Case Management (Non-Medical)

Introduction

Definition: Case Management is a multi-step process to ensure timely access to and coordination of services for a person living with HIV/AIDS and, in some cases, his or her family/close support system.

Case Management includes the following processes: intake, assessment of needs, service planning, service plan implementation, service coordination, referrals, linkage, monitoring and follow-up, reassessment, case conferencing, crisis intervention, and case closure.

Case Management activities are diverse. In addition to assisting clients to access and maintain specific services, Case Management activities may include negotiation and advocacy for services, consultation with providers, and navigation through the service system, psycho-social support, supportive counseling, and general client education.

Goals: The Goal of Case Management is to promote and support independence and self-sufficiency. As such, the Case Management process should be based on strength based, client-centered approach that requires the consent and active participation of the client in decision-making, and supports a client's right to privacy, confidentiality, self-determination, dignity and respect, nondiscrimination, compassionate non-judgmental care, a culturally competent provider, and quality Case Management services.

The intended outcomes of HIV/AIDS Case Management for persons living with HIV/AIDS include:

- Early access to and maintenance of comprehensive health care and social services.
- Improved integration of services provided across a variety of settings.
- Provide seamless transition between Supportive and Comprehensive Case Management.
- Enhanced continuity of care.
- Prevention of disease transmission and delay of HIV progression.
- Increased knowledge of HIV disease.
- Greater participation in and optimal use of the health and social service system.
- Reinforcement of positive health behaviors.

- Personal empowerment.
- An improved quality of life.

Key activities include:
- Assess each client's current situation and needs, as well as what services they are currently utilizing, in order to refer or assist appropriately.
- Screen client eligibility for all public and private benefit and entitlement programs such as Ryan White funded services, Aids Drug Assistance Program (ADAP), Medi-Cal, Social Security, State Disability, Unemployment, General Assistance, Veterans Benefits, etc.).
- Develop a comprehensive, individualized care plan.
- Coordination of services required to implement the plan.
- Client monitoring to assess the efficacy of the plan.
- Periodic re-evaluation and adaptation of the plan as necessary over the client's enrollment.
- Educate clients on community resources available, and refer and/or assist clients with accessing them as needed.
- Follow-up on referrals, linkages & outcomes including proper documentation. Assist clients who have existing benefits and provide advocacy as needed.

The Case Management can be of two different pathways: **Supportive or Comprehensive.** These two pathways provide different levels of service geared to the needs and readiness of the client.

Supportive Case Management:

Goals: The Goal of Supportive Case Management is to meet the immediate health and psychosocial needs of the client at their level of readiness in order to restore or sustain client stability, and to establish a Supportive relationship that can lead to enrollment in more comprehensive Case Management services, if needed.Supportive Case Management is responsive to the immediate needs of a person living with HIV/AIDS. Supportive Case Management is suitable for

- Clients with discrete needs that can be addressed in the short term.
- Clients who have completed comprehensive Case Management but still require a maintenance level of periodic support from a case manager or Case Management team at a minimum during the 6 month recertification.
- Clients with multiple complex needs who may best be served by Comprehensive Case Management, but who are not ready or willing at this time to engage in the level of participation required by the Comprehensive Case Management pathway. In this case, Supportive Case Management

serves as a means of assisting an individual at his/her level of readiness, while encouraging the client to consider more comprehensive services.

Central to the Supportive Case Management pathway is *follow-up* by the case manager or team to ensure that arranged services have been received and to determine whether more services are needed. Clients in Supportive Case Management experiencing a repeat cycle of the same crisis or problem should be encouraged to enroll in comprehensive Case Management services, either onsite or offsite, and assisted in attaining these services.

Comprehensive Case Management

Goals: The goal of comprehensive Case Management is to address needs for concrete services such as health care, benefits, housing, and nutrition, as well as develop the relationship necessary to assist the client in addressing other issues including substance use, mental health, and domestic violence in the context of their family/close support system.

Comprehensive Case Management is a proactive Case Management pathway intended to serve persons living with HIV/AIDS with multiple complex psychosocial and/or health-related needs and their families/close support systems. The pathway is designed to serve individuals who may require a longer time investment and who agree to an intensive level of Case Management service provision.

Central to the comprehensive pathway of Case Management is *service planning*, performed in conjunction with a comprehensive assessment and subsequent reassessments of the psychosocial and health care needs of the client and his/her family or close support system. Clients engaged in comprehensive Case Management will receive frequent contact, follow-up provided in the community and, in some programs, home visitation. Comprehensive Case Management services may be provided by a single case manager or by a Case Management team

Case Management providers are expected to comply with the Universal Standards of Care, as well as these additional standards

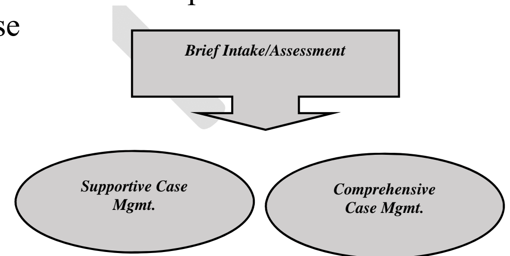
1. Standard of Care: Non-Medical Case Management Process

Brief Intake/Assessment Process

The Brief Intake/Assessment is the initial meeting with the client during which the case manager gathers information to address the client's immediate needs to encourage his/her engagement and retention in services.

The Brief Intake/Assessment may also be used to screen clients to determine if they need Case Management services, and if so, to determine the pathway of Case Management most appropriate to meet a client's needs, and to assess the client's willingness and readiness to engage in Case Management services.

In the **Supportive Case Management** pathway, the Brief Intake/Assessment is the *sole* mechanism for assessing client needs. Documentation from this assessment provides the basis for developing the Brief Service Plan and providing Case Management services. In **Supportive Case Management**, a Comprehensive Assessment is not required.



In the **Comprehensive Case Management** pathway the Brief Intake/Assessment allows initiation of Case Management activities until a Comprehensive Assessment can be completed.

