

TECHNICAL ASSISTANCE CONFERENCE CALL "FAMILY-CENTERED CASE MANAGEMENT"

*Tuesday, September 14th, 1999
1:30 – 3:00 Est*

MS. BURR: As you all know from what you got faxed, what we are going to do today is start out with just a little overview of what it means to have family centered case management. And we have asked DeAnn Gruber to do that for us. And then we are going to talk about the different models that the three projects represented on the panel have used for case management. And this would be -- If you are on a speaker phone somewhere, this would be the time to hit your mute button so we can all hear it fairly well. DeAnn, would you like to start?

MS. GRUBER: Certainly. Thanks again for asking me to participate on this. And one thing I -- Just a real quick piece about doing conference calls and TA conference calls is the sense of not really having an audience to interact with. But I know that my audience right now, as I'm standing in my living room and I have my two dogs and my three cats, who, you know -- But unfortunately, I don't get much facial expression from them because they are -- sometimes their little vacant eyes look at me. But I want to encourage individuals that if I'm not making a point very clear to please -- you know, that we can come back to that point during this conference call. Because I think that's very important.

And I am going to just try to cover this in a very brief ten-minute time and proceed with that. When we look at family centered case management, I think one thing I really want to do is back up a little bit and just even talk about a little bit more general of family centered care for a minute or two. Because I think that as we approach family centered case management we need to really think about family centered care as being more global regardless of what type of services we are offering -- whether it's case management, primary medical care, mental health, et cetera.

And, you know, family centered care is not just one model. Instead, it's an approach or a philosophy that guides an organization in developing a partnership between families and professionals or providers. And that last piece I think is the real key point of family centered care, that we are trying to develop a partnership between families and professionals or providers.

The other thing about family centered care is that it's a dynamic and evolving process, one that must adapt to the culture, needs and history of a particular community. And it does take time. It's not something that's going to, you know, occur overnight and all of a sudden, you know, you have these very clear definitions. And you say, okay, if I then proceed with this in one month I'm going to accomplish family centered case management or family centered care. But it definitely is an evolutionary process.

And also, family centered care does not mean that an organization must offer every service possible for its family. Nor does it mean that you simply add consumers and stir. Instead, again, it's really an embracing of a philosophy or approach of how we look at services.

And then the last piece I want to say about it before I go into case management specifically is that it's a sense of really encouraging or a deliberate effort to enhance and build upon the strengths of both consumers and providers, allowing equal input -- and I want to emphasize again equal input -- in three important areas. And those areas are planning, the delivery or implementation of services, and the evaluation of services. And obviously, those three areas are not on a linear model where you have a beginning point and an ending point. But instead that's a cyclical model that you do your planning, your implementation and delivery, your evaluation. And based on what you receive during your evaluation process, you go back into your whole planning to improve your services.

So, with that, I want to then talk a little bit about just case management and to talk about some of the functions of case management. Some of those may be very familiar for individuals, but I want to lay this out to make sure that we're kind of all on the same page as we proceed with talking more specifically about models in a few minutes.

When you look at functions of case management, some places say, well, there are five functions. Others say there are ten or eleven. I'm going to quickly go through eight functions of case management as far as the different steps in a case management model and then tie that in a few minutes more into the family centered case management.

The first function of case management is the outreach and identification of clients. The whole aspect of a case manager networking with other organizations, ensuring that individuals and families are aware of the services available. So, the outreach and identification.

The second, which usually occurs during an intake process, is to conduct a thorough psychosocial and medical assessment looking at strengths and needs of a family. The third -- The third function is then, based on that psychosocial assessment and medical assessment, to create then a service plan. And that service plan is in many ways the blueprint of what is going to occur with services and linkages to services, where in that service plan it is also very clearly defined of goals, objectives, action steps, responsible person, and timeline. So, that it's something again that is very, very clear and understandable of what's in the -- what's in the plan.

The fourth function is linkages and referrals to services identified in the plan based on what's in that plan and then to follow through and to identify -- or to proceed with linkages and referrals. The fifth function is monitoring and follow-up. Obviously, if a family is referred to a housing resource that there's follow-up to ensure that the family was able to access resources or services and that those services were appropriate.

The next function is periodic evaluation of a service plan. And sometimes this can -- typically it may be a quarterly evaluation, every three months. It may be a little bit longer than that. But you want to be able to go back to that service plan, identify the progress made, and also to identify if some of the needs have changed with the family.

The next function is advocacy. Case managers have a role of being advocates on behalf of families to ensure that there resources and services available in the community that, again, are appropriate, that are accessible, and that adequately address the needs of families. And then the last function is termination or transfer of a case.

And so those very quickly are some of the functions of case management. When you look at family centered case management and you think of those different functions, you also then need to consider the families as being partners, of integrating families into the -- into that whole process. Unfortunately, there's -- I've seen where the more traditional approach may be that a case manager conducts a thorough psychosocial assessment, goes back to their office by themselves, they create a very elaborate service plan. And then the next week when they see their family again, they proceed and they go through and say, well, these are the needs and these are the strengths and these are the resources. And, here, why don't you sign on the bottom of this service plan to kind of say that, yes, I agree with these things.

And I think that with family centered case management there really needs to be the family involved in every step of that process, that when even in the process of the assessment that it's not seen as what are the needs and strengths of one individual who may be identified as being HIV positive, but also looking at the entire family and having a very systems approach. And that everyone has input to be able to, again, identify and to be part of the assessment. And then to turn that into a service plan that incorporates all of those needs and strengths and resources.

The other piece too, I think, when a case manager creates a service plan is, again, to make sure that the family is able to identify and say, these are my needs and these are my strengths and this is how I want to go about receiving services. And it's a very equal partnership, not one where there is only five percent input. But instead that it's very, very equal with both provider and with the family.

Another key element when you are looking at family centered case management is to also encourage and facilitate family-to-family support and networking. And I imagine that as we begin to talk about models in a few minutes some of this information may come through a little bit more clearly, but to, you know, be able to have families connect to one another for the support that they may need and to incorporate families in all levels of the program. Again, whether it's planning, whether it's the delivery of services, and certainly the evaluation of the services that are being received.

That, in a quick nutshell, is an overview of some of the functions of case management. And, again, I think as we begin to discuss models and some of these case studies we will be able to elaborate on that. Carolyn?

MS. BURR: Thanks. That was very helpful, I think. And, you know, when you talk about the sort of theoretical piece of it, it always sounds like, well, that's good but then what do I do. So, the next part of the conference call is the "then what do I do" part. And we're going to get three different perspectives with three different kinds of models. And none of those, if you were to transplant them into your project, would quite work there either because these are all projects that developed really based on the needs and the resources in their own communities.

So, let's start with Barbara Cuene out in Wisconsin and let her tell us about her project.

