this study. This represents approximately 50% of the case management programs funded by DPH. Programs were selected to ensure diverse case management models and geographical distribution.

Two interview guides were developed for this study – one for case management supervisors and one for case managers. The guides were developed through a collaborative process between DPH, BPHC, the Health and Disability Working Group (HDWG), with additional input from the AIDS Housing Corporation and the DPH Consumer Advisory Board. The project team at the HDWG developed several drafts and revisions of the tool, which were reviewed and discussed with all involved groups. The final interview tools were approved by DPH and BPHC in December 2002.

To reduce the length of time needed to conduct each interview, several questions were sent to case managers for completion prior to the date of the interview. These advance questions were aimed at assessing caseload size, frequency of contact with clients, number of new clients per year, and case manager time allocation between administrative

and client service functions. HDWG interviewers collected the responses to these questions during the interviews.

Two to three staff members from the Health and Disability Working Group traveled to the 11 agencies to conduct the interviews. At each agency, one case management supervisor and two case managers were interviewed, for a total of three interviews at each of the 11 sites, and an overall total of 33 interviews.

To ensure the study captured a spectrum of experience levels and perspectives, we interviewed the longest-serving case manager and the most recently hired case manager at each agency, provided that the most recently hired case manager had been employed at the agency for at least a year. These criteria were established to avoid interviewing individuals who were not yet familiar with the process of case management at the agency and who might not be able to answer the survey questions. Two exceptions were made with agencies that did not have staff who met all the study criteria. In both cases, one of the case managers interviewed was employed for less than one year.

DPH and BPHC provided HDWG with additional background information related to each of the 11 agencies participating in the study. Sources of information included the results of case management chart audits, contract manager site visit reports, Title II consortia regional forum meeting summaries, and data from DPH and BPHC's Management Information Systems. HDWG staff reviewed this information prior to visiting each agency to become familiar with their programs.

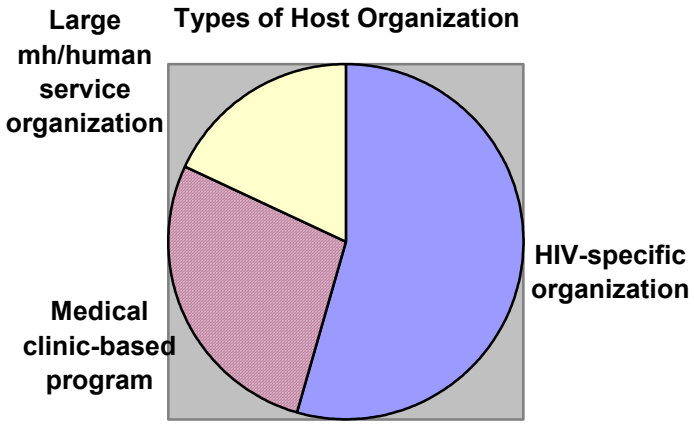
Upon completion of the interviews, all interview data was coded and entered into an excel spreadsheet to calculate frequencies and identify patterns. All sources of information were reviewed and analyzed by the HDWG project team through a qualitative assessment. A summary of the team's findings and recommendations follows.

RESULTS

Background Information and Organizational Context

Types of organizations

The eleven case management programs were housed in a variety of organizations. Six of the programs were located in HIV-specific community based organizations. HIV case management was the core service for four of these six organizations. For the other five organizations, HIV case management was a much smaller component of their organizational structure. These included three clinic-based programs and two programs based in larger mental health or human services organizations.



Case management models

All of the case management programs in this assessment were social service case management models rather than medical or mental health case management models. In examining the four major case management models described in the literature - broker, rehabilitation, full support and strengths models - the HIV case management programs in Massachusetts operated as a combination of broker and rehabilitation models. A core function of case managers was to help clients access services, primarily outside the host agency, as in the broker model. However, caseloads were not as high as described in the broker model, in part because of the complex needs of clients. Many of the programs assumed aspects of the rehabilitation model, which emphasizes using the relationship

between case manager and client as the route to obtaining services and increasing client functioning in the community.

Within this general context, three core models of case management operations emerged. Four of the organizations used some form of triage model, where individuals received an intake interview, and were referred to case management or other services/departments according to their needs. Another four programs accepted all new client referrals into case management, and maintained them in a full-fledged case management program for the duration of their affiliation with the organization. The last three programs were health center or hospital-based programs, where case managers functioned as part of a clinical team. In some of these programs, the volume of clients necessitated a default leveling system within the case management program, with some clients becoming formal case management enrollees and others receiving intermittent client services. In these programs, however, all clients were considered case management clients, regardless of the level of services they received.

Funding sources

All of the case management programs received DPH funding for case management, and for three of the organizations, this was the only HIV case management funding they received. Six of the organizations also received BPHC funding for HIV case management, and three organizations received other local or federal funding for case management. One organization supplemented its case management activities through private fundraising.

Other case management agencies

Six of the organizations reported that there were other, potentially competing case management organizations within their service area, while five of the organizations reported that they were the only, or main, case management provider in the service area. Competing case management services were mentioned in Boston, Cambridge, Worcester and Springfield.

Evolution of case management program over time

Most of the program administrators/supervisors talked about the shift in case management from helping people die in comfort, and responding to the crisis of dying with AIDS to the current situation where people are living longer. They have refocused their efforts to respond to quality of life and medical issues. Case managers now need to be more knowledgeable about medical issues, because these are more critical for clients in maintaining health and quality of life.

Several programs reported an increase in the mental health and substance abuse needs of their clients, and the need for better training in these areas. Several programs also reported more Spanish-speaking clients, and stressed the need for bilingual case managers. They noted the dearth of Spanish-speaking mental health clinicians and substance abuse treatment programs, and spoke about the difficulty of addressing the needs of Spanish-speaking clients because of the lack of resources. A few programs also noted an increase in younger people and women on their caseloads, and one program noted an increase in the number of people over the age of 50. Their older clients included people who were long term survivors of HIV as well as individuals newly diagnosed with HIV.

Several agencies reported that they have restructured their services to respond to changes in the epidemic. With more individuals presenting for services, they have implemented a triage or leveling process that channels identify individuals with intensive needs into case management services and individuals with intermittent or less intensive needs into a different level of care. This lower level of care operated differently at different agencies. For example, in one program, case management staff rotate through a walk-in or call-in program that addresses intermittent client needs. In another program, a separate staff person handles all intermittent requests for services. In a third program, case management staff have smaller caseloads, but split their time between case management functions and individual service assistance functions.

Quality Assurance/Improvement

Five of the programs described strategies to incorporate quality assurance/improvement into their work. The two strategies mentioned included annual client surveys and feedback from their Consumer Advisory Boards. As several case managers and supervisors noted, "We have a very active Consumer Advisory Board. Believe me, if there's a problem, we hear about it." However, other than these feedback mechanisms, few programs had a formal quality improvement agenda.

Keeping Appraised of Changes in HIV

Case management supervisors were asked how their agency and staff keep appraised of changes in the HIV epidemic. Nearly all of the programs reported that internal and external trainings, including conferences and update meetings, were the primary means of obtaining up-to-date information about HIV and issues related to the disease. A third of the supervisors also received publications, met with physicians, and or received email updates as a means of keeping current with developments in HIV care.

Impact of funding, future plans

Nine programs talked about the impact of recent funding cuts on their ability to provide services. None of them reported a direct impact on case management services, but most of them noted an ancillary impact[1]. Three programs reported a cut in complementary services such as emergency financial assistance, housing advocacy, or complementary therapies. Four programs mentioned that cuts to external referral services or MassHealth made it more difficult for them to provide referral services. The cuts in MassHealth were particularly acute for case managers who relied upon this funding source to help clients access medical care.