Case managers must assure the client's privacy and confidentiality in all phases and activities of case management.

Information obtained during the Brief Intake/Assessment should be shared, after client consent, with other providers to coordinate services and avoid duplication of efforts. To increase efficiency, information from an agency's program eligibility screening process may also be used in the Brief Intake/Assessment.

Staff with good interviewing skills who can put clients at ease, obtain key personal information, and recognize potentially urgent situations should perform the Brief Intake/Assessment process. Placement into the appropriate Case Management pathway and provision of initial Case Management services depend on utilizing capable, empathetic Case Manager.

1.1. SOC: Brief Intake/Assessment: Key information, concerning the client, family, caregivers and informal supports is collected and documented to determine client enrollment eligibility, need for ongoing Case Management services, and appropriate level of Case Management service.

Time requirement: Due within 0-5 days of referral to case management services. Where HIV positive persons are entering services for HIV medical care, due by completion of initial comprehensive medical visit(s).

Criteria
1.1.1. Immediate needs are identified during the Brief Intake/Assessment process. 1.1.2. Immediate needs are addressed promptly. 1.1.3. Brief Intake/Assessment documentation includes, at minimum: 1. Basic Information o presenting problem o contact and identifying information (name, address, phone, birth date, etc.) o language spoken o demographics o emergency contact o confidentiality concerns o household members o insurance status o proof of HIV status o other current health care and social service providers, including other Case Management providers 2. Brief overview of status and needs regarding o food/clothing o finances/benefits o housing o transportation o legal services o substance use o mental health o domestic violence o support system o HIV disease, other medical concerns, access to and engagement in health care services o prevention of HIV/AIDS transmission o prevention of HIV disease progression 1.1.4 Documentation includes appropriate releases, including Authorization for the Release of HIV Confidential Information and other releases for information as required by applicable law. 1.1.5 Client is assessed for program eligibility and meets eligibility criteria.

Criteria
1.1.6 Case Management Policies and Procedures contain guidelines for conducting the Brief Intake/Assessment including staff responsible for and supervisory oversight.

Selection of Case Management Pathway

The **Supportive** and **Comprehensive** pathways of Case Management provide different levels of service geared to the needs and readiness of the client. The selection of the appropriate Case Management pathway enables case managers to address short-term and long-term needs of the clients as well as transition clients seamlessly between pathways as the need arises.

For Case Management programs approved to provide both pathways of service, the ability of clients to shift from one pathway to another within the same program provides flexibility and enhances continuity of service as client needs evolve.

Selection of the appropriate pathway is critical for providing the most effective and appropriate services to the clients. When a Case Management Provider is unable to provide the level or type of service appropriate for the client, then it is crucial for the Case Management providers to coordinate with a variety of service providers and hold multiple reciprocal service agreements can best meet diverse client needs. The most effective Case Management providers are culturally competent and employ staff who culturally and linguistically represent the community served. When clients are referred for Case Management services elsewhere case notes should include documentation of follow-up and level of client satisfaction with placement.

1.2. SOC: Clients are enrolled in a Supportive or Comprehensive Case Management pathway that provides a level of service that meets the needs identified in the Brief Intake/Assessment and in which the client is ready and willing to participate.

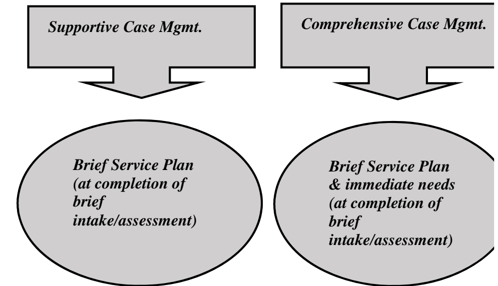
Time requirement: At completion of Brief Intake/Assessment.

Criteria
1.2.1 Case Management pathway most appropriate for client needs is determined o Acuity of client needs is ascertained. o Case Management services are explained. o Readiness and interest in Case Management is assessed. o Client is enrolled in pathway most suited to their needs. o If client not ready or drops out of case management services 3 attempts no more than 45 days apart will be made to reengage the client. 1.2.2 Program capacity is evaluated.

Criteria
o Program's service level and staff qualifications and/or expertise meet clients' needs. o Program has caseload capacity. o Program has capacity to meet clients' cultural and linguistic needs. 1.2.3 Clients are enrolled in Supportive or Comprehensive Case Management within agency. o Consent for Case Management services is obtained where required. o All required forms authorizing the release of HIV confidential information and other protected information are signed by clients as required by a contract and applicable law. 1.2.4 For RW eligible clients at agencies which are not able to provide either supportive or comprehensive pathways (or both) Case Management services necessary: o Agency refers the clients to another Case Management program within the Ryan White coordinated system of care program as needed. If there is no availability of services within the Ryan White coordinated system of care, the client must be referred to an external (non-Ryan White) Case Management Program. o Referral to another Case Management (internal or external) program occurs within 15 days after the determination of appropriate level of care. o Referring agency follows up and verifies with client that placement was appropriate and client is receiving services. 1.2.5 Agency has referral arrangements with other local providers to ensure diverse needs of clients are met. 1.2.6 For agencies providing *both* Supportive and Comprehensive Case Management pathways of service: o Agencies are able to identify which clients receive Supportive or Comprehensive Case Management at any point in time, and to report total number of clients being served in each pathway. o Policies and Procedures describe the process to move clients between pathways. 1.2.7 Case Management Policies and Procedures contain guidelines for selection of pathways including staff responsible for and supervisory oversight.

Brief Service Plan

In the **Supportive Case Management** pathway, the Brief Service Plan is completed in conjunction with the Brief Intake/Assessment and guides all Case Management activities until it is updated following a reassessment or a change in client circumstances.



In the **Comprehensive Case Management** pathway, the Brief Service Plan is an interim guide for case management, enabling clients to secure services to meet immediate needs while more extensive information is being collected for the Initial Comprehensive Case Management Assessment.