MS. CUENE: Thank you, Carolyn. I really appreciate this opportunity to talk about the program. We have a statewide program, which cares for the kids and teens throughout the state of Wisconsin. Sixty percent of the kids are in Milwaukee, but forty percent are in out state Wisconsin. So, the program was designed in a way to allow kids throughout the state to have access to state-of-the-art care right in their local communities so that the kids and their families don't have to drive five or six hours to get to Milwaukee.

So, to make that happen, the program was established around -- well, I can't say a triad -- I don't know what the word is, but when there is four people involved, where there is a primary care provider for the child in the child's local community. We have a nurse that provides intensive nurse case management, a social worker that provides a social work consultation, and then the HIV specialist that is Peter Havens in Milwaukee. We have two nurses in Milwaukee and one nurse in Madison, Wisconsin, so that the nurses are divided by region. So, patients have a nurse that's as close to their home as possible.

The work that we do with families is guided by a protocol for psychosocial care as well as for medical care. And it's supported by a psychosocial support program that we have as well. When a child is identified as having an HIV infection, typically that may happen -- For instance, our most recent child was identified in a local community hospital. He was about eighteen months old and they tested him because he had failure to thrive and it was positive. So, the nurse drove to that community that night to talk with the family, help get through that first night after hearing that the child has HIV infection and because of that the mom found out she had HIV. So, the nurse worked with the local primary care provider to get through that night so that the family had access to the support that they needed.

The next step was then in fact getting the mom into care and getting the baby into care. The nurse worked with the women's local HIV specialist and got her into care the next day. And then got the family hooked up to the local AIDS service organization, which provides support in terms of housing and many of the things that you're probably all very familiar with, food, et cetera.

The child was then seen down in Milwaukee -- we try to see the kids in Milwaukee about twice a year -- where we did a complete assessment, physical and psychosocial, and talked with the family about starting therapy. And actually developed a plan to start therapy on -- We don't like to start it usually in the middle of the week, we like to start it on Mondays. And we worked with the local nursing organization up in the child's community so that there would be somebody going into the child's house on a daily basis. Because the child was going to be started on proteus inhibitors.

So, a lot of the work is done in the child's local community with the nurses and the social workers traveling to the community or talking to other care providers over the telephone to ensure that the plan that has been established actually happens. Subsequent laboratory testing or things that actually have to happen like developmental testing or things like that, we try to, again, work in the child's local community to make that happen. And then yet to get the results back to the HIV specialist here in Milwaukee so we can review them. And that happens at least, at the minimum, on a quarterly basis.

What else? And then it's all complemented by a psychosocial support program that we got some funding for where a social worker works with the local AIDS service organizations throughout the state. And we offer family and

children -- what we call family information and networking days where families in each community can get together with other families and have a fun event. We don't emphasize HIV at these events at all. If it comes up, it comes up. But it's really to start families to start networking with each other if it's something that they want to have happen. And we have found that there are differences in the way families will accept those kinds of events throughout the state. So, we really have to work with the folks from the local community to plan an event that will work in that child's local community.

And I think I'll stop there. How was that, Carolyn?

MS. BURR: That was great, Barbara. Thank you. I think that was some nice examples of the kinds of approaches that DeAnn was telling us about. That was a nice example at the end of family-to-family support. Well, let's move from an urban/rural sort of decentralized model to a big city model and ask Alicia and Michael and Hal to talk to us about Circle of Care and how you do family centered case management there.

MS. BEATTY: Okay. Thank you, Carolyn. Just a brief backdrop for the Circle of Care. We are a consortia of thirteen programs. Three of the programs make up the case management component of the Circle. We receive funding from Title I, II, and IV to fund our case management and assistant case management services. We have three community-based agencies and two hospitals, which we fund directly for case management and assistant case management services. I'm going to ask Hal just to take a minute to talk about how we collect data for this service.

MR. SCHNEIDER: We have a centralized database that utilizes Microsoft Access. And all of the providers feed into that database electronically, using data entry programs which either gives the necessary data or they can use the data from their own systems and download it onto our information to adhere to our format. So, given that, everybody that feeds information, every encounter and every patient, is associated with a patient -- unique patient identifier. So, every patient has an identifier throughout the system, anybody who receives services.

Along with that is a family identifier. And that's the key of what my -- the next forty-five seconds of my talk.

MS. BEATTY: Thank you, Hal.

MR. SCHNEIDER: Wait, I'm not finished yet.

MS. BEATTY: You're finished. And now the real world is Michael Pollekia, who is going to talk about how it's actually done at Action AIDS West.

MS. POLLEKIA: Thank you, Alicia. Well, at Action AIDS West -- and Alicia alludes to the fact that we do have -- Action AIDS has a variety of offices. We have three offices in Philadelphia. We have one in North Philadelphia, our center city office, and the west Philadelphia office. I am currently at the west Philadelphia office.

And from this office I have approximately two-and-one-half case managers that work directly with two of our clinics. One is the Strawberry Mansion Health Center, which is in the Strawberry Mansion section of the city. And that's a community-based health center, it's a public health center. And that's where we will engage many clients. We work very closely with that health center and the social worker there, who identifies clients who are coming into the health center who are HIV positive and fairly medically needy. That was something that we have been able to identify, that those are the families that we tend to work best with. So, once the social worker at the health center identifies families that would be appropriate, she makes those referrals to our case manager, who then does the intake, a full psychosocial assessment, and basically starts to provide the case management services.

When she is at the clinic, she is also working very much in concert with other members of the professional team. And those people would be the drug and alcohol specialists, the doctor, the pediatrician. The doctor would be for the mother, the pediatrician obviously is seeing and attending to the medical needs of the child when children are coming in. The drug and alcohol specialist I said. The HIV educator, the nutritionist, and also the mental health therapist is also at the clinic. So, all of those professionals are working really in concert. They meet at the end of clinic, once all of the patients have been seen. They will meet at the end to just have a wrap-up session and make sure that everybody is on

the same page. If one or the other is seeing something that's perhaps important, that's an opportunity for the team to really discuss the situation and begin to incorporate a plan as to how they want to support the family. So, that's really how the situation works at Strawberry Mansion.

We also have one case manager who works with Children's Hospital here in west Philadelphia. And then I have another half of a case manager who also works with Children's Hospital. And they are going to do the same thing at Children's Hospital as what happens at the clinic. The mother and the child come into the clinic for their medical care. At Children's Hospital it's kind of -- it's really very interesting because the mother is seen by a physician that comes from the Hospital at the University of Pennsylvania. And the child is then seen at -- by a physician at CHOP. The case manager is on site to engage in kind of -- to engage the family and kind of address whatever kinds of needs that are coming up, as well as the nutritionist, the HIV educator, the therapist and all the other members of that kind of professional team so that their needs can be addressed.