Two organizations reported that the budget cuts impacted internal operations, requiring a shifting of other responsibilities onto case managers. In one case, case managers needed to assume more of the data management and reporting functions because administrative support was eliminated. In the other program, case managers needed to take on more

[1] Note: As of March, 2003

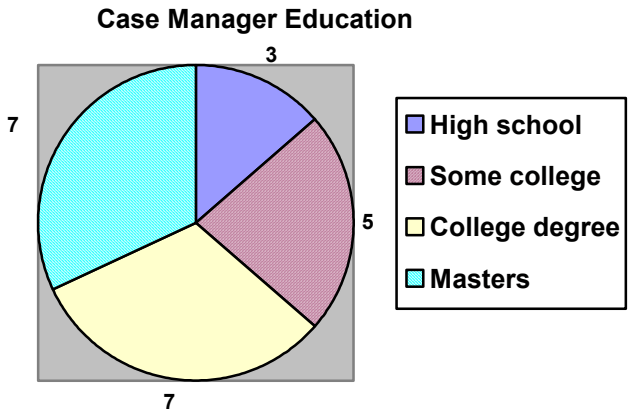
billable mental health clients which limited their ability to provide case management services. Finally, several agencies mentioned that they had eliminated vacancies in order to address the budget cuts.

Case Management Staff

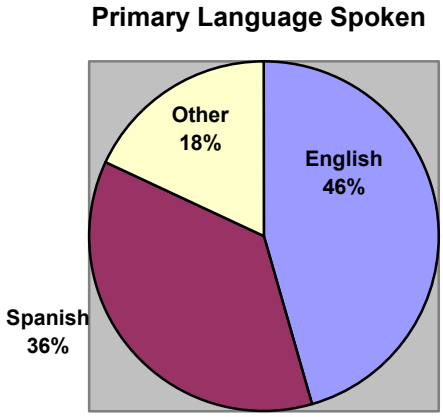
Case managers were asked about their level of education, previous work experience, primary language and length of time in the position. We obtained information from program administrators/supervisors about case manager salary ranges, and what the supervisors looked for in terms of skills, experience and educational level when hiring new case management staff.

Of the twenty-two case managers interviewed, 19 worked full time as case managers. A few case managers split their time with other duties such as handling phone calls for assistance, managing other clients service programs such as nutrition, and supervising other case managers. The majority worked and saw clients primarily in their offices, but one-third of the case managers spent at least one day per week at a partner agency. Most of these case managers provided off-site services in a medical facility and a few worked at other social service agencies such as day shelters or food pantries.

Among the case managers we interviewed, two thirds had a bachelors or masters degree, while the remaining 1/3 had a high school diploma or some college.



Over half of the case managers (55%) had a primary language other than English. Two-thirds of these were Spanish speakers. Haitian Creole and Portuguese were the other languages spoken.



The length of time case managers spent in their position ranged from 3 months to 14 years, with an average of 3.6 years. Their previous experiences varied, but most had some experience in human services. Almost one third had substance abuse counseling experience, 5 were masters level social workers or rehabilitation counselors, 5 had previous experience working directly with people living with HIV, and a few had been health educators in clinics. Two case managers started working as case managers and had advanced to become senior case managers.

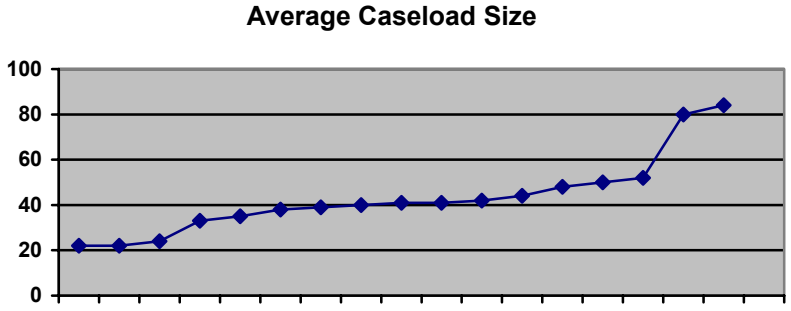
Years In Position	Number of Case managers
Less than 1 year	2
1 to 3 years	11
4 to 6 years	5
7 years or more	4

According to the supervisors, only one program required all case managers to have a masters degree and a second program required their most senior case manager to have a masters degree. Three other programs required either a college degree or 3-4 years of experience and the rest had no specific educational requirements for case managers.

Case managers' salaries ranged from the low $20,000's up to $40,000 with higher salaries for those in the Boston area. The average minimum salary was $26,700 and the average maximum salary was $30,700. Supervisors reported that their top priorities in hiring new staff were an ability to speak a language other than English and previous human services experience. Other important considerations were previous case management and/or HIV experience. Only one program said that they had difficulty hiring case managers because of the CORI regulations.

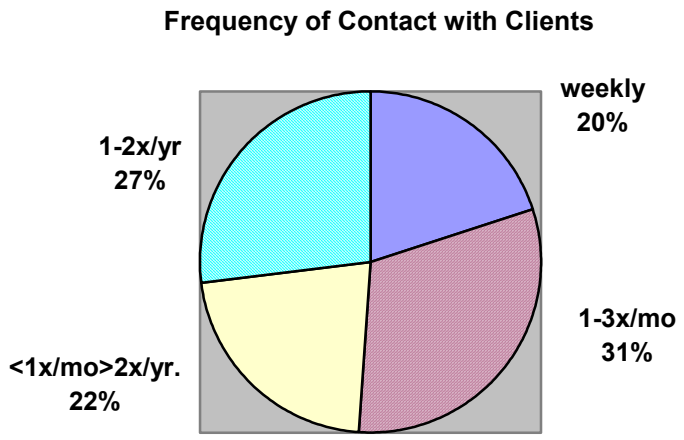
Client Profile and Needs

Case managers were asked to describe their client caseloads and level of client needs. Caseloads ranged from 10-255 clients per case manager, with a mean of 40 clients. The chart below shows the caseload distribution of all full-time case managers, with the exception of one individual who reported a caseload of 255 clients[2].



Case managers reported seeing half of their clients fairly frequently - on a weekly or monthly basis, and half of their clients less often than once/month. The chart below provides more detailed information about how often case managers saw or met with clients on their caseloads. More than one quarter of the clients who received case management were seen or spoken to only once or twice/year.

[2] This individual acknowledged, however, that she only had about 30 active clients.



Case managers described clients whom they saw weekly or monthly as being "less stable" or "not organized." These clients might be homeless, struggling with a serious mental health issue, unemployed, coping with domestic violence and/or monolingual (Spanish, Creole, or Portuguese). Clients seen or spoken with less than once per month or once or twice per year received "maintenance" services, such as help with paperwork for medications, health insurance, or fuel assistance.

Co-Morbid Conditions

Case managers were asked to report the percentage of their clients who had concurrent substance abuse, mental health, or serious medical conditions. Across all programs, approximately one-fourth of clients in case management had some involvement with substance abuse. Some clients were seeking treatment for alcohol or drugs, others might acknowledge a substance use problem but were not ready to address the issue, still others might deny or fail to reveal a problem, and finally, some clients were in recovery. Eight agencies reported that over 30% of their clients had substance abuse issues (with one agency reporting 88%), while the other 3 agencies reported fewer than 10% of the clients had substance abuse issues. The urban programs reported a higher level of substance abuse than the suburban or rural programs.

The majority of case managers believed that approximately half of their clients currently have mental health issues. Depression and anxiety were the most frequently reported

issues. Stress, anger, and other emotional issues were common concerns, and a few case managers reported seeing clients with more serious mental health illnesses such as bipolar disorder, narcissistic personality disorder, schizophrenia, dementia, paranoia, and hallucinations.

On average, almost half of the clients were also experiencing medical problems. Case managers reported Hepatitis C as the most common medical problem among their clients. Cancer, diabetes, neuropathy and side effects of medications were also common medical problems.