Service plans developed during face-to-face meetings and negotiated between client and case manager should draw out the client's strengths, encourage a client's active participation and empower client to become self-sufficient. . A copy of the service plan offered to the client emphasizes the partnership necessary in the Case Management process. Measurable goals and activities, taking into consideration cognitive and physical abilities, available resources, support networks, and client interest, result in a more realistic, client-specific plan. Although client signature denotes acceptance of a plan, a client may decline all or any portion of a service plan. Documenting changes or updates to a service plan as well as actual outcomes provides a simple method of tracking client progress. Family members and collaterals may assist in ensuring a client receives needed service. They can be included in the service plan to carry out activities.

1.3. SOC: Needs identified in the Brief Intake/Assessment are prioritized and translated into a Brief Service Plan.

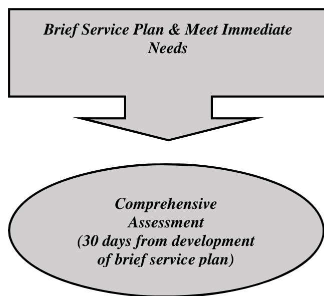
Time Requirement: At completion of Brief Intake/ Assessment.

Criteria
1.3.1. Brief Service Plan is developed and includes: o Goal(s) o Activities (work plan, action to be taken, follow up tasks) o Individuals responsible for the activity (case manager or team member, client, family member, agency representative) o Anticipated time frame for each activity o Client signature and date, signifying agreement o Supervisor's signature and date, indicating review and approval of service plan. 1.3.2. Documentation includes: o Service plan format developed by the program including the above information

Criteria
o Progress notes recording activities on behalf of the clients to implement the service plan o Actual outcomes of Case Management goals and activities. 1.3.3. Agency has an ongoing monitoring process to assess the client's ability and motivation to complete service plan activities and to address any other barriers to achieving goals. (For example if client is unable to perform specific activities alternative approaches to meet goal are explored such as skills development or staging of activities.) 1.3.4. Case Management Policies and Procedures contain guidelines for Brief Service Plan including staff responsible for and supervisory oversight.

Initial Comprehensive Assessment

The Initial Comprehensive Assessment is required for the **Comprehensive Case Management** Pathway only. It expands the information gathered in the Brief Intake/Assessment to provide the broader base of knowledge needed to address complex, longer-standing psychosocial or health care needs.



The 30 days completion time permits the initiation of Case Management activities to meet immediate needs, and allows for a more thorough collection of assessment information.

Programs offering **Comprehensive Case Management** serve the client in the context of their family and support system. The comprehensive assessment evaluates client resources and strengths, including family and other close supports that can be utilized during service planning. Case managers specifically assess the Case Management needs of children and key collaterals and arrange services for them if that will help stabilize the client's support system, enhance family functioning, or assist in attaining service plan goals.

Due to the extent of the Initial Comprehensive Assessment, supervisory oversight is required. Supervisory sign-off signifies review of the content and approval of the quality of the assessment conducted by the case manager.

In programs incorporating a team approach, team members other than the case manager assist in gathering information and completing portions of the assessment document. However, the case manager takes full responsibility for the process and for the completed documentation. A comprehensive assessment performed over time rather than in one sitting is often more complete and less intrusive and tiring for a client. Information is gathered from client self-report and (with client release) a variety of sources, including providers serving the client and the client's collaterals. When program resources and

capacity do not permit service provision to children and collaterals, referrals are made for them.

1.4. <u>SOC: Initial Comprehensive Assessment describes in detail the client's medical, physical and psychosocial condition and needs. It identifies service needs being addressed and by whom; services that have not been provided; barriers to service access; and services not adequately coordinated. The assessment also evaluates the client's resources and strengths, including family and other close supports, which can be utilized during service planning.</u>

Time Requirement: ***Comprehensive Case Management*** due within 30 days from completion of a Brief Intake/Assessment

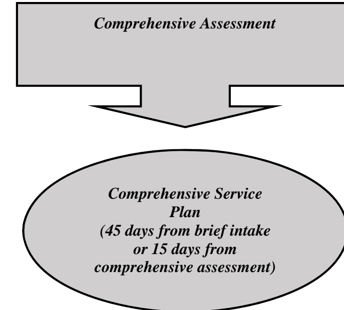
Supportive Case Management: Not required

Criteria
1.4.1. Initial Comprehensive Assessment includes at minimum: 1. Client health history, health status, and health-related needs, including but not limited to: o HIV disease progression o tuberculosis o hepatitis o sexually transmitted diseases o other medical conditions o OB/GYN, including current pregnancy status o medications and adherence o allergies to medications o dental care o vision care o home care o current health care providers; engagement in and barriers to care o clinical trials o complementary therapy. 2. Client's status and needs related to: o nutrition o financial resources and entitlements o housing (including results of home visit to assess living situation)

Criteria
○ transportation ○ support systems ○ identification of children and separate assessment of children's needs ○ identification of collaterals ○ determination of collaterals needing Case Management assessment and services ○ parenting needs ○ partner notification needs ○ HIV disclosure status/issues ○ alcohol/drug use/smoking history and current status ○ mental health ○ domestic violence ○ legal needs (e.g. health care proxy, living will, guardianship arrangements, parole/probation status, landlord/tenant disputes) ○ activities of daily living ○ knowledge, attitudes, and beliefs about HIV disease; current risk behaviors; and prevention of transmission ○ employment/education. 3. Additional information: ○ client strengths and resources ○ other agencies serving client and collaterals ○ brief narrative summary ○ name of person completing assessment and date of completion ○ supervisor signature and date, signifying review and approval. 1.4.2. The case manager has primary responsibility for the Initial Comprehensive Assessment and meets face-to-face with the client at least once during the assessment process. 1.4.3. Unless exempt, programs providing Comprehensive Case Management conduct a home visit during the assessment process. 1.4.4. Case Management Policies and Procedures contain guidelines for Initial Comprehensive Assessment including staff responsible for and supervisory oversight. 1.4.5. The Initial Comprehensive Assessment is documented in the case record on forms reviewed by RW Grantee.

