HIV Health Services Planning Council
Sacramento EMA

Service Standards

Policy Number: SSC 01
Date Approved: 7/25/01
Date Revised: 1/26/05

Subject: **Case Management Service Standards for Persons Living with HIV/AIDS**

Reference: Ryan White CARE Act Title I Manual SEC. 1.
Action taken by the Affected Communities Committee on May 29, 2001; the Executive Committee on June 19, 2001 and July 13, 2001; and the HIV Health Services Planning Council on July 25, 2001.

Policy: The attached document represents the service standards to be utilized when providing case management services to Ryan White eligible clients in the Sacramento EMA. This standard is to be used in conjunction with other service standards for medical, psychosocial and support services as developed and approved by the HIV Health Services Planning Council.

PURPOSE OF CASE MANAGEMENT

The Health Resources Services Administration (HRSA) defines case management as:
"A range of client-centered services that link clients with health care, psychosocial, and other services to insure timely, coordinated access to medically appropriate levels of health and support services, continuity of care, on-going assessment of the client's and other family members' needs, personal support systems, and inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities.
Key activities include:

- initial comprehensive assessment of client's needs and personal support systems,
- development of a comprehensive, individualized Care Plan,
- coordination of the services required to implement the Care Plan;
- client monitoring to assess the efficacy of the Care Plan; and
- periodic re-evaluation and revision of the Care Plan as necessary over the life of the client. May include client-specific advocacy and/or review of utilization of services."

The Sacramento Eligible Metropolitan Area (EMA) views case management as the "hub" of the wheel of services that enable clients with HIV/AIDS to access services. Case management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet individual's needs in a timely and appropriate manner. Case management is an on-going process to empower clients by encouraging their ability to function independently.

VALUES OF CASE MANAGEMENT

The case management system will be:

- Client focused – The client and the case manager will reach a consensus as to the client's needs, and as to the prioritization of those needs, which will culminate in the creation of an individualized plan of care.
- Focused on maintaining clients in, or assisting clients to develop constructive lifestyles and life choices that will allow clients to maintain routine medical care. Case managers will work with clients to proactively address and resolve issues that consistently and/or recurrently result in barriers to care or otherwise negatively impact the client.
- Committed to empowering the client – Case management is an ongoing process to empower clients by encouraging their ability to function independently.
- Goal-oriented – Specific mutually agreed upon goals will be set in client care plans in order to assess progress and effectiveness of case management.
- A flexible model – Case managers will periodically reevaluate and be responsive to client's immediate, emerging, or otherwise changing needs.
- Culturally proficient – Case managers must be able to address clients in terms and contexts that are understandable and account for the client's personal situation/environment.
- Efficient – The system will assess different stages of need and provide different services based upon need.
- Cost-effective – Case management will identify and encourage the use of resources that will effectively prevent the client from having to access more expensive alternatives.
- Accessible – Case management will be accessible through multiple access points, as well as available and delivered appropriately to all clients, regardless of gender, age, sexual orientation, ethnicity, religion, educational level, language, criminal history, substance use history, or ability to pay for services.
- Collaborative – Case management will facilitate referrals to provider services and other supportive resources that most closely match client needs.

FUNCTIONS OF CASE MANAGEMENT

It is the case manager's responsibility to:

- Offer accurate and current information to their client;
- Assist their client in understanding the implications of the issues facing them, and

of the possible outcomes and consequences of decisions;
- Present options to the client from which he/she may select a course of action;
- Offer opinion and direction when it is asked for, or when to withhold it would place the client or someone else at risk for harm; and
- Be available to support and problem solve and to not judge the client in the present or future based upon their decision(s) of the past;
- Gather and evaluate information from the client;
- In coordination with the client, create a care plan that addresses basic living needs, medical treatment and compliance issues, and other appropriate social service needs;
- Promote communication and collaboration between the clients and all persons involved in the client's care;
- Educate the client on available resources and assist them in accessing those resources.

CASE MANAGER EDUCATION REQUIREMENTS & TRAINING

1. The minimum education and/or experience requirements for case managers should be:
    a. A Bachelor of Social Work (MSW preferred) or other related health or human service degree from an accredited college or university, or
    b. Related experience for a period of 2 years of full time employment (or equivalent), regardless of academic preparation.
2. All case managers must complete training on the HIV Health Services Planning Councils approved Services Standards within 30 days of beginning employment. This does not preclude an employer's (contracted Ryan White provider) ability to provide other training to the case manager, as it deems appropriate and necessary.
3. Attendance at ongoing Case Management training opportunities organized by the Fiscal Agent and others as appropriate.
4. Case Managers must also be familiar or become familiar with health and human services available within the EMA, regardless of funding source.

CASE MANAGEMENT PROCESSES

The core activities of case management are:

- Intake
- Assessment
- Reassessment
- Care Plan Development
- Care Plan Implementation
- Care Plan Follow-up and Monitoring
- Transfer and Discharge
- Evaluation of Client Satisfaction

INTAKE

Each prospective client who requests or is referred for case management services will be properly screened and evaluated through a face-to-face intake process designed to gather information for future service delivery and assist in decision-making regarding immediate needs. The service request/referral will be screened for basic admission criteria and assesses whether the client is in a crisis situation and/or requires immediate direct service referral. If immediate intervention is needed, the client shall be immediately referred to the appropriate entity.

At minimum, the following activities will take place during initial intake:

1. The Ryan White Program Intake form will be completed in its entirety.
2. The client's Informed Consent to Participate in the case management program shall be obtained.
3. The client will be informed of their right to confidentiality and confidentiality procedures.
4. The client will be informed of the Release of Information Form, and will be asked to provide consent to the appropriate release of information to other pertinent entities.
5. The client will be informed of, and agree to the Client's Rights and Responsibilities form.
6. The client will be informed of the agency's as well as the Ryan White Program's Grievance Procedure.
7. The client will be informed of the role and purpose of case management.
8. Assuming basic eligibility, the client may proceed to formal assessment, or be referred to another case management agency (if the client would be better served based upon their particular need for case management services).
9. Create a client file and archive all relevant documents and forms.