Services provided to clients

Case managers provided a wide variety of services to clients. They reported the number of clients that they helped to receive a specific service in the past year and then ranked the service referrals that required the most of their time. The services that case managers reported spending the greatest amount of time on included: housing, food, transportation, benefits and entitlements, and mental health services. Other services such as assistance with medications, attending and setting up medical appointments, and finding substance abuse treatment facilities also consumed much of the case manager's time.

The chart below shows the ranking of the amount of time spent on different referral services. To develop this ranking we used the following criteria:

- If the case manager listed the service as one of the top five activities that required their time or attention, or if they provided 20 or more referrals for this service in the last year, the service received a score of 2;
- If the case manager provided 4-19 referrals for the service in the past year, but it was not ranked as one of the top five activities the case manager spent time on, the service received a score of 1;
- If the case manager reported providing this service for 0-3 clients/year, the service received a score of 0.

The scores were then totaled across all case managers, with a maximum possible score of 44. The table below shows the referral services that case managers spend the most time on in rank order from top to bottom.

Referral Service	Time Intensity Score
Housing	39
Food	35
Transportation	34
Benefits	31
Mental Health	29
Medications	28
Medical Appointments	21
Legal Assistance	21
Substance Abuse Treatment	20
Moving	13
Immigration	12
Employment	9
Dental Care	8
Fuel Assistance	5
Transitional programs	3
Support Groups	3
Childcare	2
Shelter	2

It is interesting to note that with the exception of child care services, all the referral services from dental care to the end of the list were not part of the closed-ended questions that we asked. Dental care, fuel assistance, transitional programs, support groups and shelter referrals were mentioned by case managers as "other" services that they spent a significant amount of time on. It is possible that if these services had been on the closed-ended list, they would have ranked more highly as time-consuming referral services.

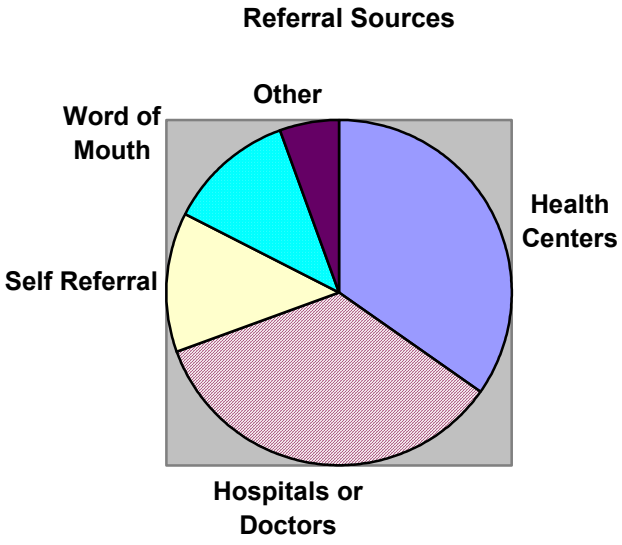
Service Gaps

Case managers were asked to identify services that were difficult to access in their area. Affordable housing was the most frequently reported gap in service with several case managers reporting that their clients had to wait 6 months - 1 year to get housing. Lack of dental care required case managers to spend significant time helping clients to locate a dentist or sending clients to Boston. Obtaining financial, legal, and housing services specifically for undocumented clients was also difficult, despite case managers' knowledge of programs. Day shelters and substance abuse treatment were other common gaps in service.

Process of Care

Referrals to Case Management

Approximately one in five of the case management clients were new to case management services in the past year. Most of these the new referrals to case management programs in the past year came from health care providers, 32% from community health centers and 32% from hospitals or doctors. Another 12% came from self-referrals, and 11% from word of mouth or friends. Very few came from outside agencies (5%), support groups, or HIV counseling and testing.



Four of the programs used a triage system for new referrals with the result that only some of the new clients were referred to case managers. In some cases, clients were assigned a "level," indicating that they could receive specific client services, but did not need case management. Criteria for assigning individuals to specific case managers included caseload balance (5 programs), language spoken (4 programs), and the match between the client and the case manager. For example, several programs had case managers with a background in addiction services and these case managers received most of the clients who were active substance users. In one program, the case manager with a background in addiction treatment had a slightly lower case load than other case managers. In one program each, assignment was based on the physician the individual client saw or where the client lived.

Use of Time and Resources

Case managers completed two charts prior to the interviews about the use of their time. One chart consisted of a list of job functions that did not necessarily involve direct contact with clients, such as paperwork, developing new resources, meetings, training, traveling, and reporting requirements. The other chart consisted of job functions that involved direct client contact such as assessment, service planning, talking, counseling, crisis intervention, taking people to appointments, and medical translation. We asked each case manager to indicate the average amount of time spent per week on each of these tasks, such that the total came to 40 hours or the number of hours worked per week. The chart below summarizes these results.

	Average	**% of Work**
Job Function	**Hours/Week**	**Week**
Paperwork	6.3	16%
Reporting requirements	2.3	6%
Developing new resources	1	3%
Internal meetings	3.5	9%
External meetings	1.2	3%
Training	1.2	3%
Outreach	1.3	3%
Travel	1.4	4%

Intake	0.9	2%
Assessment	1.4	4%
Reassessment	1.9	5%
Service planning	1.8	5%
Making referrals	2.3	6%
Talking with clients	2.8	7%
Talking about sexual risk reduction	1.3	3%
Talking about drug risk reduction	1	3%
Providing more formal counseling	1.4	4%
Crisis Intervention	2.1	5%
Taking clients to appointments	0.5	1%
Accompanying clients to medical appointments	1.3	3%
Accompanying clients to non-medical appointments	1.5	4%
Medical translation	1.2	3%
Other	0.5	1%

Interestingly, nearly half of the case managers' time (45%) was spent on activities that did not involve direct client contact. Administrative paperwork was the most time-consuming job function, requiring an average of 6.3 hours/week, or 16% of a 40 hour week. Internal meetings, including supervision, were the second most time consuming activities, at 3.5 hours/week. The third most time-consuming activity was talking with clients, at 2.8 hours/week. It is important to note that we asked about risk reduction and counseling as separate activities. Altogether, talking, counseling and risk reduction required on average 6.5 hours/week.

Although the average amount of time spent on medical translation, 1.2 hours/week, was fairly low, this average masks the inordinate amount of time that several of the case managers spent on this function. For example two case managers at different agencies reported spending nearly 6 hours/week providing medical translation services, and several others reported spending 3-4 hours/week. Similarly, although case managers on average spent 1.3 hours/week accompanying clients to medical appointments and 1.5 hours/week accompanying clients to non-medical appointments, only about half of the

case managers performed this role. For some of the case managers, this activity consumed 5-10 hours/week.

Intake, assessment, reassessment, and service planning, the core functions of case management monitored by the DPH reporting system, required an average of 6 hours/week, a little less than the amount of time spent on paperwork.

Resources and Referrals

Most of the referrals resources were maintained by the case managers themselves, or by their colleagues in the agency. Case managers shared resources amongst each other, and updated them as new needs arose or as agency staff turned over. In most cases, there was no other designated individual responsible for maintaining referral sources.

For the most part, case managers were able to describe the external agencies that they worked with for referrals to legal services, housing search, shelters, mental health services, substance abuse treatment, and other support services.

Mental Health and Substance Abuse

We asked case managers if they used a mental health screening tool. Many of them mentioned that their intake form included several mental health questions, but they were not certain if this constituted a formal screening tool. However, in two agencies, both case managers responded that they used a mental health screening tool. One of these agencies used licensed social workers as case managers and the other had a history of employing a clinical model of case management.

Approximately one third of the case managers reported that they used a substance abuse screening tool, again as part of their intake process[3]. However, only 30% of the case managers reported that they did any direct counseling themselves. Most were very clear that their job responsibilities might include listening to people, but not providing formal

[3] For the most part, this was not a specific tool, but a series of questions asked as part of the intake or assessment process.

counseling. If the client had a need for formal counseling, the case manager referred the individual for mental health services if the client was willing to accept this service.

