



Harris County
Public Health
Building a Healthy Community

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FY 2014 CASE MANAGEMENT CHART REVIEW REPORT

RYAN WHITE GRANT ADMINISTRATION

HARRIS COUNTY

PUBLIC HEALTH

(HCPH)

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Overview

PREFACE

In 2014 the Houston Eligible Metropolitan Area (EMA) awarded Part A funds for Medical and Clinical Case Management Services to five organizations. More than 7,200 unduplicated-HIV positive individuals are serviced by these organizations

Harris County Public Health must ensure the quantity, quality and cost effectiveness of both clinical and supportive care services. Positive Outcomes, Inc. was selected as the contractor to conduct the case management services chart review for FY 2014.

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Introduction

Positive Outcomes, Inc. was contracted by Harris County Public Health (HCPH) to provide an evaluation of Part A funded Medical Case Management Services funded by the Ryan White Part A grant. This grant was awarded to HCPH by the Health Resources and Services Administration (HRSA) to provide HIV-related health and social services to persons living with HIV/AIDS (PLWHA). The purpose of the evaluation project is to determine the extent to which medical and clinical case management services adhere to case management guidelines set forth in the Houston EMA case management service definition standards of care.

Tool Development

Positive Outcomes, Inc. worked with Ryan White Grant Administration (RWGA) and the Ryan White funded case management providers to develop data collection elements and processes that would allow evaluation of medical and clinical case management services based on the service definition and standards of care. Topics covered by the data collection tool include, but are not limited to, the following: case management assessment, service plan development, referrals, coordination of services, progress notes and case closure. See Appendix A for a copy of the tool.

Medical Case management services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and

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personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact and any other forms of communication. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPH/RWGA policies.

Clinical Case Management services identifies and screens clients who are accessing HIV-related services from a clinical delivery system that provides Mental Health treatment/counseling and/or Substance Abuse treatment services; assessing each client's medical and psychosocial history and current service needs; developing and regularly updating a clinical service plan based upon the client's needs and choices; implementing the plan in a timely manner; providing information, referrals and assistance with linkage to medical and psychosocial services as needed; monitoring the efficacy and quality of services through periodic reevaluation; 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 HCPH/RGWA policies.

A comprehensive review of client case management records was conducted for services provided between 3/1/2013 and 2/28/2014. The review period covers case management

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services in the Houston Part A program. The guidelines in effect during the time period the patient sample was seen were used to determine degree of compliance. The guidelines are detailed in the service definition above, and outlined in the FY 2014 Standards of Care. The current Standards of Care guidelines are available as well. The initial activity to complete this evaluation project was the development of a client record data abstraction tool that addresses elements to the guidelines, followed by medical record review, data analysis and reporting of findings with recommendations.

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Chart Review Process

All charts were reviewed by a Masters-level licensed social worker experienced in identifying documentation issues and assessing adherence to social work/case management guidelines. The chart abstractor has extensive experience conducting clinical chart reviews, specifically of the field of HIV case management. The data collected during this process is to be used for the service improvement.

The specific parameters established for the data collection process were developed through in-depth research of national HIV care standards and a series of working meetings between Ryan White Grant Administration, its service providers, the Houston EMA Clinical Quality Improvement (CQI) committee, and Houston HIV community advocates.

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<p>Medical Case Management</p>	<ul style="list-style-type: none"> • Clients are considered appropriate if one or more of the following conditions are met: • Newly diagnosed • New to HARRT • CD4<200 • VL>100,000 or fluctuating viral loads • Excessive missed appointments • Excessive missed dosages of medications • Mental illness that presents a barrier to the patient’s ability to access, comply or adhere to medical treatment • Opportunistic infections • Viral resistance • Clinician’s referral
<p>Clinical Case Management</p>	<ul style="list-style-type: none"> • Clients are considered appropriate if one or more of the following conditions are met: • Client is actively symptomatic with an axis I DSM-IV diagnosis especially including substance-related disorders (abuse/dependence), mood disorders (major depression, Bipolar depression), anxiety disorders, and other psychotic disorders; or axis II DSMIV diagnosis personality disorders • Client has a mental health condition or substance abuse pattern that interferes with his/her ability to adhere to medical/medication regimen and needs motivated to access mental health counseling or chemical dependency treatment.