Initial Comprehensive Service Plan Development

Service planning is a critical component of the **Comprehensive Case Management Pathway** and guides the client and case manager/team with a proactive, concrete, step-by-step approach to addressing client needs.



The Initial Comprehensive Service Plan is ***not*** required in the Supportive Case Management pathway, which uses the Brief Service Plan developed at the Brief Intake/Assessment.

The Comprehensive Service Plan can serve additional functions, including: focusing a client and case manager on priorities and broader goals, especially after crisis periods; teaching clients how to negotiate the service delivery system and break s into attainable steps; and serving as a review tool at reassessment to evaluate accomplishments, barriers, and re-direct future work.

Goals and activities of the service plan are determined with the participation of the client and, if appropriate, family, close support persons and other providers.

In programs incorporating a team pathway, team members other than the case manager may assist in developing a service plan. However the case manager has full responsibility for the process and completed documentation.

Service plans developed during face-to-face meetings and negotiated between client and case manager encourage client active participation and empowerment. A copy of the service plan offered to the client reinforces client ownership and involvement in the Case Management process. Measurable goals and activities, taking into consideration the client's cognitive and physical abilities, available resources, support networks and motivation, result in a more realistic, client-specific plan. Although client signature denotes acceptance of a plan, a client may decline all or any portion of a service plan. Documenting changes or updates to a service plan as well as actual outcomes provides a simple method of tracking client progress. Family members and collaterals may assist in ensuring a client receives needed service. They can be included in the service plan to carry out activities.

1.5. SOC: Client needs identified at Initial Comprehensive Assessment are prioritized and translated into an Initial Comprehensive Service Plan, which defines specific goals, and activities to meet those needs.

Time Requirement: ***Comprehensive Case Management*** 45 days from completion of Brief Intake/Assessment or 15 days from development of Comprehensive assessment.

Supportive Case Management Not required.

Criteria
1.5.1. Initial Comprehensive Service Plan includes at the minimum: o Goal(s) o Activities (work plan, action to be taken, follow up tasks) o Individuals responsible for the activity (case manager or team member, client, family member, agency representative) o Anticipated time frame for each activity o Client signature and date, signifying agreement o Supervisor's signature and date, indicating review and approval. 1.5.2. The case manager has primary responsibility for development of the service plan. 1.5.3. The Initial Comprehensive Service Plan is included in the case record and completed on forms reviewed by RW Grantee. 1.5.4. The Initial Comprehensive Service Plan is updated with outcomes and revised or amended in response to changes in client life circumstances or goals. o Client signature and date, signifying agreement o Supervisor’s signature and date indicating review and approval 1.5.5. Case Management Policies and Procedures contain guidelines for Initial Comprehensive Service Plan development including staff responsible for and supervisory oversight.

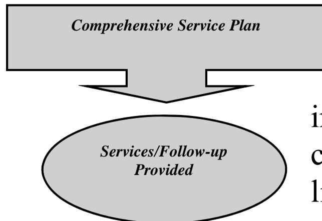
Service Plan Implementation, Client Contact, Monitoring and Follow Up

The bulk of Case Management work occurs in the implementation of the service plan. For Brief and Comprehensive Service Plans, implementation involves carrying out of tasks listed in the plan, including the following activities:

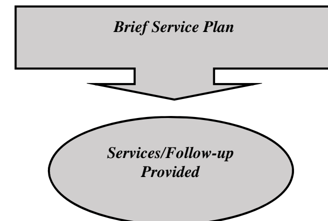
- provider contact in person, by phone, or in writing
- assistance to client and collaterals in applications for services or entitlements
- assistance in arranging services, making appointments, confirming service delivery dates
- encouragement to client/collaterals to carry out tasks they agreed to
- direct education to the client/collaterals as needed
- support to enable client/collaterals to overcome barriers and access services
- negotiation and advocacy as needed
- other Case Management activities as needed by client, and as expected and permissible by program initiative including referral, linkage and follow-up.

In general the type and frequency of contact should be based on client needs or based on approved agency policy on minimum requirements for frequency and type of Case Management contact by providers.

In the **Comprehensive Case Management Pathway**, client contact and monitoring are expected to be frequent and proactive in order to anticipate problems, stabilize the client's status, prevent crises, and support the client in achieving service goals. Expectations include face-to-face contacts, home visits, and accompaniment of clients to providers where necessary, referral follow-up and linkage to ensure service acquisition.



In the **Supportive Case Management Pathway**, at a minimum, client contact and monitoring is required to follow up on referrals and linkage, determine the status of service acquisition, and to assess whether the client has further needs requiring additional Case Management services. In Supportive Case Management programs, home visits are not required.



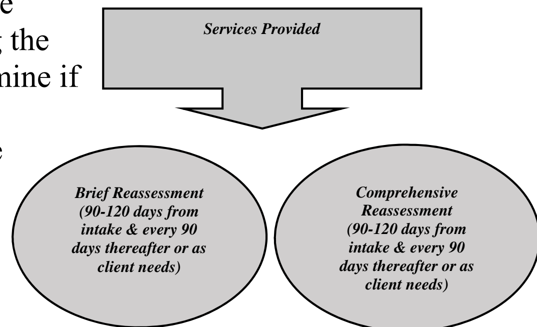
1.6. SOC: Provision of Case Management services outlined in the Brief or Comprehensive Service Plan proceeds immediately after its completion. Clients are contacted based on their level of need. Client status is monitored. Case Management staff follows up to determine receipt of service. In both Supportive and Comprehensive pathways, frequency and type of client contact as necessitated by client needs.