In several cases, case managers who were also licensed to provide therapy explained that while they could perform this service, it was not part of their job responsibilities and they referred the individual out for care. However, among those who stated that they provided formal counseling, only half had the clinical qualifications to perform this function.

Risk Assessment

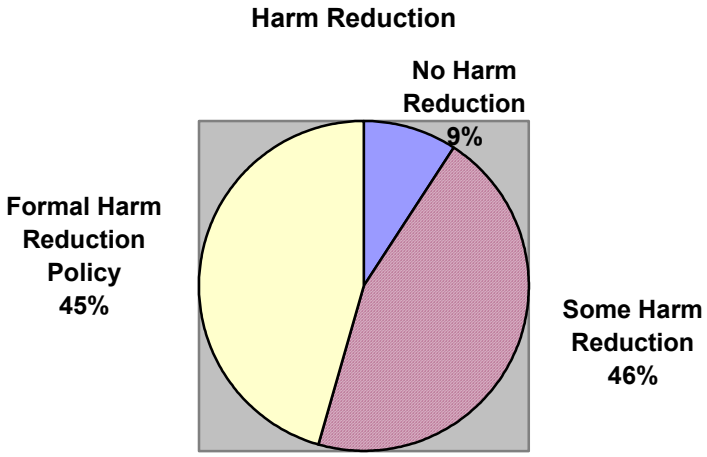
Only three of the case managers used a formal risk assessment tool. Interestingly, these case managers all worked for different agencies, and the second case manager in their agency did not report using a risk assessment tool. However, most of the case managers (77%) discussed risk reduction with their clients. Almost all of them talked about condom use, and some were comfortable talking about cleaning works and using clean needles. However, many of the case managers reported that this was often a difficult subject, and in the interests of building a relationship with clients, they let the clients bring up the subject rather than initiate discussion directly.

Harm Reduction

Some of the programs embraced a harm reduction approach to client care. Five of the programs had a formal harm reduction policy, but most of the supervisors acknowledged that they struggled with the implementation of this policy. For example, not all of the staff embraced this approach, or some case managers might understand harm reduction as it related to risk reduction – use of condoms or cleaning works – but did not understand how to incorporate harm reduction into their day-to-day interaction with clients around other issues.

Another five agencies reported no formal harm reduction policy, but said that they "met clients where they were at" and offered harm reduction training to staff (some only recently). Supervisors in these programs reported that individual staff had very different views, and that they needed to take this into consideration in their work. One of the

programs had no idea what harm reduction meant, and stated that they would not see anyone who was under the influence of drugs or alcohol.



We asked case managers if they used a harm reduction approach in working with their clients, and if so, how. Four of the case managers had little or no knowledge of harm reduction. The remaining case managers (18) were equally divided between those who exhibited limited knowledge and those who were able to provide examples or had received harm reduction training. There was a difference in harm reduction and knowledge between case managers whose primary language was English and case managers whose primary language was Spanish, Haitian Creole, or Portuguese. Case managers whose primary language was English were much more likely to provide examples of how they used harm reduction in their work than case managers whose primary language was not English.

Relationship to medical care/case conferences/outreach

Nearly all of the case managers reported that 95%-100% of their clients had a regular source of HIV medical care. Although they did not have formal systems to document medical visits, they knew people were receiving regular care because they worked in an HIV clinic and got all their case management referrals from the clinic, or because they routinely asked clients about their medications, CD4 counts and viral loads. In addition, nearly all of the case managers (82%) reported that they had relationships with health

care providers whereby the providers would ask them to help find someone who had missed an appointment or dropped out of care.

However, there was a wide variation in the number of times/year that case managers convened or participated in case conferences with medical providers. Half of the case managers reported that they participated in case conferences monthly or more frequently. Most of these case managers were clinic-based case managers. Among community-based case managers, 5 (23%) reported that they participated in case conferences 3-4 times per year, while the remainder (27%) said that they participated in case conferences seldom or never.

Standards of Care

All of the case managers were fairly familiar with the DPH standards of care, although a few of the newer case managers acknowledged they were still learning the standards. Although this assessment did not include chart audits, we asked case managers what they put in the client chart, in order to give them the opportunity to mention some of the DPH standards. All but one of the case managers mentioned client releases, the grievance policy, client rights and responsibilities, documentation of HIV status, and other documents required under standards of care without prompting.

In addition, nearly all of the case managers reported that they attempted to contact clients every six months for a reassessment. Most of the case managers had received training in the standards of care.

Discharge/Independence

Very few of the case managers (3) had a formal process to assess client independence, and only five of the case managers reported that they closed any cases in the past year for reasons other than death or moving. When case managers did close cases, this occurred within agencies that had an alternative option for client services for individuals who did not need ongoing care. One case manager reported that as her clients learned the English language and how to navigate the health care system, they no longer needed her ongoing

services. However, this was the exception, not the rule. Many case managers indicated that they strongly believed clients would need to access their services forever, and they did not discharge anyone.

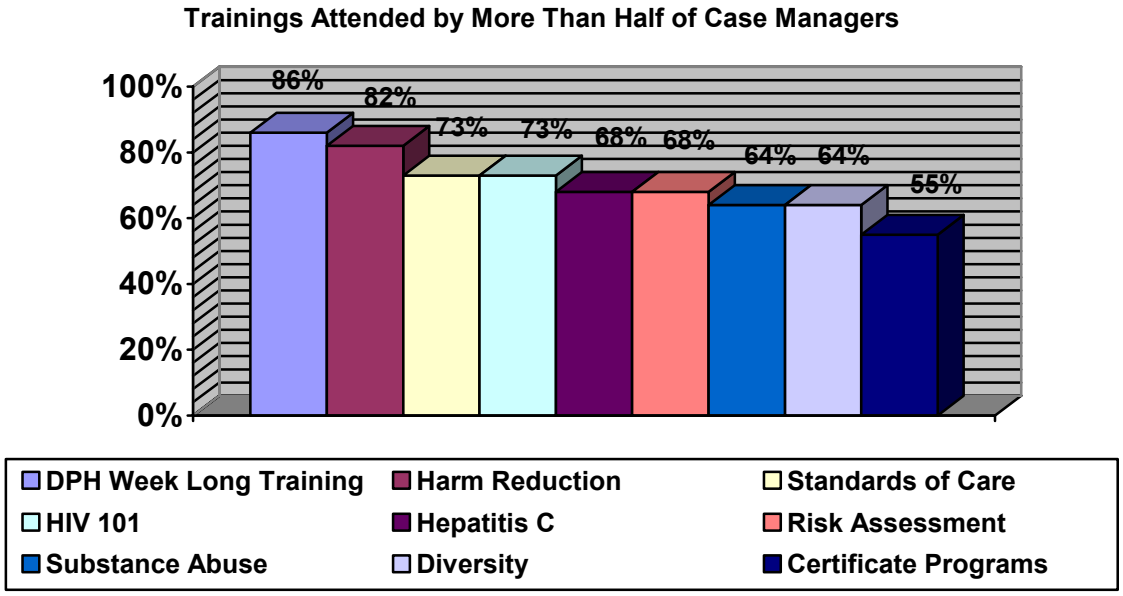
Case Manager Orientation and Training

Case managers were asked to describe the orientation or training they received when they first began their job. There is a distinction between orientation and training. We defined orientation as the process of familiarizing new staff about the functions of the agency and the day-to-day role and activities of case managers. Training was defined as an educational session about a specific content area related to HIV or the case management process.

Approximately three quarters of the case managers reported receiving orientation to the agency when they first began their jobs. The scope of this orientation ranged from a one-day overview of the agency's functions to several weeks of shadowing other case managers to learn the functions of their job. Other orientation activities included agency policies and procedures, confidentiality policies, case management paperwork and forms, data entry systems, information about resources within the community, and meetings with other case managers to learn about their experiences in their position.