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<p>Comprehensive Medical Case Management</p>	<p>Clients with substance abuse, mental illness and/or housing issues should receive intensive case management by a licensed case manager or have an active referral to a licensed case manager. Clients enrolling in intensive case management services should be placed on “open” status in the Centralized Patient Care Database Management System (CPCDMS).</p>
<p>Brief Medical Case Management</p>	<p>Clients who are not appropriate for intensive medical case management services may still receive brief medical case management interventions. In lieu of completing the comprehensive client assessment, the medical case manager should document each brief intervention in the progress notes. Any referrals made should be documented, including their outcomes in the progress notes.</p>
<p>Intake</p>	<p>A thorough intake is completed at the earliest convenience of the client, but no later than two weeks after initial contact. An RWGA-approved comprehensive client assessment form must be completed within two weeks after of initial contact.</p>

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<p>Case Management Assessment</p>	<p>The medical case manager will provide client information regarding the range of services offered by the case management program during intake/assessment. The brief or comprehensive client assessment as appropriate will include but not be limited to an evaluation of the client’s medical and psychosocial needs, strengths, resources(including financial and medical coverage status), limitations, beliefs concerns and projected barriers to service Other areas of assessment include demographic information, health history/status, sexual history, substance abuse history, medication adherence and risky behavioral practices adult and child abuse (if applicable) . An RWGA-approved comprehensive client assessment form must be completed within two weeks after of initial contact.</p>
<p>Case Management Re-assessment</p>	<p>For clients continuing to receive intensive medical case management services for more than six (6) months, the clients will be reassessed at six (6) month intervals following the initial assessment or more often if clinically indicated including when unanticipated events or major changes occur in the client’s life (e.g. needing referral for services from other providers, increased risk behaviors, recent hospitalization, suspected child abuse, significant changes in income and/or loss of psychosocial support system). Clients receiving brief assessment and interventions must be reassessed at least every six (6) months</p>

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Service Plan	<p>Medical case management service plan following a comprehensive assessment should be initiated at the time of the assessment. The plan will reflect the needs, choices, and goals of the client based upon their health care and related needs (including support services). The medical case manager shall develop the service plan in collaboration with the client and if appropriate, other members of the support system. An RWGA-approved service plan form will be completed no later than 10 working days following the completion of the client assessment. A temporary care plan may be executed upon intake based upon immediate needs or concerns). A new service plan is completed at each six (6) month reassessment. The case manager and client will update the care plan upon achievement of goals and when other issues or goals are identified and reassessed. Service plan must reflect an ongoing discussion of primary care, treatment and medication adherence, per client need.</p>
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Case Closure	<p>A client may be discharge from medical case management services for the following reasons. • Client becomes self-sufficient • Death of the client • At the client's or legal guardian request • Changes in client's need which demands services from another agency • Fraudulent claims or documentation about RWGA diagnosis by the client • Client actions put the agency, case manager or other clients at risk. Documented supervisory review is required when a client is terminated or suspended from services due to behavioral issues • Client moves out of service area, enters jail or cannot be contacted for sixty (60) days. Agency must document three (3) attempts to contact clients by different methods (e.g. phone, mail, email, text message, in person via home visit).</p>
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The Sample Selection Process

The sample population was selected from adults (age 18+) who accessed Part A or MAI medical or clinical case management services from one of four co-located adult case management and primary care providers or from the EMA's Part A-funded substance abuse treatment provider between 3/1/13 and 2/28/14. Annually, Part A funds support medical and clinical case management services for approximately 7,867 unduplicated clients. The case management charts (medical record) of 311 clients were reviewed, representing 5.29% of the pool of unduplicated clients. The number of client selected at each site was proportional to the number of case management clients served at the respective provider. However, providers serving a relatively small number of clients were over-sampled in order to ensure sufficient sample sizes for data analysis. In an effort to make the sample population as representative of the Part A medical and clinical case management population as possible, the EMA's Centralized Patient Care Data Management System (CPCDMS) was used to generate the lists of client codes for each site. The demographic make-up (race/ethnicity, gender, age, stage of illness) of clients assessing primary care services at a particular site during the study period was determined by CPCDMS which in turn allowed Ryan White Grant Administration to generate a sample of specified size that closely mirrors that same demographic makeup.