The interesting things are I think that, you know, the hospital social worker or the clinic social worker is really identifying the needs for the client when they are in that facility. And then it's the case manager from our program that really is addressing the ongoing needs that occur when the client is not at the clinic. So, we are kind of picking up from that point forward.

The other thing that I think is really unique and very instrumental in our program is the implementation of the assisting case manager services. Both of the case managers, the one at Strawberry Mansion Health Center and the case manager at Children's Hospital, both supervise the assistant case managers. And they are basically going out into the home delivering practical in-home support to the family. So, they are kind of an extension of the case manager. They are really going into those families that are most needy, in terms of the furthest along I think in their medical condition and therefore having the most number of practical kinds of needs.

The assistant case manager is also very instrumental, I think, in helping to develop and maintain a relationship with the family. We have been very successful at utilizing the assistant case managers to develop those kinds of connections for us with families.

One of the situations that really comes to my mind recently was a woman who was being case managed but was actively in her addiction. And she had been really kind of withdrawing from the program. And we have an assistant case manager who is very good at being able to kind of put things out to people in a very kind of basic but really connecting kind of way. And I think we had just -- had gone out in the field and popped out. And I happened to bring the assistant case manager along. And she was able to develop a really nice -- very good connection, to the point that I kept sending the assistant case manager. And that was kind of my foot in the door which allowed us to ultimately begin to work the case manager into the situation and began to allow us to develop a trusting kind of relationship so that we could begin to deal with some of the linkages that DeAnn had talked about.

So, I'm trying to think if there was anything else that -- Well, basically the other thing that I just wanted to touch on too is just roughly, I think each case manager is case managing anywhere between thirty to thirty-five families. And then out of that, probably -- I would say anywhere from eight to fifteen of those families would probably be receiving assistant case manager services at any given time. The assistant case manager services kind of come in and out in a very kind of fluid on an as-needed kind of basis so that we can serve as many families as possible, as their needs kind of fluctuate and change. So, that's the way it works.

MS. BEATTY: Thank you, Michael. Let me just add one thing. You may wonder where -- how all the other families are seen. Most of the families in the Circle have a hospital-based social worker as the case manager on record. The case managers in our system see the neediest of the needy families.

MS. BURR: Thank you, thank you, Alicia. And, Hal, just so you know, one of the other technical assistance needs is around data. So, we'll get back to you on that. I think we would all like to hear more about that in the future. And then the final model is from DeAnn to talk about New Orleans and how they have applied the principals of family centered case management in the New Orleans program.

MS. GRUBER: Thanks, Carolyn. Children's Hospital -- The Title IV program in Children's Hospital in New Orleans basically has evolved over the last eleven years. When we first got started, case management was certainly always a component of the program, but I know that during the first few years of that the way that we were offering case management changed because of some of the changing needs that were coming up.

And one of those things that we definitely integrated was the aspect or the piece about case managing an entire family, that if we had an HIV positive child who came into our program, that the mother then also became part of the consumer/client family that was being offered case management, rather than having a case manager for a child and then another case manager for an HIV positive mother. And really trying to integrate that as approaching this in a holistic manner so that hopefully you would have a little bit more continuity as the assessment was being done and certainly as a service plan was being created.

With Children's Hospital -- I guess I need to back up one quick second. Although we are a program at Children's Hospital, we actually are not a primary medical care clinic that serves HIV positive children. Instead, our program at Children's is much more community based and we are located in a place other than the hospital. And the services that we offer to families are primarily psychosocial support services, including case management, health education, mental health counseling, child and respite care, developmental assessments, support groups, those types of things. The primary medical care in New Orleans for many of the families is offered at the public hospital, the state public hospital, charity hospital. And they have an HIV outpatient program that itself has developed over the past ten to fifteen years. So, with our program in New Orleans, the case managers actually are located, again, in a community based setting and also spend a lot of time at the HIV outpatient program as families go there for their primary medical care.

You know, the other piece I think that as this program evolved over the years is that, again, it was kind of identified as what are some of the differing needs of families. And to really incorporate input for families into their service plans. Initially, I think that, you know, it was like here is case management and this is, you know, a carte blanche type of model so here is what we can offer and that's it. But certainly over years it was identified that everybody doesn't need the same level or intensity of case management. And families may need very intense case management who have multiple complex needs. And so, there is a level of intense case management with many of those functions that I had gone through earlier.

A few years later we also developed then a second tier, which is what we term as "services only." And services only is a family that, you know, is referred to our program, an assessment is still conducted. But then it may be identified that this family, you know, what they really need is -- they are interested in attending a support group. Or they need some HIV education. It may be a foster parent with an HIV positive child and they need some education and perhaps some other type of support. But they do not need a very intense type of approach. And so, instead they are kind of put into a tier of services only. And with that, there is still regular contact with that family. The family is engaged in services. But a service plan is actually not -- not created for those families unless their needs change. And then at that point it's seen as they go into intense case management.

The other -- The final tier that was created in the New Orleans project is called -- it's minimal contact. It's families who maybe have come to our program, they have received some services, their needs have changed. And so, they want to remain in contact but do not necessarily again need to have regular home visits or engagements into all the different services. And so instead, it's seen as somebody who, you know, we will contact them on a regular basis and check in to see how things are going. If needs change, then obviously they can always be moved into another tier.

And so those are -- You know, that was a model that was created because, again, we saw that every family obviously does not need the same level of intensity or the same level of services. And so we just tried to accommodate that.

And then the last component I wanted to talk about with the case management piece in New Orleans is some of the real strong peer and consumer involvement that has involved over the years where -- And one specifically, several

years ago, about six years ago, the program began to create several positions, paid positions, for HIV positive consumers to be -- to apply and be a part of our program. And one of the -- two of the positions that were created were case management/client assistants. And these are individuals who have been receiving services for a while and now they are working as a partner with the case managers in the program. And they will go on home visits with case managers or go on home visits, you know, by themselves to see families. And they'll go to the clinic and spend half a day in the clinic to -- just to really provide some emotional support, some peer-to-peer networking, some experiential advice as far as how -- you know, how they have tried to address some of the needs that they had while living with HIV. And, again, to really just be a companion with individuals. And that has been a -- I think it has been a very strong component with our case management piece, to make sure that that has been integrated, that peer involvement has been integrated into the model. And, again, it is really seen as being equal partners.

So, that's a brief description of the case management model in New Orleans.

MS. BURR: Great. Thanks, DeAnn. Before we move to the case studies, I just wanted to check and see if we had -- some other folks have joined us along the way. Did we pick up anybody from the Memphis folks or Baton Rouge?

(No response).

MS. BURR: Well, maybe not.

MS. PLUNKETT: Carolyn, I had Vialog call them and all they got was their answering machines. So, I think they are on -- we just can't hear them!

MS. BURR: Okay. Well, we'll just move forward. Julie, am I right that just the speakers have the case studies?

MS. PLUNKETT: Correct.