The case managers who did not receive any orientation were employed by their agencies for an average of over 6 years. For the long-term case managers, it is possible that policies and procedures were not in place when they were hired because the concepts were new to the field, and therefore orientation programs were not offered.

Most (86%) of the case managers attended the DPH weeklong case management training sometime during the course of their employment at their agency. Other trainings received by more than half of the case managers included DPH Standards of Care, harm reduction, risk assessment, Hepatitis C, substance abuse, and diversity. Just under half of case managers attended a training related to mental health.



Training Needs

Case managers identified several content areas in which they did not feel sufficiently educated and would like additional training so they could better serve their clients. More than half of the case managers said they could use more training in mental health training. This is not surprising, given that less than half of the case managers had attended a training on mental health during the time they were employed as case managers.

What is interesting, however, is that when case managers were asked if they felt sufficiently trained to serve clients who struggled with mental health problems, 14 said that they felt able to deal with these issues appropriately. It is possible that this apparent discrepancy may be attributed to the receipt of training or education related to mental health prior to their employment with the agency. Nevertheless, there is a clearly identified need for additional mental health training among a large percentage of case managers, particularly on the interaction of psychotropic medications and HIV and mental health assessments so they don't "miss" a client who may need a referral to care.

Eight case managers indicated that they would like more training on substance use and abuse, specifically on the effects of "new drugs like party drugs," interactions between substance use and HIV medications, and the type and availability of substance abuse

treatment services. Despite the fact that many case managers had already received some substance abuse training, there was clearly a need for ongoing case manager education, as case managers acknowledged that they were not always fully prepared to recognize and address these issues.

Several case managers also identified a need for training on medical topics including hepatitis C, updates on HIV medications and medical issues, assisting clients in coping with medication side effects, and learning to manage other medical complications such as diabetes and high blood pressure.

Case managers also requested trainings related to self-care, coping strategies, and grieving. Those that reported this need issue felt very strongly that all case managers would benefit from such training. They spoke about the emotional difficulty of working with people living with HIV, particularly when working with difficult clients or coping with the death of a client. Case managers indicated a strong need for training in how to manage the stress of their work and how to create boundaries between their work and their personal life.

Several case managers also mentioned a need for training in the changes in benefits and eligibility for public programs, particularly MassHealth. Case managers expressed frustration with the cuts in benefits, and the constantly changing eligibility and benefit rules. They said it was often impossible to get answers to questions because the rules changed so frequently that the people responsible for administering the programs could not answer questions from clients or case managers.

Other training needs included discharge planning, harm reduction, motivational interviewing, risk assessment, and how to work more effectively with undocumented clients.

Supervision

Case management supervisors were asked to describe their backgrounds, education, and role within the agency. Of the 11 supervisors, 80% had a Masters degree, and half were bilingual, mostly Spanish speakers. The average length of time they had spent in this position was 1.9 years with a range from 2 months to 7 years. However, their average length of time with the specific agency was much longer, 5.5 years. Supervisors' previous experiences varied, but 8 of the 11 supervisors had been case managers before becoming supervisors. Seven of the supervisors had done HIV prevention work and/or medical social work and 3 of them had previous outreach experience.

Their role as supervisors varied widely. Most of the supervisors oversaw other programs in addition to case management. Some had more responsibility than others and participated in writing grants and agency planning. Most supervisors described their role as conducting internal meetings, representing the agency in external meetings, networking and overseeing reports, in addition to supervising case managers and conducting performance evaluations. A few case management supervisors spoke at length about administrative supervision and how they worked with case managers to understand, implement, and monitor the case management standards of care. The case managers in these agencies confirmed this oversight and expressed clear knowledge of the standards of care.

Only three of the supervisors had an actual case management caseload and a fourth supervisor conducted triage activities. The number of people they supervised ranged from 3 to 23, with an average of 8 people. The number of case managers they oversaw ranged from 3-5.

Case managers were also asked to discuss the scope of their administrative and clinical supervision. They indicated how often they received supervision, whether supervision was conducted individually or in groups, and what topics were discussed during this supervision.

Administrative Supervision

Approximately three quarters of the managers received 1 to 4 hours per month of administrative supervision on an individual basis, and nearly half received 1 to 4 hours per month of administrative supervision on a group basis. One third of the case managers received both individual and group administrative supervision. Two case managers reported that they did not receive administrative supervision.

The spectrum of topics discussed in administrative supervision meetings was broad. While some agencies primarily discussed policies and procedures, data reporting, chart audits, appropriate use of the standards of care and updates on the program, other agencies utilized administrative supervision as a time to discuss difficult clients, how to meet client needs, and how to identify new resources in the community.

Clinical Supervision

Two of the 11 case management programs did not provide clinical supervision to their case managers. In one agency, the clinical supervisor left the facility and the position was vacant for a year. At the time of the interview, a new clinical supervisor had just been hired and it was expected that this supervision would begin again soon. Case managers at this agency indicated that it was very difficult for them to go without clinical supervisor for so long because during that time there was no outlet for them to discuss difficult clients, overwhelming issues, and the general stress of their job.

The second agency that did not provide clinical supervision demonstrated no understanding of the role and purpose of clinical supervision. The case manager supervisor was a nurse and provided both the administrative and clinical supervision to case managers. Both the case managers and the supervisor indicated that clinical supervision consisted of chart reviews, discussion of new clients and difficult cases, note-taking, and how to serve clients more effectively. There seemed to be no mechanism through which case managers could discuss the stresses of their job. This agency also experienced high staff turnover rates.

The remaining 9 agencies provided clinical supervision for their case managers. All of the case managers received at least one hour/month of individual supervision, and eight of the case managers also received clinical supervision as a group. In 7 of these 9 agencies, clinical supervision was conducted by a LCSW or LICSW, and in the remaining 2 agencies, a licensed psychologist provided the clinical supervision. Clinical supervision meetings primarily focused on helping case managers deal with the stress of their job, discussing difficult clients, grieving, ethics, sexuality issues, harm reduction, and clinical approaches to their clients. Most case managers felt that the clinical supervision was very important and helpful. Several reported that they had access to additional clinical supervision on an as-needed basis, and that this helped them deal with stress and burn-out.

Staff Turnover and Burn Out

The average length of time case managers remained in their jobs, as reported by supervisors, was 3.6 years. The actual turnover rate, however, varied greatly between agencies. While some agencies did not have any case managers who had been employed with them for more than a year, other agencies had case managers who had all been on staff for at least 4 years. Although we requested interviews with the most experienced case manager and the most recently hired case manager who had been with the organization for over one year, we interviewed one case manager who was employed with the agency for only 3 months. The most experienced case manager was employed with the agency for 14 years. Several supervisors expressed concern about their high turnover rates, while several others did not have high turnover and therefore did not view this as an issue.

Almost half of the agencies reported that at least two case managers left in the past year, and three more agencies reported that at least one case manager left in the past year. The most common reasons for case managers terminating their employment included low salary, personality conflicts, burnout, lack of social service skills, lack of job stability and

funding, difficulty working with HIV clients and the complex issues they faced, personal/family reasons, and moving.

Challenges and Rewards of Being a Case Manager

As the interviews came to a close, we asked each of the case managers what was the hardest part of their job, and what they felt was most rewarding about doing this work. The case managers' responses revealed how deeply they felt about their clients and the importance of the work they did. They also pointed out how difficult it was to work in this environment, with individuals who have multiple, complex social issues and a life-threatening illness with all of its medical complications. Case managers are the people who listen to clients, and who try to help them access services, and who take great satisfaction out of making a difference, no matter how small, in someone's life.