Eligibility

Eligibility requirements for Ryan White services can be found in SSC 05 – Eligibility and Fees for Ryan White Title I/II Services.

ASSESSMENT

Each client of case management services will participate in at least one (1) initial face-to-face interview with a case manager to assess their bio-psychosocial needs. The assessment will be used to collect, analyze, and prioritize information which identifies client needs, resources, and strengths for purposes of developing a Care Plan. Assessment will be conducted by a case manager and performed in accordance with written policies and procedures established by the individual Ryan White provider utilizing appropriate Ryan White Program forms (including the Client Intake Form), as required.

CARE PLAN DEVELOPMENT

A Care Plan shall be developed in an interactive process with each client of case management services. Development of the Care Plan is a translation of the information acquired during Intake and Assessment into specific measurable goals and objectives with defined activities and time frames to reach each objective. The Care Plan outlines interventions and services that will allow the client to overcome barriers and fulfill their needs, and identifies strategies and action plans for implementing those interventions and accessing needed services. The Care Plan will include explanations of referral and follow-up, and realistic objectives and goals to be achieved by program compliance. The client and case manager will work together to decide what actions are necessary to accomplish each objective and who will take responsibility for each task. The client and case manager must mutually agree to all goals and objectives outlined in the Care Plan.

CARE PLAN IMPLEMENTATION

The case manager shall be available to assist the client in facilitating access to services when needed and/or provide advocacy assistance to help problem solve as necessary when barriers impede access. The Case Manager will always first attempt to encourage clients to resolve their challenges, and support clients in thinking through solutions before acting on behalf of the client to achieve care plan objectives. Referral agencies shall be assessed for appropriateness to client situation, lifestyle, and need. The referral process shall include timely follow-up of all referrals to ensure that services are being received. Agency eligibility requirements shall be considered as a part of the referral process. Any referral made shall be appropriately documented in the client record.

CARE PLAN FOLLOW-UP AND MONITORING

Periodic Care Plan follow up and monitoring will be used to ensure that: 1) the care plan is adequate to meet client needs; 2) the client is actively pursuing Care Plan objectives; 3) care is coordinated; and 4) changing or emerging needs are being addressed.

REASSESSMENT

At least annually, clients receiving case management services will have their needs reevaluated through a comprehensive psychosocial reassessment. Reassessment will occur at least every (6) six months for clients requiring more extensive case management. The reassessment will be used to identify resolved issues, unresolved issues, and emerging need as compared to the prior assessment, and will guide appropriate revisions in the Care Plan, and make informed decisions regarding discharge from case management services and/or transition to other appropriate services. Reassessment will be conducted utilizing the same process outlined for initial assessment.

TRANSFER AND DISCHARGE

A systematic process shall be in place to guide transfer of the client to another program or case manager, and/or discharge from case management services. This process includes clear documentation of the reason(s) for discharge, notifying the client of case closure, and the appropriate appeals process.

Conditions Under Which Transfer/Discharge is appropriate:

1. Client achieves self sufficiency.
2. Death of the client
3. The client and/or client's legal guardian requests that the case be closed
4. The client is found not to be HIV+

Conditions Under Which Transfer/Discharge May Occur:

1. Client proves proficiency in ability to navigate health and support services systems.
2. Client is "lost to follow-up" (defined later)
3. Client moves into a system of care which provides in-house case management
4. Client moves out of the case manager's geographic service area
5. Client becomes self sufficient or no longer meets financial guidelines
6. Client is unwilling to participate in Care Plan as developed by Case Manager and client
7. Client exhibits a pattern of abuse towards agency staff, property or abuse of services
8. Client needs are more appropriately addressed in other programs (Case Manager is responsible for ensuring that a smooth transition occurs)
9. Client provides false information or documentation.

Process for Transfer/Discharge

1. Reason for discharge or transfer is discussed with the client and options for other service provision is explored and documented (preferably face-to-face).
2. In instances where the case management agency initiates termination:
   (a) The case manager shall consult with supervisor about their intent to discharge client.
   (b) The client is informed of intent to discharge and is provided with information regarding the appropriate appeals process of that decision.
   (c) The client is informed of other community resources available that may be able to meet their needs.
   (d) In some circumstances, a client may be suspended from services for a specified period of time. Document efforts made to assist the client in being successful in meeting expected program guidelines and becoming re-eligible for services.

3. Discharge Summary is prepared, which includes careful documentation of reason(s) for discharge and a service transition plan. Document efforts made to assist the client in being successful in meeting expected program guidelines and becoming re-eligible for services.

Criteria

1. A client is considered "lost to follow-up" when a case manager has made a minimum of three (3) good faith attempts within a 90-day period to contact the client, with no response from the client or his/her representative. This can be done through phone messages, letters, provider contacts, or home visits.

Documentation

The Discharge Summary is included in the Progress Notes in the client's file.

Grievance Process

If the client disagrees with the termination of his/her case management services, the case will be reviewed through the agency's specific grievance procedure.

If a resolution is not mutually resolved between the client and agency, then the case will be reviewed by the Fiscal/Administrative Agent (FAA) and a written response sent to all parties involved (e.g. agency, client) within twenty (20) working days with a disposition. If an extension is needed, a letter shall notify all parties involved of an extension for an additional ten (10) working days. Final disposition shall occur no later than thirty (30) working days following the initial filing with FAA.

Adopted: ________________________________

Joseph Robinson, Chair