Criteria
1.6.1. Oversight of service plan implementation is the responsibility of the **case manager**. 1.6.2. Progress notes in the Case Management record in detail the advancement of the Case Management effort for client and collaterals and record **actual outcomes** of activities. 1.6.3. Evidence is documented in the client's chart that the case manager and/or team members contact the client and/or providers by a means and frequency appropriate to the client's needs, or according to established standards. 1.6.4. Documentation indicates contact with client and/or providers occurs after arranging services to determine if services are: delivered as expected o utilized by the client o satisfactory to the client o continue to be appropriate to the client's need

Criteria
o result in positive outcomes 1.6.5 Case Management provider follows up on problems with service delivery. 1.6.6 Status of the client/collaterals is monitored on a regular basis. 1.6.7 The client's right to privacy and confidentiality in contact with other providers and individuals is assured: 1.6.8 The client's consent to consult with other service providers is obtained. 1.6.9 Confidential HIV and client level documentation is secured against unauthorized access. 1.6.10 Case Management Policies and Procedures contain guidelines Service Plan Implementation, Client Contact, Monitoring, and Follow-up including staff responsible for and supervisory oversight.

Reassessment

Reassessment provides an opportunity to review a client's progress, consider successes and barriers, and evaluate the previous period of Case Management activities. In conjunction with updating the Service Plan, Reassessment is a useful time to determine if the current level of service and pathway of Case Management is appropriate, or if the client should be offered a change or if case needs to be closed.



A case conference with key parties before or during the reassessment process can augment and verify reassessment information and bring all parties into the service planning process.

1.7. <u>SOC: A reassessment is performed which re-evaluates client functioning, health and psychosocial status; identifies changes since the initial or most recent assessment; and determines new or ongoing needs.</u>

Time Requirement:

Comprehensive Case Management: Comprehensive Reassessment required 90-120 days after completion of Initial Comprehensive Assessment. Thereafter, every 90 days at minimum, or sooner if client circumstances change significantly.

Supportive Case Management: Brief Reassessment required 90-120 days following completion of the Brief Intake/Assessment and every subsequent 90 days for active Case Management clients, or sooner if client circumstances change significantly.

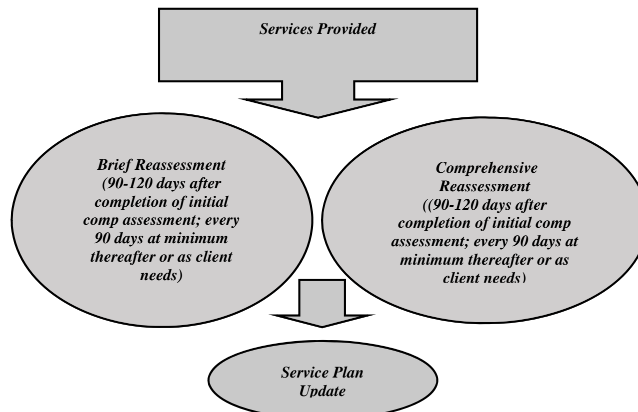
Criteria
In **Comprehensive Case Management** programs 1.7.1. Each Comprehensive Reassessment includes: 1. Updated personal information o current contact and identifying information o emergency contact o confidentiality concerns o household members o insurance status o other health and social service providers, including other Case Management providers. 2. Updated client health history, health status, and health-related needs outlined in **Initial Comprehensive Assessment**, including but not limited to: o HIV disease progression o tuberculosis o hepatitis o sexually transmitted diseases o other medical conditions o OB/GYN, including current pregnancy status o medications and adherence o allergies to medications o dental care o vision care o home care o current health care providers, engagement in and barriers to care o clinical trials o complementary therapy. 3. Updated client status and needs related to: o nutrition o financial resources and entitlements o housing (including home visit to assess living situation) o transportation o support systems o identification of children and separate assessment of children's needs o identification of collaterals o determination of collaterals needing Case Management assessment and services o parenting needs o partner notification needs

Criteria
○ HIV disclosure status/issues ○ alcohol use/drug use/smoking ○ mental health ○ domestic violence ○ legal needs (e.g., health care proxy, living will, guardianship arrangements, parole/probation status, landlord/tenant disputes) ○ activities of daily living ○ knowledge, attitudes, and beliefs about HIV disease; current risk behaviors; and prevention of transmission ○ employment/education. 4. Additional information: ○ other agencies serving client and collaterals ○ brief narrative summary ○ name of person completing assessment and date of completion ○ supervisor signature and date, indicating review and approval. 1.7.2. The **case manager** has primary responsibility for the Comprehensive Reassessment and meets face-to-face with the client at least once during the reassessment process. 1.7.3. Unless exempt, programs providing **Comprehensive Case Management** conduct a home visit during the Comprehensive Reassessment process. If client declines home visit proper documentation including reason for declining, attempts made by case manager, should be included. 1.7.4. Documentation includes appropriate releases, including Authorization for the Release of HIV Confidential Information as required by applicable law. 1.7.5. Case Management Policies and Procedures include guidelines for conducting the Comprehensive Reassessment, staff responsible for performing it, and supervisory oversight of the reassessment process. In **Supportive Case Management p**rograms 1.7.6. Each **Brief Reassessment** includes: 1. Client's presenting needs. 2. Updated client information in the following areas: ○ contact and identifying information ○ emergency contact ○ confidentiality concerns ○ household members ○ insurance status ○ other health and social service providers, including other case managers. 3. A re-evaluation of the client's status and needs regarding:

Criteria
○ food/clothing ○ financial/benefits ○ housing ○ transportation ○ legal ○ substance use ○ mental health ○ domestic violence ○ HIV diseases and other medical concerns ○ prevention of transmission and secondary prevention ○ support system. 1.7.7. The **case manager** has primary responsibility for the Brief Reassessment. The Brief Reassessment is performed in person or by phone. 1.7.8. In **Supportive Case Management**, the Brief Reassessment is documented in the chart. A new or clearly updated Brief Intake/Assessment form, a form developed for the purpose, or a detailed progress note covering the areas of information listed in numbers 1 through 3 above may be used as documentation of a Brief Reassessment. 1.7.9. Documentation includes appropriate releases, including Authorization for the Release of HIV Confidential Information required by applicable law. 1.7.10. Case Management Policies and Procedures include guidelines for conducting the Brief Reassessment, staff responsible for performing it, and supervisory oversight.