MS. BURR: Right? Okay. We have three. And we are going to try to move through -- I think we can get through all three of them and still have some time for questions. These came from the projects themselves. So, let me read you the first one. And the panelists have had a chance to look at these, those of you in -- otherwise on the call will not have. But we are hoping that everybody will have some things they would like to contribute.

The first case study is CD, an 11-year-old little boy who is currently in foster care. He is classified as C-3, due to his severe immune suppression and symptoms, and has a history of failure to thrive and ear infections. He attends special education and has been classified with borderline intelligence. His mother is a 24-year-old woman with four children, two older and two -- four other children, two older and two younger than CD. And he is the only child who is HIV infected.

The family has housing problems and CD has complex medical care needs. His father is involved with his life, as well as his mother and his maternal grandmother. Mom has a history of substance abuse. She rarely keeps medical appointments for herself. This is a family with many problems. The child protective services has been called multiple times due to medical neglect. Mom would not bring CD in for medical care, would not give the medication as directed, and did not bring him for medical care when he was ill.

Most recently, CD was removed from the mother's care and the other children are with relatives. The reason he wasn't placed with a relative is because of a history of the relatives giving him back to his mother. They also didn't want to bring him to care when his mother was unable to.

So, panelists, how would you see family centered case management working for this child and his family?

MS. GRUBER: Carolyn, did you direct that to somebody?

MS. BURR: No, I didn't. I just directed it to the panel in general.

MS. GRUBER: Okay.

MS. BURR: But, DeAnn, -- Go ahead and start. One of the issues here, I think, is that this is a child in foster care. And I think that brings up some issues that we hadn't really touched on.

MS. GRUBER: Yeah. This is DeAnn. I think that -- That was one of the notes that I made, was related to, you know, the needs of that foster family. And really looking at what are some of -- (At which time, there was a brief interruption).

MS. BURR: Go ahead.

MS. GRUBER: -- what kind of education may they need, what kind of support do they need, to ensure that, you know, they can adequately take care of a child who is HIV positive.

MS. BURR: Would you, in your situation, would you maintain an involvement with mom once the child is in foster care?

MS. GRUBER: Is that specific, Carolyn, to --

MS. BURR: Yeah. DeAnn, would you all?

MS. GRUBER: Actually, yeah, we would. We would continue to offer services and engage the mother in care. Primarily to, you know, even for her own personal care, to try to ensure that she can seek medical care. And, also, you know, one of the issues that was brought up was substance abuse and to try to address some of those needs. And hopefully, you know, bring back -- bring unification, if that's appropriate.

MS. CUENE: This is Barbara.

MS. BURR: Yes.

MS. CUENE: And we also would maintain contact with the birth mother for the reasons that DeAnn mentioned. And then in addition to that, legally the mother still is the guardian for that child and still needs to give consent for care. So, it would be important to maintain that. And there have been a number of situations where we have chased one particular mother across the city trying to find her just to keep her updated on her child's care.

MS. BURR: Right. That may differ from state to state as to who ultimately has the decision making --

MS. CUENE: Oh, okay.

MS. BURR: I expect that's true for some of the folks on the phone and it may not be in other situations. It probably depends on whether -- you know, the status they are with the child protective services.

MS. POLLEKIA: Yeah. This is Michael in Philadelphia. We too would also work with the mother. We would probably also -- We would engage all of the parties in that system -- the foster -- Assuming that the eleven-year-old is our client, and the way that this scenario is written we'll go on that. So, we would continue to facilitate whatever his needs are while he is in foster care, but continue to work with the mother, perhaps identify whether or not reunification would be at all an option for this family, and work toward providing any kinds of additional supports that would be helpful in that end.

MS. BURR: Yeah. If he were not in foster care, if he were still with the family, for example, is that the kind of situation where you might use a case management assistant, Michael?

MS. POLLEKIA: Probably, yes. Because, I mean, with her not following through with her medical care and let's -- you know, just trying to assess what some of the obstacles are for her in being able to do that, sometimes the assistant case managers are very instrumental in helping to either remind mom of when appointments are or working out a schedule or maintain a calendar or actually escorting the client to the medical appointment or actually escorting maybe mom and the child to the medical appointment. So, depending on what the level of needs are, what the obstacles are, we would definitely use an assistant case manager in that situation.

MS. BURR: Right, right. Because if -- if I understood what you were saying, depending on where she went for care, you might be able to get mom's care and the child's care under the same roof on the same day.

MS. POLLEKIA: Exactly. Exactly.

MS. BURR: Right. And I think that's -- that's one of the things I think we have learned along the way that can be very helpful. Again, it depends I think on your community. Some places tried a sort of one-stop shopping and found it to be a barrier instead of something that helped because of their own local situation. But in a lot of places where they have been able to, you know, bring the mountain to the patient, that has been very helpful. And I know the Philadelphia project is one of those places.

MS. POLLEKIA: And the other thing about this situation too, that I think is really important and that we would probably try to -- I know the case manager would be instrumental in looking at -- is the strength in the other relatives. I mean, if the other relatives are engaged enough with the mother in terms of, you know, taking on the other children that she had, they may also be willing or -- I guess we would do a full assessment in terms of what they can do, how much support they can be to this particular mother and child.

MS. BURR: Right. Do other people have comments or questions about this case?

(No response)

MS. BURR: Okay. Well, let's move on to case study number two. The client is a 22-year-old woman diagnosed with HIV infection. The actual time of her diagnosis is not known. She has five children under the age of eight. She has not had HIV care for herself in several months. She lives in a neighboring state in our metropolitan service area and refuses to get treatment in her own community, but has agreed to seek treatment in a larger neighboring city. Both the client and her mother are alcoholic.

There are numerous community agencies and organizations involved with this family regarding allegations of neglect of her younger children's chronic illness conditions. The agencies include the Department of Human Services, the local police department, the local health department, and a local family health care center, which administers the Ryan White Title II fund.

There's a question in my mind as to whether that might be the Title III funds.

But in any case, the client is overwhelmed by all the agencies and the people involved in her care. She has a very limited education and comprehension skills and a very limited income. There is a male partner involved who allegedly is physically and mentally abusive at times.

The grandmother has custody of the client's older child. There is occasional conflict between the client and her mother. The client and her mother were evicted from their apartment. The client was initially referred to the Family Care Network by the local health department for support group information and referral. The grandmother is now hospitalized and the client is doing her best to keep up with the numerous medical appointments for her sick children.

Her six-month-old baby was constantly running high fevers, which made for repeat visits to the emergency room. She is dependent on others for transportation, which is unreliable. There was and still is no telephone in the home. Both the client and her mother have been unable to locate housing.

Well, this one sort of has a bit of all of the needs here. Does somebody want to tackle this around the issues and how family centered case management might be helpful to this family?