In terms of the challenges, the most common response was "not being able to help someone" when services that a client needed were not available. And one of the hardest parts of the job was losing a client – either to death or to drugs – or helping clients and their families/partners cope with dying. Others spoke about the difficulty of juggling everything and not having enough time to do everything. Another common theme was the challenge of dealing with difficult behaviors, "client relapses, dealing with harm reduction, not being able to help or change people with self destructive behaviors, when clients do not follow through with simple things, when people do not take their medications and end up in the hospital, and when clients do not see for themselves what they have accomplished." Several people mentioned that they found it difficult to deal with verbal abuse or not being appreciated for what they try to do. Finally, several case managers mentioned that reporting to DPH or completing other paperwork, and being judged by numbers rather than their hard work, were the most difficult aspects of their job.

On the positive side, case managers found many rewards in their work. Nearly all of them mentioned that "knowing I have helped someone" or "seeing that what I did made a

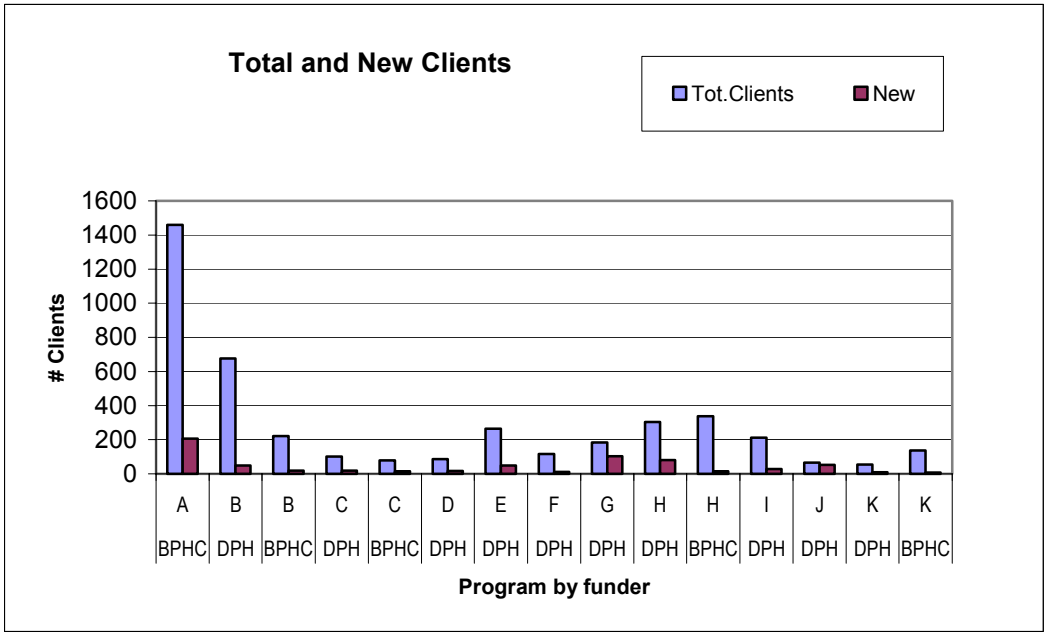
difference" were the most rewarding parts of their jobs. Another common reward was watching people grow, self-actualize, and achieve a better quality of life. As one case manager put it, "People may come to me in crisis thinking they are going to die any day. Six months later, they are on medications, they are taking better care of themselves, and they understand about the disease. They are not in crisis anymore, they are living." Others spoke about the one-on-one patient contact, the ability to make a difference just by listening, and getting to know the diversity of people living with HIV. Several individuals spoke about their satisfaction in navigating systems, putting things in order, and working with people in their communities. Finally, several case managers spoke about how rewarding it was to hear from a client, a co-worker, or a supervisor about the good job they had done. When a client says thanks, it has a powerfully rewarding impact.

Data reporting

To assess the accuracy of the data reporting systems for case management services, information reported to the DPH and BPHC management information systems (MIS) was collected, reviewed and compared to the total numbers of clients reported by supervisors during the interviews[4]. Four of the 11 agencies received funding from, and reported data to, both DPH and BPHC in fiscal years 2002 and 2001[5].

The following graph shows the number of total and new clients reported to both funders through their MIS systems.

[4] BPHC data corresponds to data reported to BPHC for FY 2001 (March 2001 to February 2002) and DPH data corresponds to data reported to DPH for DPH FY 2002 (July 2001 to June 2002).
[5] One agency was omitted from the BPHC analysis because their reported numbers were small.



The number of clients reported by programs A and B were much higher than those reported by other programs. These two programs have significant client services programs and may have been reporting some of their client services clients as case management clients.

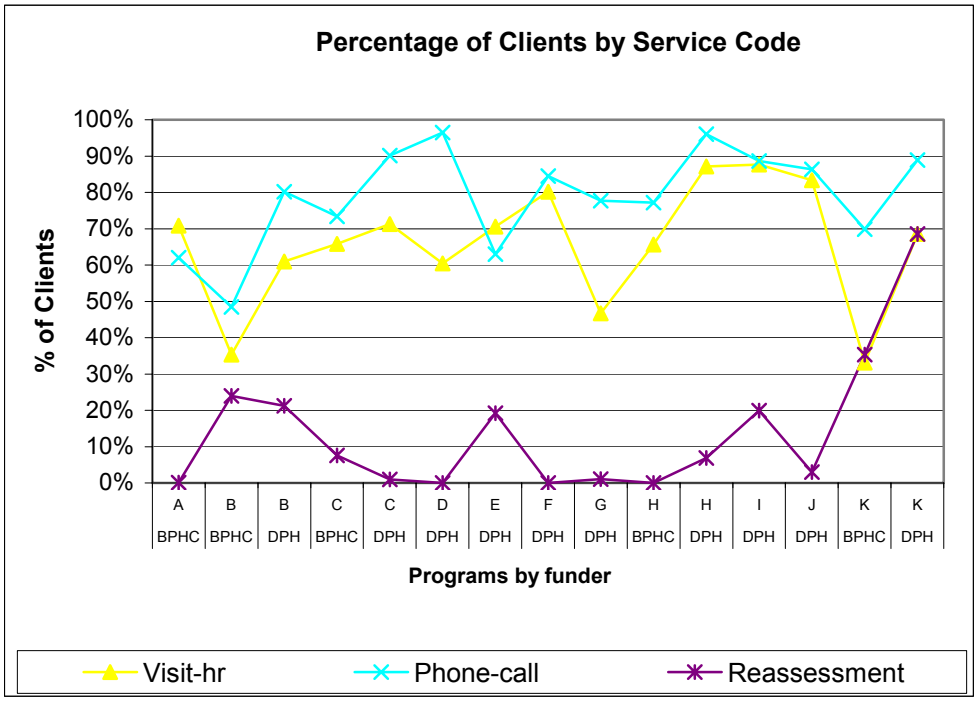
According to the Massachusetts standards of care, every new HIV case management client is expected to receive an assessment. The chart below shows the number of new case management clients and the number of completed assessments reported by the programs in the MIS system.[6] Based on the reported data, six of the agencies conducted assessments for fewer than 50% of their new clients (see numbers in italics).

Funder	Program	Assessments	New Clients
BPHC	A	217	-
BPHC	B	21	-
DPH	B	136	49
BPHC	C	14	-
DPH	C	16	19
DPH	D	*7*	*16*
DPH	E	*24*	*49*

[6] BPHC did not reported number of new clients in their MIS to HDWG.

DPH	F	*5*	*12*
DPH	G	*16*	*103*
BPHC	H	23	-
DPH	H	*26*	*80*
DPH	I	*5*	*28*
DPH	J		53
BPHC	K	10	-
DPH	K	7	10

The next graph shows that between 33% and 88% of the case management clients at the 11 agencies received case management visits and between 48% and 98% received phone calls. However, 7 of the 11 agencies reported that less than 10% the percent of their case management clients received a six month reassessment. Even when considering that 20% of an agency's case management clients might have entered care during the reporting year (thus not requiring a six month reassessment during that time period), these data suggest that reassessments are either vastly under-reported or under-conducted.