Service Plan Update

A Reassessment is always accompanied by a revision of the Service Plan. However a Service Plan may be updated between reassessments to reflect changes in direction of client goals and Case Management activities. A case conference with key parties before or during the reassessment process can augment and verify reassessment information and bring all parties into the service planning process.

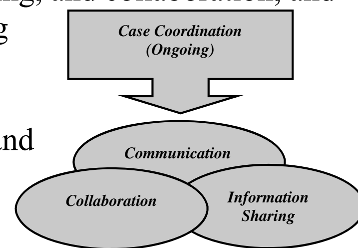


1.8 SOC: A new or updated Service Plan is required at completion of each Reassessment, or sooner if client circumstances necessitate a change in goals, or Case Management activities

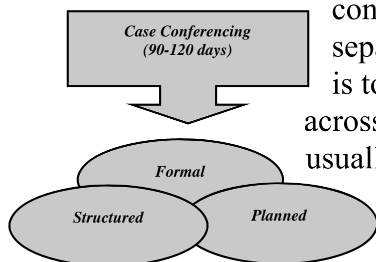
Criteria
1.8.1 In **Comprehensive Case Management** programs, a Comprehensive Service Plan accompanies each Comprehensive Reassessment. 1.8.2 In **Supportive Case Management** programs, a Brief Service Plan accompanies each Brief Reassessment. 1.8.3 Case Management Policies and Procedures for conducting the Service Plan Update, staff responsible for performing it, and supervisory oversight.

Case Coordination and Case Conferencing

Case coordination includes communication, information sharing, and collaboration, and occurs regularly with Case Management and other staff serving the client within and between agencies in the community. Coordination activities may include directly arranging access; reducing barriers to obtaining services; establishing linkages; and other activities recorded in progress notes.



Case Conferencing differs from routine coordination. Case conferencing is a more formal, planned, and structured event separate from regular contacts. The goal of case conferencing is to provide holistic, coordinated, and integrated services across providers, and to reduce duplication. Case conferences are usually interdisciplinary, and include one or multiple internal and external providers and, if possible and appropriate, the client and family members/close supports.



Case conferences can be used to identify or clarify issues regarding a client or collateral's status, needs, and goals; to review activities including progress and barriers towards goals; to map roles and responsibilities; to resolve conflicts or strategize solutions; and to adjust current service plans.

Case conferences may be face-to-face or by phone/videoconference, held at routine intervals or during significant change. Case conferences are documented in the client's record.

A case conference form can help document the participants, topics discussed, and follow up needed as a result of a case conference. When distributed immediately to attendees, the form reminds each participant of the roles and activities they've agreed to perform.

Although more difficult to arrange, a face-to-face case conference can clarify issues or resolve conflicts more directly than conferring with parties separately or by phone. Involving clients in face-to-face case conferences with providers encourages participation and recognizes their role in the process.

1.9 SOC: Supportive and/or Comprehensive Case Management providers routinely coordinate all necessary services along the continuum of care, including institutional and community-based, medical and, social and support services. Case conferencing is utilized as a specific mechanism to enhance case coordination.

Time Requirement for Case Conferencing:

Comprehensive Case Management: *Case Conferencing* required every 90-120 days at minimum.

Supportive Case Management: *Case Conferencing* required every 90-120 days at minimum.

Criteria	
1.9.1	Coordination activities include frequent contacts with other service providers and case managers and are documented in the progress notes.
1.9.2	Evidence of timely case conferencing with key providers is found in the client's records.
1.9.3	The client's right to privacy and confidentiality in contacts with other providers is maintained.
1.9.4	The client's consent to consult with other service providers is obtained.
1.9.5	Case Management Policies and Procedures for conducting the Case Coordination and Case Conferencing, staff responsible for performing it, and supervisory oversight.

Crisis Intervention

A clear crisis intervention policy and staff training on crisis intervention help ensure quick resolution of emergencies to minimize any damaging consequences (i.e., acute medical, social, physical or emotional distress).

A crisis plan is specific to an individual client’s needs. Plans should be developed to ensure a client is able to navigate services during crisis and has specific instructions and provider contact information. Co-occurring disabilities or life circumstances affect the nature and extent of the plan, i.e. people with mental illness or at risk of domestic

violence need to have their special needs addressed in advance to minimize the impact of emergencies.

Case managers discuss with clients what constitutes a crisis.

Case Management agency has assessed crisis intervention service providers to ensure quality and appropriateness of their services and care.

Programs develop a mechanism to assess a pattern of individual use of crisis intervention services (i.e., frequency, repeat types of situations, resolutions) in order to minimize situations leading to crisis.

1.10 SOC: Agency has a policy for client crisis intervention services that ensures all onsite emergencies are addressed immediately and effectively. Clients are provided resources to address a crisis after hours.

Criteria
1.10.1 All clients are provided with emergency contact information that includes resources and guidance to secure assistance outside of agency business hours. 1.10.2 The need for a crisis plan is determined for each client. Individual crisis plans must include at minimum information on service providers who are accessible 24 hours a day and able to handle emergency situations. 1.10.3 Program staff is trained on agency crisis policy and how to respond to crisis situations. 1.10.4 Administrative Policy and Procedure manual addresses crisis intervention protocol for incidents that occur on site.

Case Closure

Clients who are no longer engaged in active Case Management services should have their cases closed based on the criteria and protocol outlined in a program's Policies and Procedures. A closure summary usually outlines the progress toward meeting identified goals and case disposition. Common reasons for case closure include:

- Client lost to care or does not engage in service.
- Client chooses to terminate service.
- Client relocates outside of service area.
- Agency terminates as described in Policies and Procedures.
- Mutual agreement.
- Client is no longer in need of service.

- Client completed Case Management goals.
- Client no longer eligible.

Client is referred to a program that provides comparable Case Management services.

Providers attempt to reconnect clients lost to care to service. These attempts may include home visits, written/electronic correspondence, and/or telephone calls and may require contact with a client's known medical and human service providers (with prior written consent).