MS. CUENE: Well, this is Barbara. I can be brave and start. This family has a lot of needs. When I was thinking about the needs, one thing, first of all, the mother came to mind. And that isn't discussed in the case, but I would be wondering about -- she's a young woman, twenty-two, having five kids -- if there were sexual abuse, some kind of abuse with her as a child. And if that has ever been discussed and if that has some kind of implications in the alcohol that she is involving in right now. And so, I would want to explore that to see what kind of impact that would have potentially on where she is at in her own addictions right now.

And then the second thing that struck me was the number of people involved in the case. And to have one person like as the point person. I was one day in a client's house when I think she got three or four people coming to visit her and she didn't know who anybody was. And it was -- it struck me, being in her home trying to figure out who all those people are myself, that if we have one person that's trying to coordinate the rest of everybody else so that everyone -- so it's coordinated and not different organizations perhaps trying to do the same thing just not in a coordinated fashion.

So, I guess those were the two biggest things that struck me. And then finally, to me, housing is key. And if somebody doesn't have a house we can't do anything else. And so that -- that would be a huge priority. That's a little start.

MS. GRUBER: Yeah, Barbara. I think to -- you know, to piggyback on some of your points. I think that it's true that there are many multiple complex needs with this case. And as I'm just kind of making a quick list of them, it's pretty amazing as the list is growing. And through this case, I mean, even certainly a very brief type of description, but trying to identify any resources or strengths that come through in this particular case. And really then trying to identify are there -- is there any way to build upon any of those strengths. And I have to admit at this point I am glancing through this and I don't see a tremendous stuff that's described that has a strength related to it.

The housing issue --

MS. CUENE: The family is together yet.

MS. GRUBER: I'm sorry?

MS. CUENE: The family is there together.

MS. GRUBER: Well, the grandmother has the custody of the client's older child. And then the male partner, who I don't know if he is in or out, but he seems to, you know, be physically and mentally abusive at times.

MS. CUENE: Okay.

MS. GRUBER: I think the housing issue is a big one too, saying that they have been evicted from their apartment. I'd be curious to know where are they living right now then. Have they moved in with some other relatives or friends or are they living in a shelter. Because I think that is probably one of the first things to really try to address, to get them into some kind of a stable living environment for a period of time.

I also think your point about the coordination, since there are so many multiple players and many, many needs. I think the family centered case management approach is important to make sure that it's seen to try to coordinate the services rather than potentially duplicating them across different agencies.

MS. BURR: Yeah. I think one point both of you have made, but we just sort of haven't said it explicitly, is that I think the family centered case model -- case management model, is a model that builds on strengths rather than on

deficits. And so going into the situation, this is a tough case because there are not -- there is not a lot to build on here. But I think when there is, all of you have pointed out that that's where the interventions come, is to look for those. And I think some other models sort of miss that and forget to look for those -- for those strengths within families on which you can build.

Any other comments on this case?

(No comment).

MS. BURR: All right. Let's go to the third one and then we'll just sort of entertain some larger questions.

This client is a 26-year-old undocumented mentally challenged Mexican woman who is living in a local shelter. She has a two-year-old HIV negative boy under state custody in North Carolina where her parents also live but refuse to take care of the client or her baby. The client has a sister in the city where she is living, but she hasn't been helpful either. The client's goals are to regain custody of her son and to find independent housing.

Again, how would you start with family centered case management for this family? Michael, do you want to take that on?

MS. POLLEKIA: Actually, yeah. I can take a look at this here. Well --

MS. BURR: What kind of challenges, for example, does the fact that she is undocumented, what -- what kind of limitations or what kinds of things does that open up for you?

MS. POLLEKIA: Well -- I mean, the fact that she is undocumented, I mean -- I guess, you know, one of the challenges that we would immediately come up against would be just what her -- her own fears are. I don't think there is any real -- well, there are -- but she would have access to medical care and she would have access, at least here, to the real necessities. But things like shelter and if she was -- her being undocumented and, you know -- She would face the possibility of deportation and that kind of thing. So, that -- Trying to assess what her fear level is there, because she may not feel comfortable going to various agencies or services, accessing certain services for fear that they will deport her or have some obligation to do something about that. So, that's a major challenge I think.

And then in terms of -- I'm just looking here. This is a tough one because -- I'm not sure about how realistic her chances would be of her getting custody of her child.

MS. BURR: Yeah. I think that's an important part.

MS. POLLEKIA: We would probably be very -- I mean, certainly we would be seeking some legal advice for her and connecting her to available legal services in the city. And so that would definitely be occurring from the case management point of view. But she too doesn't look like she has a whole lot of support. She seems really estranged from the rest of her family. And her being undocumented here and with them not willing to take any kind of responsibility for her, I would think would put her on very, you know, shaky ground in terms of what -- whether or not she could stay here. That would also create a lot of fear, depending -- I mean, I'm assuming she would go back to Mexico then. And she may have a lot of feelings about the level of care that she could access in Mexico versus the kind of care that she can access here. That may be her reason or her -- you know, that may be her way to stay here, too.

MS. BURR: I think one of the other issues that -- that this raises, the case study doesn't say that she was a substance abuser at all. But I know that oftentimes folks who have been using drugs have kind of burned their bridges with their families. And it takes some effort to try to get families, larger extended families, back in the picture because families may, you know, have had some difficult times when the person was actively using.

Have you all had some success in getting more extended families back involved with folks who are either current or former drug users?

MS. POLLEKIA: I think we have. I think a lot of times just by virtue of the fact that, you know, we are coming in there with some additional support and some additional services, it's enough to kind of allow the family who has maybe been dealing with it by themselves and alone. It gives them a chance to kind of breathe and realize that they are not alone and they are not isolated in this situation.

MS. BURR: Right. They have got some other supports for them as well as for the family.

MS. CUENE: Right. I totally agree. The other service that may be helpful to her, I guess it depends on how mentally challenged she is, is we have been using some of the services available for -- I don't know what they call them in other states, but these are centers for independent living. They offer some of the women we have been caring for the education and support to help them learn to live on their own so that they in fact can leave shelters. They are group homes, but can live on their own. And while that may not help her get her baby back, one of her goals is independent housing. And that may be a resource.

MS. BURR: Barbara, are those tied in with welfare-to-work kind of funds? Or are they just freestanding?

MS. CUENE: They are freestanding.

MS. BURR: That's interesting.

MS. CUENE: I don't know how they are funded, though. And the whole undocumented thing though, after I said that I'm thinking about the undocumented piece. And I don't know what kind of impact that might have on that.

MS. GRUBER: It does have unique challenges.

MS. CUENE: But they have been really pretty awesome in helping some of our women.

MS. VALERO: This is Eda. I have a lot of experience with undocumented people here in Washington. I know that our legal assistance -- and I'm talking about from the community based perspective, not from HRSA -- work very, very hard at getting people -- getting them to become legal residents so that then they can have -- they can have the custody of their child. And apparently there is -- it's easier to do when they have a child who is already an American citizen than if the child were not. So, I mean, legally apparently it is possible. It's a lot more work for the community legal organization, but it's -- I've seen it done here in Washington.