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Findings

Case Management Assessment Houston EMA medical and clinical case management standards specify that a comprehensive assessment must be conducted with the client no later than 10 working days from initial contact. Chart review finding indicate:

The review and observation period was between March 1, 2013 and February 28, 2014. The comprehensive assessments that were abstracted and automated include those assessments conducted in that period. Progress notes were reviewed from the period between March 1, 2013 and February 28, 2015 were reviewed to determine the date of the last medical visit and face-to-face medical case management visits. These measures help to determine if clients are lost to medical care and lost to medical case management.

Needs Require Comprehensive Case Management

EMA guidelines require that a client that exhibits unstable housing, mental illness that presents a barrier to their ability to access, comply, or adhere to medical treatment, and/or substance abuse that presents a barrier to their ability to access, comply or adhere to medical treatment, be enrolled in intensive or *comprehensive* case management.

Number of Brief Assessments in the Review Period, 3/1/2013 - 2/28/2014	Review Site							Total
	Access Health	HACS	Harris Health	Legacy	Montrose	St. Hope		
Number of Brief Assessments	0	# 29	14	67	11	20	32	173
		% 96.7%	42.4%	67.7%	15.7%	100.0%	58.2%	56.4%
1	#	1	19	30	55	0	23	128
	%	3.3%	57.6%	30.3%	78.6%	0.0%	41.8%	41.7%
2	#	0	0	2	4	0	0	6
	%	0.0%	0.0%	2.0%	5.7%	0.0%	0.0%	2.0%
Total	#	30	33	99	70	20	55	307
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

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Number of Comprehensive Assessments in the Review Period, 3/1/2013 - 2/28/2014	Review Site							Total
	Access Health	HACS	Harris Health	Legacy	Montrose	St. Hope		
Number of Comprehensive Assessments	0	# 29 % 96.7%	33 100.0%	89 89.9%	56 80.0%	8 40.0%	24 43.6%	239 77.9%
	1	# 1 % 3.3%	0 0.0%	10 10.1%	13 18.6%	8 40.0%	31 56.4%	63 20.5%
	2	# 0 % 0.0%	0 0.0%	0 0.0%	1 1.4%	4 20.0%	0 0.0%	5 1.6%
Total	# 30 % 100.0%	33 100.0%	99 100.0%	70 100.0%	20 100.0%	55 100.0%	307 100.0%	

Number of Service Plans in the Review Period, 3/1/2013 - 2/28/2014	Review Site							Total
	Access Health	HACS	Harris Health	Legacy	Montrose	St. Hope		
Number of Service Plans QM	0	# 29 % 96.7%	33 100.0%	90 90.9%	55 78.6%	8 40.0%	30 54.5%	245 79.8%
	1	# 1 % 3.3%	0 0.0%	9 9.1%	14 20.0%	9 45.0%	25 45.5%	58 18.9%
	2	# 0 % 0.0%	0 0.0%	0 0.0%	1 1.4%	3 15.0%	0 0.0%	4 1.3%
Total	# 30 % 100.0%	33 100.0%	99 100.0%	70 100.0%	20 100.0%	55 100.0%	307 100.0%	

Unduplicated Clients With Comprehensive, Brief, Both, or No Assessments in the Review Period, 3/1/2013 - 2/28/2014	Review Site							Total
	Access Health	HACS	Harris Health	Legacy	Montrose	St. Hope		

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Number of Clients With Comprehensive or Brief Assessment	No Assessment	#	29	30	68	30	8	23	188
		%	96.7%	90.9%	68.7%	42.9%	40.0%	41.8%	61.2%
	Comprehensive Only	#	1	0	9	12	12	21	55
		%	3.3%	0.0%	9.1%	17.1%	60.0%	38.2%	17.9%
Total	Brief Only	#	0	3	20	26	0	2	51
		%	0.0%	9.1%	20.2%	37.1%	0.0%	3.6%	16.6%
	Comprehensive and Brief	#	0	0	2	2	0	9	13
		%	0.0%	0.0%	2.0%	2.9%	0.0%	16.4%	4.2%
Total		#	30	33	99	70	20	55	307
		%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

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Highlights from FY 2014 Performance Measures

Clinical Case Management

- During FY 2014, from 3/1/2014 through 2/28/2015, 1,266 clients utilized Part A clinical case management. According to CPCDMS, 641 (51%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing clinical case management.
- Among these clients, 298 (24%) accessed mental health services at least once during this time period after utilizing clinical case management.