When services are terminated, an exit interview is conducted if appropriate.

Case managers attempt to secure releases that will enable them to share pertinent information with a new provider.

A management review is completed in situations where an agency intends to terminate services related to a client who threatens, harasses or harms staff.

1.11 SOC: Upon termination of active Case Management services, a client case is closed and contains a closure summary documenting the case disposition.

Criteria
1.11.1 Closed cases include documentation stating the reason for closure and a closure summary 1.11.2 Supervisor signs off on closure summary indicating approval 1.11.3 Policies and Procedures outline the criteria and protocol for case closures.

2. Standard of Care: Knowledge, Skill, and Experience

Staffing Structure - staffing plan for the delivery of Case Management services. Indicate pathway(s) of Case Management to be delivered, individual or team approach to staffing, and line(s) of supervision. Include a job description for each position, an organizational chart of agency and Case Management program.

Case Manager Supervision - description of ongoing supervision of Case Management staff and their activities. Include staff responsible for supervision, type and frequency of supervisory activities (including evaluations of staff job performance), and required documentation.

Additional Standards identified in Universal Standards of Care (USOC 2)

2.1 SOC Staff Qualifications - description of qualifications required for all Case Management staff positions.

Criteria
Case Manager Qualifications: 2.1.1 Preferred qualifications for a Case Manager include a Bachelor's or Master's degree in health, human or education services and one year of Case Management experience with HIV+ persons, and/or persons with a history of mental illness, homelessness, or chemical dependence. For Comprehensive Case Manager, and for certain Supportive Case Manager programs, experience with families is preferred. 2.1.2 *Waiver for Meeting Case Manager Qualifications* The qualification requirements listed above may be waived on a case-by-case basis with approval of RW Grantee. Experience or education which would be considered for waiving Case Manager Qualifications include: o Two years' experience providing Case Management services or HIV-related services, or o One year of Case Management experience and an associate's degree in health or human services, or o One year Case Management experience and an additional year of experience in other activities with HIV+ persons, or o A bachelor's or master's degree in health or human services **Case Management Supervisor Qualifications** 2.1.3 Preferred qualifications for a Case Management Supervisor include a Master's or higher degree in Health or Human Services, one year of supervisory experience, and one year of Case Management experience with HIV+ persons, and/or persons with a history of mental illness, homelessness, or chemical dependence. For Comprehensive Case Management Supervisor, experience with families is preferred. 2.1.4 Alternately, a Case Management Supervisor may hold a Bachelor's degree in Health or Human Services, and have two years of supervisory experience and two years of Case Management experience with HIV+ persons, and/or persons with a history of mental illness, homelessness, or

Criteria
chemical dependence. For Comprehensive Case Management Supervisor experience with families is preferred. 2.1.5 Alternately, a Case Management Supervisor may possess an Master's or higher degree in health or human services, licensure as an RN or LPN, and two years of Case Management experience with HIV+ persons, and/or persons with a history of mental illness, homelessness, or chemical dependence. For a Case Manager in a Comprehensive pathway, and for certain Supportive Case Management initiatives, experience with families is preferred. 2.1.6 *Waiver for Meeting Case Management Supervisor Qualifications* The qualification requirements listed above for Case Management Supervisor may be waived on a case-by-case basis with approval of the RW Grantee. o Case Management experience should encompass the functions of intake, assessment, reassessment, service planning, case coordination, case conferencing, and service plan implementation, crisis intervention, monitoring and follow-up of services provided, and case closure.

3. Standard of Care: Licensure or Assurance

Standards identified in Universal Standards of Care (USOC 1)

4. Standard of Care: Staff Training

4.1 SOC: Description of how staff will be trained, including orientation, required training topics, and frequency of training. Describe the process for assessing staff training needs, monitoring and documenting all training, including where training records are located. Training must include annual confidentiality training, with an attestation signed by each staff person agreeing to abide by confidentiality requirements.

Additional Standards identified in Universal Standards of Care (USOC 8)

5. Standard of Care: Client Rights, Responsibilities, Confidentiality

Standards identified in Universal Standards of Care (USOC 3)

6. Standard of Care: Access to Services

Standards identified in Universal Standards of Care (USOC 4)