MS. BURR: Well, how about questions from our colleagues out in Phoenix, Fresno, and Asheville? Things that you would like this panel to tackle for you?

MS. GONZALEZ: This is Robin in Fresno. And I heard one of the folks mention the number of case -- of families per caseworker. But I didn't -- I didn't hear that from the others and I'm wondering if I could get some info about that.

MS. BURR: I think Michael told us thirty-five.

MS. POLLEKIA: Yeah. Between thirty and thirty-five.

MS. GRUBER: Yeah. This is DeAnne in New Orleans. The caseload for case managers here is between actually twenty-five and thirty.

MS. CUENE: This is Barbara in Wisconsin. And the caseload for the nurses doing case management is about thirty to thirty-five in the pediatric world. In the adult world we are finding -- the one nurse that is doing women's intensive case management has about twenty-five patients and that's too many. I think it's about five too many for her.

MS. GONZALEZ: Thank you.

MS. VALERO: With so many patients and so many families per caseworker, how do you distribute your time along those families?

MS. BURR: Good question.

MS. GRUBER: I think for I -- You know, speaking for our program, the assistant -- again, because we have the additional support of the assistant case managers, they do -- they are out there sometimes several times a week working with our most needy families. So, that does take away some of the burden, I think, from the case manager in having to do a lot of the direct kinds of contact that might come up. So, that -- the assistant case manager is an incredible resource for the case managers in our program.

MS. BURR: I think another strategy that the existing programs found over the years was what DeAnn described about the tiers of services that were available to people. I think when you are a new program you -- you feel like you have to offer everything to everybody. And once you've been there a little while, it's clear that not everybody needs everything, and so you've got some flexibility. So, maybe you've got a case load of thirty-five, but they may spread themselves out hopefully through those kinds of levels of services that DeAnn described from people who don't need much to people who need a lot.

MS. GRUBER: Absolutely. Right. Right.

MS. BURR: And I think one of the things you would want to look at in your case manager load, is just to periodically review and be sure that somebody hasn't ended up with way more of the needy cases than somebody else just by happenstance.

MS. GRUBER: Yeah. I think that's true, Carolyn. I also -- As far as distribution of time, I also think that with case managers going to the clinic and actually being able to see families who come in for their clinic appointment, that potentially in a morning period they could see up to six or seven of their families who are there in one place, rather than spending a tremendous amount of time running around the city doing home visits, although they also do that of course as well. But at times, you know, that can be a very good period of time that they are able to accomplish an awful lot and see a lot of different families in the clinic.

MS. POLLEKIA: That would be very true for us as well.

MS. GRUBER: You know, I also -- to piggyback with what Philadelphia said, I think it's true too with the case management assistants that we have in our program, which sounds somewhat similar to what Philadelphia has, that has been a tremendous help with the case managers, too. Just to reinforce that.

MS. CUENE: This is Barbara in Wisconsin. One of the things that I found with the nurse that's working with the women is that someone needs to help her step back and look. Because I think this nurse cares so much that she would work until eight or nine at night. It's really important to have somebody support the staff doing the work, to help them realize that there are an endless amount of needs and we can't -- we can't do everything for everybody.

So, to have somebody that -- that's why we have team meetings so we can talk about stuff and really look at what it is that we're trying to accomplish within the resources that we have available.

MS. BURR: Yeah. I was struck by that as I read these cases too. Because one of my areas of interest and research is how do you keep people doing HIV work. And these are -- these three cases are extremely challenging. And I think you have to think about how do you keep your staff from feeling frustrated and feeling like there is really not much they could do.

And three or four things I wanted to leave you with on that. One is, I think, to help the staff frame the issues as situations they can learn from. Because not many of these three are things that you are going to solve very quickly. But the skills and the information that they gain along the way in working with these cases are going to help other -- other cases along the line. And as Barbara said, I think case conferences can be a really important way to do that. If you are -- If you keep the conversation focused on the case and on the resources and the approaches. And even to give people some theoretical understanding, you know, family assistance theory or various other kinds of theories that can help people have a framework in which to do the problem solving. I think that's an important way that people don't get overwhelmed, rather than letting case conferences kind of deteriorate into a gripe session either about the families or about each other.

Another thing I think we can do is to provide the kind of administrative support people need. So, you know, you've got the computer support or you've got access to things that lighten your load as far as paperwork and things like that so you really can spend more of your energy on the clients and less of your energy shuffling paper.

And to give staff a way to diversify their activities so that if your -- one of your staff members has particularly tough cases, you offer them some other outlets for their creativity -- you know, precepting students or giving a talk in the community or leading a support group -- so that they have some other ways to feel positive about the work that they are doing. And as Barbara said, to nurture that sense of a team so that there are people that you can share both the joys and the frustrations with.

And then the last thing I think is to help the staff realize how much the families have to teach them, how much they can learn from the families. And I think helping people look at the issues that way gives them a way to see what -- what they are getting from the situation as well as what they are giving to it.

Other thoughts on that, Alicia or --

MS. BEATTY: That sounds really good, Carolyn.

MR. GOMEZ: This is Carlos Gomez. And I have a question about loads.

MS. BURR: I'm sorry. About what, Carlos?

MR. GOMEZ: Case loads.

MS. BURR: Yes.

MR. GOMEZ: It sounds like everybody has around thirty-plus families, except for one. So, that could potentially be about sixty to sixty-plus individuals that the case managers are handling?

MS. GRUBER: Actually, yes. It's a little higher than that. Probably about a hundred to a hundred and twenty individuals they could be working with.

MR. GOMEZ: Okay. And do you keep a single file for the whole family or do you have to keep your paperwork for each individual?

MS. POLLEKIA: In Philadelphia here, we do identify one -- one person in that family system as the identified patient, so to speak. And there is one -- one file open on that person. Now, we would be addressing any -- you know, all of the issues that might be coming up in the family. But it's -- You know, so we are only identifying one -- one person in that chart. Does that answer your question?

MR. GOMEZ: Yes.

MS. CUENE: And that could be the child or the parent?

MS. POLLEKIA: It is a bit cumbersome, though. Yeah. It could be the child or the parent. We tend to -- I think if there is a choice between who will that be, we would tend to go with the person who is most advanced in their illness by virtue of the fact that that's where -- that would be the person that we would be able to access more services for. Does that make sense?

MR. GOMEZ: Yes. And actually, I have another question and that has to do with -- I'd like to hear about your experience with child protective services in each one of your cities or whatever. That's a -- you know, it's a fairly new phenomenon for us in western North Carolina for families who are involved with the child protective system. And, you know, how cooperative they are; what their attitudes have been to HIV affected families; and how have you all worked with them to educate people or to, you know, just get a good response.