Local Pharmacy Assistance

- During FY 2014, 2,919 (92%) of Local Pharmacy Assistance Program (LPAP) clients increased or maintained their CD4 count.
- Among LPAP clients with

Medical Case Management

- During FY 2014, 5,053 clients utilized Part A medical case management. According to CPCDMS, 2,664 (53%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing medical case management.
- Among these medical case management clients, 548 (11%) accessed mental health services at least once during this time period after utilizing medical case management.
- Among these clients, 1,875 (37%) clients had third-party payer coverage after accessing medical case management.

Non-Medical Case Management / Service Linkage

- During FY 2014, 7,105 clients utilized Part A non-medical case management. According to CPCDMS, 3,528 (50%) 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, the average number of days between the first service linkage visit and the first primary medical care visit was 38 days during this time period.

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Oral Health Care

Among 20 diagnoses for HIV/AIDS-related and general oral pathologies with follow-up appointments during FY 2014, 20 (100%) had resolved at follow-up.

Primary Medical Care

- During FY 2014, 7,024 clients utilized Part A primary medical care. According to CPCDMS, 4,106 (75%) of these clients accessed primary care two or more times at least three months apart during this time period.
- During this time period, 5,321 (92%) primary medical care clients increased or maintained their CD4 count.
- Among clients whose initial primary care medical visit occurred during this time period, 272 (20%) had an AIDS diagnosis (CD4 < 200) during this time.
- Among primary medical care clients with viral load tests, 4,058 (80%) clients were virally suppressed during this time period.

Transportation

• Van-Based Transportation:

- During FY 2014, 424 (69%) clients accessed primary care after utilizing van transportation services.
- Among van-based transportation clients, 353 (58%) clients accessed LPAP services at least once during this time period after utilizing van transportation services.

• Bus Pass Transportation:

- During FY 2014, 984 (35%) clients accessed primary care after utilizing bus pass services.
- Among bus pass clients, 483 (17%) clients accessed LPAP services at least once during this time period after utilizing bus pass services.

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For FY 2014 (3/1/2014 to 2/28/2015), 1,266 clients utilized Part A clinical case management.

Primary Care and Mental Health Services	FY 2013	FY 2014	Change
A minimum of 75% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing clinical case management	641 (49.8%)	641 (50.6%)	-0.8%
Percentage of clinical case management clients who utilize mental health services	268 (20.8%)	298 (23.5%)	2.7%

According to CPCDMS, 22 (1.7%) clients utilized primary care for the first time and 74 (5.8%) clients utilized mental health services for the first time after accessing clinical case management.

For FY 2014 (3/1/2014 to 2/28/2015), 5,053 clients utilized Part A medical case management.

Primary Care and Mental Health Services	FY 2013	FY 2014	Change
A minimum of 85% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing medical case management	2,548 (55.3%)	2,664 (52.7)	-2.6%
Percentage of clients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits	2,379 (27.0%)		
Percentage of clients with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year	490 (19.8%)	664 (24.9%)	5.1%
Percentage of medical case management clients who utilized mental health services	611 (13.3%)	548 (10.8%)	-2.5%

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According to CPCDMS, 227 (4.5%) clients utilized primary care for the first time and 184 (3.6%) clients utilized mental health services for the first time after accessing medical case management.

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Summary

Overall, all case management and service linkage staff need to improve their ability to assess co-morbidities and expand their knowledgebase of the domain areas. In many cases clients were not being accurately referred or case managed by a Clinical or Medical Case Manager; in these instances, Service Linkage Workers were observed doing 'most of the work'. Service Linkage Workers need to shift the focus towards reviewing the 'problem list' and whether clients missed appointments. Incorrect data was entered under the cultural domain and there was confusion over what should be entered under each domain. Medical Case Managers were not handling the coordination of care and services as they should. During the observation period, it was difficult to determine what was occurring with the patients clinically. In several organizations, Brief Assessments were commonly completed by SLWs along with identification, referral, and case management and handling other aspects which require care coordination. Lastly, in some agencies there was sporadic data on whether patients had been 'lost-to-care'.