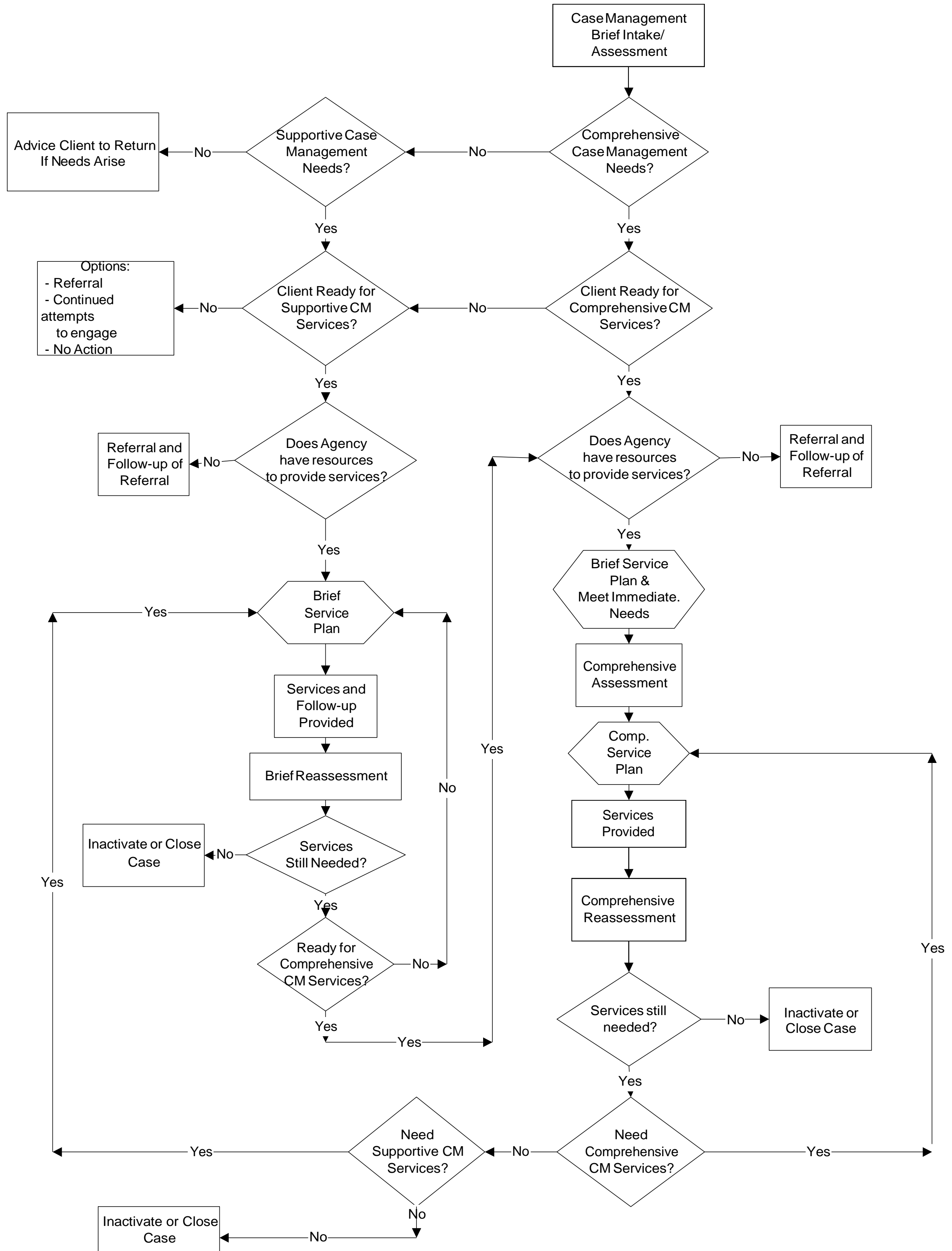
7. Standard of Care: Outreach and Provider Continuity

Standards identified in Universal Standards of Care (USOC 6)

8. Standard of Care: Continuous Quality Improvement

Standards identified in Universal Standards of Care (USOC 7)

Non-Medical Case Management Flow-Chart



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6. http://www.acphd.org/media/187285/case-mgmt-standard-alco.pdf
7. For a comprehensive overview of references, guidelines and resources please see the official website for Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB) at http://hab.hrsa.gov
8. https://careacttarget.org/library/service-standards-guidance-ryan-white-hivaids-program-granteesplanning-bodies
9. **Ryan White Title I Standards of Care for Case Management Services.** Approved by the Santa Clara County HIV Health Services Planning Council March 12, 2013.
10. **San Jose, CA TGA –** Definitions of **Case Management Services** for Eligible Services *Ryan White HIV/AIDS Treatment Extension Act of 2009*, September 9, 2012, Page 5.

Non-Medical Standards of Care Revision Process

In accordance with the RWHAP Parts A and B program manuals, service standards have been developed for each funded service category offered within the county. These standards are in place to ensure that RWHAP providers offer the same fundamental components of a given service category within a given service area. Measurement of service outcomes is greatly facilitated by the development of service standards and indicators addressing expected or desired service results, including the HRSA/HAB performance measures. These standards are continuously evaluated to keep abreast with changes in case management landscape at local, state or federal level.

The service standards are developed and revised by the Santa Clara County HIV Planning Council Quality and Standards (PC Q&S) Committee. With the advent of Affordable Care Act, there are significant changes to Ryan White services with a heavy emphasis on Case Management and Related Services. The current NMCM SOC does not provide adequate guidance to the Case Management providers. Also with new Case Management contracts to be executed in July 2015, the updating the current SOC is critical. Therefore the PC Q&S committee decided to prioritize revision of the Non-Medical Case Management Standards of Care (NMCM SOC) and make it more relevant to the current environment. The process for revision was as follows:

- The PC Q&S committee had committed a major part of FY14-15 towards developing the new NMCM SOC.
- The PC Q&S committee researched standards from other jurisdiction throughout the country including, Texas State, New York State, San Mateo County, Alameda & Contra Costa County, Los Angeles County, San Francisco County, Boston County and Kings County.
- The PC Q&S Committee was unable to establish quorum for the major part of FY14-15 grant year. Hence it was decided that a PC Q&S member work collaboratively with Grantee Quality & Control (QC) staff for developing the new standards. PC Q&S member had ongoing technical *weekly* meetings with Grantee QC staff between December 2014 and February 2015 to develop the new standard.
- Grantee QC staff along with contracts/budget staff met with current NMCM service provider's to get a thorough understanding of current process in administering Ryan White NMCM services in San Jose TGA. Gaps in current processes were identified.
- After a comprehensive review of the standards from above mentioned jurisdictions and also local process, it was decided to adopt the New York State Department of Health's NMCM SOC which best fit the current needs of our TGA. The New York NMCM SOC was customized to address local needs.
- The newly revised NMCM SOC is a significant change from the previous standards. Apart from change in page count (a jump from 2 pages to 28 pages), the revised standard follows the newly released guidelines provided by HRSA. (https://careacttarget.org/sites/default/files/file-upload/resources/Service%20Standards%20HRSA%20HAB%20Guidance%2012_14.pdf) along with the HRSA Part A & B fiscal and program monitoring standards.
- The revised NMCM SOC went through a thorough multiple internal reviews by social workers, compliance staff and program planning staff. The NMCM SOC was also sent for external review by social workers and case managers.
- All proposed revisions were compiled and discussed during weekly meetings by PC Q&S workshop and Grantee QC staff. Final revised draft was submitted to the PC Executive Committee on 4/21/2015 for recommendation & submission to the full PC body on 05/12/2015.
- The full PC body approved the NMCM SOC on 8/11/2015