MS. POLLEKIA: Yeah. We're still doing it here in Philadelphia. We've been -- I mean, that has been a very -- Actually, it's been a real learning experience I think for everybody involved, for both DHS and for us. Clearly, you know, we have a number of families where DHS is involved. And I think that they are -- You know, immediately there is a difference between what our expectations are of what that system can do. And here in Philadelphia that system is incredibly overwhelmed. And what we often encounter are really issues of neglect and that kind of thing, which is, you know, really hard. But the DHS system doesn't respond very well to issues of neglect when they have got real physical abuse that is occurring. So, that can be a real frustrating factor.

Another factor is I think the sensitivity that the system has to people with HIV and AIDS. You know, there are individual workers within the system that know a lot and are more sensitive than other -- than other workers. And so, some of our families have lucked out and have gotten decent, what I would say really professional progressive kinds of DHS workers. And then other families have not been so lucky and we have to really do some kind of advocacy within that system itself so that -- so that some of the issues that we are seeing are being addressed.

MS. BEATTY: But what DHS has done a good job at -- Michael, I hope you agree -- is the foster care issue with children that are HIV positive.

MS. POLLEKIA: Oh, absolutely right.

MS. BEATTY: The response was very immediate and it has been a system that has been working for us and with us for at least the last ten years that I have been running the Circle of Care. So, that is one thing that we really are proud of in Philadelphia, and that's the response for foster care.

MS. POLLEKIA: Right. I would agree with that.

MS. BURR: You know, in New Jersey we tackled some of the issues that Michael was describing sort of head-on in a couple of ways. One is that we have a couple of staff -- a nurse and a social worker -- in our, you know, in our clinical arm in the -- (inaudible) -- Center, who are sort of designated as liaisons to the child protective services. So, they know a lot about that system because they are -- you know, they are sort of the point people. And we get some funding for them from the child protective people. And it gives sort of an identified person who sort of knows what the other side of the street is like for the child protective workers to talk to.

We have also done a lot of direct training. And that's one of the things that those folks do I'm sure everywhere. Like, in New Jersey the workers turn over pretty quickly. So, the training is sort of endless but it's important to do. And you can -- you can raise the knowledge and understanding level of what the issues are around children and families and HIV by sort of doing a little in-service in an office for an hour or so, you know, once or twice a year just to get -- so that people at least have the baseline information around testing and management and so forth.

And that, I think has helped. We have a pretty good relationship with our child protective agency, which doesn't mean that we don't come down on different sides of issues, but we have -- the working relationship is there. And it's one that we have had to nurture over the years.

MR. GOMEZ: Thank you.

MS. GRUBER: If I could respond to his earlier question as well, about the file and the chart for a second?

MS. BURR: Yes.

MS. GRUBER: In the program in New Orleans we actually do have one chart that is for the entire family. And that chart has separate sections, so the chart may have like three separate sections for a mother and two children who are HIV positive or exposed. And so, it is certainly one single chart that you can have everything in one place, but they are also a little bit more delineated as far as having different pieces of information depending upon which information you are referring to for services and stuff.

MS. BURR: Other questions?

MS. SMITH: This is Angela from the Arkansas project.

MS. BURR: Yes.

MS. SMITH: And I was interested in knowing what is the level of training among the assistant case managers and the case managers that are -- (inaudible) -- program.

MS. POLLEKIA: Right. The case managers all have bachelor's degrees in either social work or psychology. So, they are all bachelors prepared. Some are masters. I have -- Yeah. One is a masters prepared social worker.

The assistant case managers have completed high school. And several of them have gone through some training. And then the Circle actually has provided some extensive training as well as the agency, extensive HIV training and in-services. So, they are --

MS. BEATTY: And let me just add to that. The training that Michael referred to was done under a SPINS grant. And we do have a curriculum that we would be very happy to share with you. So, Carolyn, I can get that to you if you want it.

MS. BURR: That would be great. We would be glad to duplicate it and share it.

MS. BEATTY: Fine.

MS. POLLEKIA: Yeah. Because that has a big impact in terms of what the assistant case managers are able to do in terms of their feeling confident to go into the family situation to help with the medications; to understand what the medications are; how they need to be taken; to offer some direction perhaps in terms of whether they should be taken with meals or without meals and how to do that; what kinds of foods to eat, what kinds of foods to stay away from. Assistant case managers are really offering a lot of that direct kind of, you know, information.

MS. BURR: In New Jersey, the AIDS Education and Training Center also has a pretty intensive course for case managers. So, you might see whether your ETC, you know, offers something like that as well. There may be things that are offered primarily for folks who are adult case managers, but that might be applicable to folks who are going to be working with kids and families, too.

Other questions out there?

MS. GONZALEZ: This is Robin in Fresno. I have a question about when you were talking -- I think DeAnne was talking about creating a service plan and the concept of integrating the families into that in equal input. And I was

wondering logistically how that works. Is that -- Do you normally have a meeting with the mother and the child is present or not present and when do you bring in extended family; that kind of thing.

MS. GRUBER: Yeah. Logistically, it is typically that following the psychosocial assessment, at the next meeting, with -- typically it is the mother or the primary caregiver. If it's an HIV positive child, it may be a grandmother or somebody like that, that the case manager does sit down with a form and then goes through and review the various things that were identified during the assessment. And then together, you know, they basically come up with what are the priorities and what are the needs that the family really feels like are important to address.

I think there is several things about service plans. You know, how many things are you going to identify during that -- during that -- especially the very first service plan that's being created with the family. And, you know, typically we really do -- I think some service plans, you know, all of a sudden you have this whole laundry list of twelve things that need to be addressed. And I think that we have taken the approach to really try to identify the top three or four, and especially those that are also really attainable. You know, certainly some are going to be very long-term, but to be able to identify the steps.

So, the process is really having a dialogue with the family to try to integrate their input and have some ownership with this service plan. I don't know if that -- Is that extensive enough to help you?

MS. GONZALEZ: That helps. Thanks.

MS. BURR: And I think, DeAnn, too, the point you are making that sometimes if you don't talk to the family about it, their priorities and our priorities are often not the same. Because we come to it from a very -- sort of a medical model, even though we may not intend to. And that may not be the family's priority.

MS. GRUBER: Right. Exactly. And I think, you know, the staff -- to really go through some good training with the staff -- as you're alluding to, Carolyn -- to try to shift some of the ways of, you know, bringing families into this process and stuff. Because it does take a while for a staff person to at times even feel very comfortable doing that.

MS. BURR: Right.

MS. POLLEKIA: I was just going to add, like using the case example number three, where the mother was the undocumented immigrant into the U.S. and she had -- she wanted to get reunited with her child. I think probably we would -- we would take an approach of since that's where she -- since that's a real goal of hers, that's something that she is clearly identifying -- how realistic that is, I don't know and I would be a little doubtful that it could happen. But the thing about that would be that if that's something that she wanted to pursue we would probably break that down into steps. In other words, I wouldn't make the goal being that she's going to be reunified with her son. But if that's ultimately what she is going to do, what are the individual steps that would possibly lead us to that final outcome.