DPH uses several additional service codes in its case management reporting system. These are family visits/calls, provider visits/calls, home visits, financial services, legal services and case conferences. During the period examined only one of the ten providers reporting to DPH reported data on home visits, financial or legal services and case conferences.

Comparison of MIS Data to Interviews

The data reported to DPH and the BPHC through their MIS systems was compared to the information provided by the supervisors and case managers during interviews. The table below shows the results. In two of the eleven programs, the caseloads reported through the MIS were fairly consistent with caseloads reported in the interviews (in bold below). Some of the discrepancy may be due to programmatic or funding changes, as the supervisors were reporting current client caseloads and the data corresponds to the previous fiscal or reporting year.

Agency	**Total Clients reported in MIS System**		**Total clients reported by Supervisors**
	DPH	***BPHC***	
A	-	1460	2300
B	677	221	130
C	101	79	**180**
D	265	-	600
E	116	2	84
F	86	-	225
G	184		400
H	304	338	350
I	211		N/A
J	66		90
K	66	136	**200**

The data also show that two agencies reported approximately the same number of clients to both DPH and BPHC. Three programs under-reported their total case management

clients. This may be because the agency received funding for case management from multiple sources, but the numbers were only reported to DPH. Another possible reason for the inconsistencies might be an internal agency tracking system that manages both case management services and other client services such as food, transportation, or housing. Four agencies that received funding from both DPH and BPHC had inconsistent numbers suggesting that the numbers for client services were being combined with case management services when data was submitted to DPH or BPHC.

Finally, staff support for data management may also play a role in the quality of data reporting. In five agencies, data collection and management was part of the case management role. Six agencies reported having a separate staff member or department that assists with data management. The two agencies whose reported data was consistent with the information received in interviews were among this group.

Use of Service Codes

Case managers were asked if the service codes accurately reflected what they did, and if they had recommendations for additional codes. Half of the case managers expressed an issue or problem with the service codes. The remaining group either expressed satisfaction with the system or did not offer an opinion because another staff member was responsible for the data reporting.

Several case managers expressed concern that the current codes did not reflect the time spent with a client and captured the "minimal amount of work." For example, a case manager might spend 2 hours on the phone with a client and address several service needs but this activity was only recorded as 1 phone call. In addition, there were no codes to record the paperwork required to assist clients in obtaining services or for reporting activities to DPH/BPHC. As mentioned previously, case managers spent a significant portion of their week on paperwork. One case manager described the system as follows: *"…The codes show a minimal amount of work… I can be working on notes all day long and maybe not see a person or talk with a person, does that mean I'm not doing something?… I don't think it is accurate…"*

Another common issue was lack of specificity in the codes for their activities. For example, there were no codes for providing medication assistance, making referrals, providing food or housing, or serving as a translator. These are important activities in the role of the case manager and the current system is not able to track these services reliably. Where there was no code for an activity, case managers stated they would write up a description in the progress note but not report the activity in the data system.

A third issue was the lack of clarity about when to use certain codes. A few case managers selected two or three codes and used those codes consistently, such as phone call and visit, because they were not sure how to categorize the activity. For example, case managers rarely recorded home visits and case conferences, and these services were entered in the system as a general visit. Another case manager expressed confusion about when to code an activity for a client service versus case management. Several case managers suggested DPH/BPHC provide examples next to codes to improve the accuracy of reporting.

In general, it was evident from the interviews that that case managers were not aware of the purpose of the reporting system other than it being a requirement for DPH/BPHC. There was also a feeling among many case managers that data reporting was not their priority compared to working with clients. The supervisors were aware of the importance and necessity of managing the data and were working with staff to create more manageable and efficient systems. Agencies that had a staff member (either supervisor or assistant) assigned to handle the data and work closely with case managers had more consistent data.

DISCUSSION

As HIV has become, for most people, a long-term chronic illness rather than a short term death sentence, the major challenge for case management is to adapt to this new environment. While there are still some people who need support and services at

terminal stages of illness, the majority of individuals living with HIV need a different kind of support; support that helps them emerge from crisis, reduces harms in their lives and risks to themselves or others, maintains their health, and builds the relationships they need to achieve these aims. This is a complex paradigm shift for case management. It requires a new look at the goals of case management, the process of care, the relationship between case management and other services, and the roles and responsibilities of case managers. This paradigm shift also suggests that we look at some new philosophical approaches to case management, including the strengths-based or empowerment models that are used in other human services sectors.

Some case management programs have already begun to address these issues. They have "leveling" systems that direct some people at intake to client services while others are directed to case management. Or they have a walk-in capacity for individuals who need a single service, which is staffed on a rotating basis by individuals who also carry an ongoing caseload of individuals who have more complex needs. Another program brings all clients into case management, and helps them become familiar with the culture, the language, and the health care system until they are able to manage things on their own. In all of these scenarios, individuals living with HIV can transition in or out of case management based on the level of their needs, without being discharged from services or the agency.

Some programs we spoke with expressed strong disagreement with the "triage" model, and were very resistant to the concept of discharging people from case management. As several case managers put it, "People need to be able to know they can always come back here." That is one of their main arguments against a triage model. However, as noted above, the programs that use a triage approach do not discharge clients from services or the agency. Clients might not come back into full-fledged case management unless they need it, but they can always come back for services.

Furthermore, people who are considered "case management clients" have widely varying needs. On average, case managers see over one quarter of their caseload only once or

twice per year. Given limited resources for case management, it does not make much sense to require a full reassessment of every individual at 6 months, even if they have not needed any case management services during that period. Perhaps there should be one protocol for individuals who have used a certain amount of case management services during the six month period, and a second check-in protocol for people who have not needed services during that time.

The check-in protocol could be designed to determine if the person is likely to require case management services in the coming six months. If not, then the individual could be informed of the opportunities available to continue receiving client services as needed, and to rejoin the case management program if their needs become complex again. These individuals would be "discharged" from case management, but not discharged from services.

The case managers we interviewed were wonderful people, extremely dedicated to their clients and their jobs. Many would do anything for clients – take them places and help them fill out the same forms time and again. While it is certainly true that some individuals may need this assistance all of their lives, it is also very likely that many individuals can learn to do these things on their own after a little help. However, it appears that some of the case management programs are still operating under the approach that characterized HIV in the first 15 years of the epidemic, when case managers were mainly responding to crises and helping people die with dignity. The questions we asked about assessing clients' readiness for independence, or empowering individuals to manage their own care were often not answered. Very few case managers mentioned that they assisted clients in obtaining employment or employment counseling. Making the philosophical and practical shift from helping people die to helping people live requires a conscious effort, and is a major paradigm shift for many individuals in the helping professions. Yet a few of the case managers in some of the programs have begun to figure this out. DPH should consider working with these individuals to develop discussion groups and training for the broader case management population.

One of the greatest strengths of the case management programs we assessed was the cultural, linguistic and experiential diversity of the case management staff and supervisors. Many case management programs in other parts of the country struggle to achieve this level of diversity, and strict educational requirements for case managers often stand in the way of achieving this diversity. The Massachusetts Standards of Care do not require advanced degrees for case managers, nor do they include requirements for case managers to perform clinical tasks such as assessment of Activities of Daily Living or mental health crisis intervention that are required in other states. These functions are delegated to clinicians, allowing case managers to fulfill all the other very important support service and coordination functions that do not necessarily require advanced degrees. As long as the case managers receive clinical and administrative support and supervision from qualified individuals, as was the case in most of the programs we met with, they can continue to provide high quality services in a culturally relevant manner.

RECOMMENDATIONS

Triage or Leveling Models

Implementation of this model would require a number of changes for some of the agencies:

- An intake tool with clear guidelines to distinguish between individuals with short-term, specific needs and individuals with more complex or long-term needs;
- Staffing arrangements to accommodate individuals with short term needs (in some agencies this was a designated staff, in other agencies individual case managers performed both functions); and
- A 6 month check-in tool for individuals in either level of care who have not presented for services in the past six months, and a protocol for discharge to a less intensive level of care if that is the reason why the client has not presented for care.