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Appendix A – Chart Review Data Collection Tool

MCM and SLW Chart Review Tool

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

/___/___/201___ / Client Case Status: Open/Active

Closed Unk Brief Assessment Date 1:

Comp Assessment Date 1:

Service Plan Date 1:

Case Closure Date:

Last OAMC Date:

Last MCM Date:

Brief Assessment Date 2:

Comp Assessment Date 2:

Service Plan Date 2:

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

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

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

-
4. Was the client reported to have any of these conditions? (Check ALL That Apply)

- Sexually transmitted infections (STIs)
- Pregnancy
- Homeless

SERVICE LINKAGE

5. How was the client assisted by a SLW in the observation period

- NA (Client not assisted by SLW)**
- Brief assessment

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- SLW referred client to OAMC
- OAMC visit scheduled by SLW
- SLW accompanied the client to OAMC visit
- SLW called client to remind about the OAMC visit
- Client did not keep OAMC appointment and SLW contacted the client
- Other SLW activity:

LOST TO CARE AND COORDINATION ACTIVITIES

6. Was the client lost to OAMC care? Yes No NA
7. Was there acknowledgement in the chart that the client was lost to OAMC care? Yes No NA
8. What activities did the **MCM** undertake because the client was lost to care? (Check all that apply)

- NA (Client not lost to care)**
- No activities documented to contact client lost to care
- Letter to client's last known address
- Telephone call to client's last known telephone number
- Telephone call to client's emergency contact person
- Referral to outreach program:

9. Did the MCM receive information from the program about the client's status? Yes No NA

a. Client status?

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

a. Evidence:

NEEDS REQUIRING COMPREHENSIVE CASE MANAGEMENT

CPCDMS Insurance Status: Uninsured

11. Insurance, Benefits, and FPL

Health Insurer

Medicaid

Medicare

Commercial Name?

Coverage?

Full? Managed Care? Share of Cost?

Medically Needy? QMB?

Part A? Part B? Part D?

SSA SSDI

Disability/Survivor Benefits

SSA Old Age (> 65 Years)

SSA SSI

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VA
Other Insurers Name?

Survivor Benefits (Widow, Widower, Child)
Commercial Disability/Worker's Comp

NEEDS REQUIRING COMPREHENSIVE CASE MANAGEMENT

CPCDMS Insurance Status: Uninsured

11. Insurance, Benefits, and FPL

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

CLINICAL CASE MANAGEMENT

12. Was the client referred for **clinical case management** services in the review period? Yes
 No Unk

If YES, was there evidence of coordination of services between primary care provider and clinical case management at least every three months in the client's chart?

- Yes, there is coordination of services
- There is no evidence of coordination of services
- Client refusal documented in client's record
- NA, client not referred to clinical case management services

CASE DISCHARGE/TERMINATION/CLOSURE

13. Was case discharged/closed case during the review period? <input type="checkbox"/> 1. Yes <input type="checkbox"/> 0. No <input type="checkbox"/> 8. NA <input type="checkbox"/> 9. Unk	Closure 1	Closure 2	Closure 3
Case Closure			
Client met agency criteria for closure?	Y N Unk NA	Y N Unk NA	Y N Unk NA
Date of closure noted?	Y N Unk NA	Y N Unk NA	Y N Unk NA
Summary of services received noted?	Y N Unk NA	Y N Unk NA	Y N Unk NA
Referrals noted?	Y N Unk NA	Y N Unk NA	Y N Unk NA
Instructions given to client at discharge noted?	Y N Unk NA	Y N Unk NA	Y N Unk NA
Reason for closure			
All goals met / no needs	Y N Unk NA	Y N Unk NA	Y N Unk NA

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Client continues no show, lack of follow-up	Y N Unk NA	Y N Unk NA	Y N Unk NA
Client refused service	Y N Unk NA	Y N Unk NA	Y N Unk NA
Client died	Y N Unk NA	Y N Unk NA	Y N Unk NA
Client lost to care	Y N Unk NA	Y N Unk NA	Y N Unk NA
Client moves out of service area	Y N Unk NA	Y N Unk NA	Y N Unk NA
Client incarcerated	Y N Unk NA	Y N Unk NA	Y N Unk NA
Unk, unclear, contradictory documentation	Y N Unk NA	Y N Unk NA	Y N Unk NA

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

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

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