MS. GRUBER: Exactly. And I think you bring a very good point of, you know, within that service plan, again, of having, you know, the pieces of goal, objective, action steps, who is going to responsible for doing these different action steps, and then a timeline to be able to, you know set that up so that you have something to work towards.

MS. BURR: And, you know, I think in this era where we are pushing more and more for pretty complex medical management of people with HIV infection, it's all the more important to find out where families are. Because you don't want to start a child on triple drug therapy and mom on triple drug therapy if they are not ready to do that. Because the risk of doing harm if they can't adhere to their medication regimen is pretty good. And so you just want to kind of see where the family is and start from there and move on toward the medical management piece of it.

And to be honest, that's not always going to be easy because your physician colleagues are going to be pushing hard to offer the best management for these children, which is absolutely what we want. But the question is, how do we -- how do we get that and sustain it over the long haul.

Other questions out there?

(No response).

MS. BURR: Well, maybe we will wrap up a few minutes early then, if we don't have any more. Again, I want to thank our panelists: Our mini-panel in Philadelphia, Hal and Alicia and Michael, we thank you; and Barbara in Wisconsin and DeAnne in New Orleans. And thank you all for being such good participants. We'll look forward to doing this again.

Our next technical assistance conference call for the new grantees, this group of grantees, has been postponed until early December. And, Julie, remind me what our topic is.

MS. PLUNKETT: Building a community network.

MS. BURR: There you go. Okay. But between now and then, on the 29th of September is a bigger TA conference call on mothering and HIV/A with what we feel is a pretty exciting group of panelists talking about the needs of HIV infected women and their uninfected children. And that's technologically a little fancier conference call where you actually call in and are already on mute and only the panelists can hear each other -- can talk to each other, that is, in the beginning. And then at the end there will be a question and answer period. So, if you haven't signed up for that and would like to or if you don't think you have the information on it, just give us a buzz at the Resource Center and we'll fax you that information.

MS. SMITH: I'd like to interrupt for just a brief moment. I was looking through my notes. And, again, this is Angela from the Title IV Arkansas project. And as I was going through my notes -- (inaudible) -- ask for information pertaining to the case managers and their level of training, but if I can -- if my recollection is correct, I do recall Philadelphia's program indicating that the assistant case managers were for the neediest of families?

MS. POLLEKIA: Correct.

MS. SMITH: I just want to make certain that I heard that correctly; is that true?

MS. POLLEKIA: Yes. But now, they are doing that in conjunction with the case manager. Okay?

MS. BEATTY: They really are an assistant to a case manager who is also involved with that family.

MS. POLLEKIA: They are a team. Right. So, they are working very much as a team in that family.

MS. SMITH: What about counseling experience? Do they have -- Do you all also go through counseling training for them so they can deal with those families?

MS. POLLEKIA: Right. Well, the Philadelphia EMA, the Extended Metropolitan Area, has -- the AIDS Activities Coordinating office offers kind of regular annual trainings and in-services to make sure that case managers have -- have basic standard information throughout the entire EMA. So, there is -- there is constant continuing kind of education requirements that are being developed and maintained by all of the AIDS services organizations.

MS. BEATTY: And, Michael, if I can just add to that, we see the case manager assistants as sort of the eyes and the ears for the case managers. Since they have the medical-based training, they are also able to be the eyes and ears for the physicians and the nurses at clinic. And they are a complementary piece to the case management team. They do not in any way try to do case management. But what they provide is emotional and practical support. Is that about right, Michael?

MS. POLLEKIA: That's perfectly said.

MS. BEATTY: Okay.

MS. SMITH: And how many case managers do you have and what about the assistant case managers?

MS. BEATTY: The Circle of Care funds three-and-a-half case managers and we fund a total of seven case manager assistants. Maybe it's -- I'm sorry. It's four case managers -- four-and-a-half case managers and seven case manager assistants.

MS. BURR: DeAnn, you talked about -- Oh, I've forgotten their title now.

MS. GRUBER: Ours are case management assistants.

MS. BURR: And lots of those folks, it sounded like, were HIV infected themselves.

MS. GRUBER: Yes.

MS. BURR: So, it's a kind of peer-to-peer support as well.

MS. GRUBER: Right. It's more of a peer -- peer advocate, peer support, working as a partner with the case manager as well. Plus doing home visits and emotional support.

MS. BURR: Right. So, a lot of similarities to Philadelphia except that these are also folks living with HIV.

MS. GRUBER: Right. Right.

MS. SMITH: Okay. Thank you so very much.

MS. BURR: You're welcome. Any other final thoughts from our HRSA colleagues or otherwise?

(No response).

MS. BURR: Okay.

MS. VALERO: I just want to say that I hope that for -- that this has been helpful and I'm sorry only that we don't have other participants of other new grantees participating. Because I think this is the chance that you guys have to clarify so many questions. I know you have -- (inaudible) -- run the program.

MS. BURR: I think also it taps you into resources and colleagues across the country like Alicia's training module.

MS. BEATTY: Well, can I just say that for us here at the Circle of Care, it really is a pleasure to be able to do this. Because there is really no reason to reinvent the wheel. If we can help you, any of you, in any way, we are just a phone call away. So, please feel free to give us a holler.

MS. SMITH: Is there any way that HRSA could provide us -- this is Angela again -- possibly with contact names and numbers? If we should have any questions, then we know who to contact.

MS. BURR: From this call?

MS. SMITH: Yes.

MS. BURR: Sure. We can do that from the Resource Center. We can send you a list of who the presenters were. And, Julie, did we tape this? Did we have this taped, do we know?

MS. PLUNKETT: Yes.... I should be able to send out the transcription within 3-4 weeks.

MS. GRUBER: The other thing I wanted to offer, Carolyn, is some of the -- just some of the beginning pieces that I talked about, the key elements of family centered care and case management, you know, I obviously pulled those partly from experience but definitely from a number of different resource books and manuals that have been very helpful over the years. And I would be happy to create a quick reference list if you want to send that out.

MS. BURR: That would be great.

MS. GRUBER: And they can then -- And some of these reference manuals we are all familiar with. I think they can probably get some of them from your Resource Center, Carolyn, or from ACCA -- (inaudible) -- and stuff. So, I'll put that together and e-mail it to you.

MS. BURR: That would be great. And I'll wait for that and get Alicia's training manual and we'll send that out to everybody as a little packet of follow-ups from this call. Good. All right.

Well, thank you, everybody. And, again, my apologies for the technological glitches at the beginning. But I think except for that it was a great call. And thanks to everybody.

(Conclusion of conference call).