This would also require a few changes to the DPH reporting requirements and in the messages that programs receive. For example, very few programs conduct any form of discharge. Perhaps if the term is changed to "transition," and refers to a less intensive

level of care, it will be less of a problem. In terms of reporting, DPH could place an equal value on reassessments and transitions. Another underlying issue with the concept of discharge is that many of the programs are anxious to be able to "count" all of their clients. However, the reporting and reimbursement systems could be set up to allow every program to count both their case management clients and their "client services" clients.

Empowerment

Promoting empowerment is a complex task and will require a process, some tools and training. Suggestions include:

- Convene a meeting of consumers and case managers to begin the discussion about how to promote empowerment, and to educate case managers/supervisors/funders about the aspects of care that do not promote empowerment;
- Develop specific tools and guidelines for assessing and promoting a client's readiness for more independence;
- Incorporate these guidelines into the Standards of Care;
- Develop and implement case manager and supervisor training around the tools, guidelines, and approach for promoting empowerment and independence.

Risk Assessment and Harm Reduction

While most of the case managers were comfortable talking about condom use, fewer talked about drug use. A common response to the question, "Do you talk with your clients about risk reduction?" was – "I do if they bring it up. But I try to meet people where they are at, and do not force a discussion. Some people just don't want to discuss this stuff." Thus it appears that initiating discussion with clients about risk reduction is viewed as being in conflict with the harm reduction approach of "meeting people where they are at." Training in harm reduction is needed across the board, as evidenced by the fact that more than half of the case managers either did not know what it was or could not provide concrete examples of how they used it. However, it is particularly important that this training be targeted to address the needs and thinking of other cultures. Case

managers whose primary language was not English were the least knowledgeable about harm reduction.

Suggestions for addressing this issue include:

- DPH/BPHC need to clarify the role of case managers regarding risk assessment and risk reduction.
- If DPH/BPHC determine that this is a role for case managers, then case managers need to be provided with risk assessment tools.
- Determine if every case manager should perform this role, or if only case managers with a certain level of education/training should perform this role.
- Provide intensive training that includes "how to implement" practice needs to be conducted.
- Incorporate harm reduction training into the week-long DPH case management training program.
- Provide refresher training on harm reduction, with a practical "how to" focus.
- Convene a planning group with Latino/a, Haitian, and Portuguese-speaking case managers to begin figuring out how to tailor harm reduction training and practice to different cultural environments.

Training for Administrative Supervisors

The supervisors we spoke with had a wide range of skills. Many were former case managers, and thus understood the case management process and resources very well, but did not have any previous supervisory experience. At the same time, several supervisors have developed strong systems for monitoring the standards of care; and others have developed creative strategies to minimize staff stress and prevent burn-out. Supervisors could benefit from sharing performance evaluation techniques with each other, and sharing strategies to address difficult personnel, client, and agency issues.

Recommendations include:

- Develop a training/networking program for new and ongoing supervisors.
- Consider using some of the current supervisors to provide this training.
- In addition to general supervision skills, incorporate specific training on implementing the Standards of Care, data reporting, and case manager orientation.

Audit for Clinical Supervision

Almost all of the case managers received clinical supervision, but for those who did not, this was a serious problem. It is important, in terms of program viability, stability, and the quality of care provided, that case managers receive this supervision on a regular basis. Recommendation:

- Prioritizing this standard of care in the contracting monitoring process.

Communication with medical providers

While most case managers reported that their clients were receiving medical care, there were no formal tracking mechanisms to verify this information. Apart from those case managers who were located in clinics, only a few of the community-based case managers communicated with medical providers on a regular basis (monthly or more frequently). Over one quarter of the case managers had no formal contact with medical providers to discuss client needs.

Recommendations:

- Begin a planning process to consider how to incorporate communication with medical providers into the reporting requirements and standards of care;
- As part of the planning process, convene case managers and medical providers to consider the confidentiality issues, best practices, and systems needed to make this work.

Data Reporting

DPH and BPHC need to clarify the purpose of the reporting system, for themselves, and for case managers and supervisors. And to reduce provider burden and confusion, the reporting systems need to be very similar. At the very minimum, the data need to reflect basic components of the service: intakes, assessments, reassessments, and discharges completed, and this needs to be matched with the number of new clients entering the system and the total client caseload of the agency. Some of the data being collected and reported to DPH/BPHC describes the type of interaction between a client and case manager (phone call or visit), but it fails to capture the support services for clients. One

of the major roles of case managers is to link clients with other support services such as housing, medical care, transportation, and food. While the DPH system collects some information on the content of service encounters, such as legal or financial services, few agencies appear to be using these codes. Case managers remain very confused about when to use what codes and how to communicate with different funders.

- Focus on using the reporting system to monitor compliance with the standard of care for DPH and BPHC case management services, including major training of supervisors/data personnel on how to do this.
- Collect information on services as an indicator of how case management improves HIV service outcomes, and more accurately reflects the case manager's role.
- DPH and BPHC reporting requirements should be completely consistent to minimize confusion.
- Data reporting should be audited to ensure that clients are not double-reported, or better yet, data submission should be merged and overseen by a joint DPH/BPHC data management system such that programs would only report once on all of their jointly funded clients.
- The next case management procurement should consider funding and a mandate for agencies to hire/assign a staff member to at least a 25% time position to work with case managers on data entry and management issues.

Additional Training

In addition to the training mentioned above in the areas of risk assessment and harm reduction, other case manager training needs to include:

- The linkages between mental health and substance abuse and HIV;
- Reinforcement of the role of case managers and the distinction between being supportive and providing formal counseling;
- Hepatitis C;
- Medical updates;
- Stress and coping; and

- Changes in MassHealth eligibility.

In addition, several case managers related that DPH used to convene statewide case management meetings, and that these meetings were very valuable experiences for case managers.

Quality Improvement Planning

With all of the other recommendations and potential changes mentioned above, quality improvement planning may be less important. However, it was striking that most of the programs had no formal process for monitoring or improving the quality of their case management programs. It is likely that many of the case managers and supervisors are not very familiar with the basic principles of quality improvement. This might be an area for additional training and some contractual requirements to initiate a process to identify a minimum of one area for improvement annually, and then to identify outcomes and implement change strategies that can be measured over the course of the year.

Purchasing Strategies

Future purchasing strategies need to consider programmatic objectives. At this time, all contracts are cost reimbursement, and therefore the main incentive is to keep positions filled. Alternative strategies include unit rate contracts, where programs are reimbursed on the basis of the total number of clients served, or the number of units of certain kinds of services such as face-to-face visits, intakes, assessments, phone calls, etc. In unit rate contracts, the incentives are to reward the volume of clients or specific visits. Both of these reimbursement systems are essentially process-based, and both have their weaknesses, but for provider stability, one system or the other needs to be the base of case management contracts.

However, DPH/BPHC may want to consider tying a portion of the reimbursement to specific programmatic objectives or client outcomes. For example, client outcomes might include the number of clients without insurance who obtain some form of coverage; the number of clients without stable housing who obtain stable housing, or the

number of people who present with mental health issues who enter some form of counseling. Programmatic objectives could include activities related to risk assessment, harm reduction, or transition of clients to a more independent role. These contracts would be more difficult to design and administer, but it is possible to tie a portion of reimbursement to some of these outcomes. The steps in developing such a system would be:

- Identify the core objectives desired, including the mix of objectives between client outcomes and program process;
- Determine the percentage of the contract that should be tied to a cost reimbursement mechanism or unit rate, and percentage that should be tied to performance outcomes;
- Establish systems to identify, report, and bill for performance outcomes; and
- Establish rates for the performance outcomes.