



HIV Planning and Coordination
Health Care Agency

**CASE MANAGEMENT
STANDARDS OF CARE**

FOR

**RYAN WHITE ACT-FUNDED SERVICES IN
ORANGE COUNTY**

Effective March 1, 2014

**COUNTY OF ORANGE
HEALTH CARE AGENCY**

**Ryan White HIV/AIDS Treatment Modernization Act
Case Management Standards of Care**

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SECTION 1: INTRODUCTION

The goal of case management is to enhance independence and increase quality of life for individuals living with HIV through adherence to medical care. Case management shall target individuals who need support in accessing and maintaining regular medical care. Case management addresses the needs of clients with HIV disease and assists them in overcoming the obstacles they face in obtaining critical services. Case management shall be flexible to accommodate the medical and psychosocial needs of clients with different backgrounds and in various stages of health and illness. The services delivered shall reflect a philosophy of service delivery that affirms a client’s right to privacy, confidentiality, self-determination, nondiscrimination, compassionate and non-judgmental care, dignity, and respect.

Case management is a client-centered process. This means respecting the client’s perception of his/her needs and developing service plans in collaboration with him/her. This also means empowering the client to take control of his/her care. It is recommended to incorporate a strengths-based approach, by helping clients identify barriers to accessing care and subsequently identifying personal strengths to overcome these barriers. This is especially important when working with newly diagnosed clients or clients who are returning to care and linking them into medical care. A client-centered process is beneficial to relationship and trust building between the client and his/her case manager.

Case managers shall also see themselves as educators and seize opportunities to educate clients about HIV prevention and care. When appropriate, case managers shall educate their clients on life skills such as: practical living skills, functional communication, community integration, treatment adherence, nutritional counseling, and skill building exercises.

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Goals of the Standards. These standards of care are provided to ensure that Orange County's Ryan White-funded case management services:

- Are accessible to all persons infected with HIV who meet eligibility requirements
- Promote continuity of care, client monitoring, and follow-up
- Enhance coordination among service providers to eliminate duplication of services
- Foster interagency collaboration
- Provide opportunities and structure to promote client and provider education
- Maintain the highest standards of care for clients
- Protect the rights of persons living with HIV/AIDS
- Provide support services to enable clients to stay in medical care
- Increase client self-sufficiency and quality of life

SECTION 2: DEFINITION OF CASE MANAGEMENT

There are two categories of case management: 1) medical case management and 2) non-medical case management. Definitions for each service are stated below:

Medical Case Management: Includes a range of client-centered services that link clients with health care, psychosocial, and other services provided by trained professionals, including both medically credentialed and other health care staff. The coordination and follow up of medical treatments are a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Case management shall also ensure continuity of care through ongoing assessment of the client's needs and personal support systems.

Non-Medical Case Management (Benefits Counseling): Includes the provision of guidance and assistance in obtaining medical, social, community, legal, financial, and other needed services. Services that refer or assist eligible clients to obtain access to non-Ryan White public and private programs for which they may be eligible, including:

- Medicaid,
- Medicare Part D,
- Social Security Disability Insurance,
- State Disability Insurance,
- Supplemental Security Income, General Relief,
- State Pharmacy Assistance Programs,
- Pharmaceutical Manufacturer's Patient Assistance Programs,
- Health Insurance Premium Programs,
- and other supportive services.

This service includes helping clients to understand the eligibility criteria for:

- Benefits,
- Benefits provided by the program,
- Payment process and the rights of beneficiaries;
- Providing consultation and guidance regarding benefits programs

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- Helping clients' complete benefits application forms;
- Negotiating on the behalf of clients with benefits administration staff;
- and/or referring to and coordinating with legal services in cases of judicial litigation.

Benefits Counseling may include following up with clients who need follow-up assistance in accessing services or benefits.

Non-Medical Case Management (Client Advocacy): Includes assessment of client needs, education (as necessary), and referral to services. Client advocacy services do not require regular follow up and coordination of client services as described in this document.

SECTION 3: STAFFING REQUIREMENTS AND QUALIFICATIONS

Quality case management starts with well-prepared and qualified staff. To ensure this, Ryan White providers must meet all of the following requirements and qualifications:

- 3.1. HIV/AIDS Information.** Staff shall have training and experience with HIV/AIDS related issues and concerns. At a minimum, case managers will have completed one educational session on any of the topics listed below on an annual basis. Certificate of completion shall be included in employee files as proof of attendance. Education can include round table discussion, training, one-on-one educational session, in-service, or literature review. Topics may include:
- HIV disease process and current medical treatments
 - Adherence to medication regimens
 - Mental health or psychosocial issues related to HIV/AIDS
 - Cultural issues related to communities affected by HIV/AIDS
 - HIV/AIDS legal and ethical issues
 - Human sexuality, gender, and sexual orientation issues
 - Prevention issues and strategies specific to HIV-positive individuals (“prevention with positives”)
 - Partner Services
 - Strengths-Based approach to case management trainings
- 3.2. Community Resources (Required for Benefits Counseling and recommended for case managers).** Case managers shall be knowledgeable about local, state, and federal resources and eligibility requirements of available resources for clients. At a minimum, benefits counselors will have completed one educational session on any of the topics listed below on an annual basis. Education can include round table discussion, training, one-on-one educational session, in-service, or literature review. Topics may include eligibility criteria and process for obtaining the following:
- Medical care including Medi-Cal, Medicare, Medical Services Initiative (MSI), and California Major Risk Medical Insurance Plan (MRMIP)
 - Disability insurance including State Disability Insurance, Social Security Disability Insurance
 - Financial assistance including Supplemental Security Income (SSI) and Cash Assistance Program for Immigrants (CAPI)

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- Health insurance assistance including CalOptima Health Insurance Premium Payment Program, Office of AIDS-Health Insurance Premium Payment program
- Medications including Medicare Part D and AIDS Drug Assistance Program
- California Health Insurance Exchange (Covered California)

3.3. Licensure. Staff shall have the necessary State of California licenses for the functions they perform.

- Staff performing intensive level case management shall have a Master's or nursing degree.
- Staff performing moderate or basic level case management shall have a minimum of Bachelor's degree in a social service field or comparable case management experience.
- Marriage and Family Therapists (MFTs) and Master of Social Work (MSW) interns who are earning hours toward licensure are appropriately and clinically supervised.

Caseloads. Staff shall have caseloads set at levels that allow them to conduct their activities adequately and competently. Caseloads shall be established based upon intensity of needs of clients and program managers shall conduct periodic assessments to see if caseload assignments allow for quality services and completion of job duties. Actual caseload figures vary as a result of multiple factors that may include, but are not limited to, the following:

- Extra time a case manager spends with a client due to language barriers or the need for use of an interpreter.
- The number of client's who are newly diagnosed on a caseload. Case managers providing active linkage coordination for newly diagnosed may have a smaller caseload.
- The mix of clients with basic, moderate, and intensive acuity scores that a case manager may have in their caseload.
- The above caseloads refer to community-based case management. Clinic-based caseloads (including the Health Care Agency's 17th Street Care) serve a different programmatic function and typically carry higher caseloads and have different standards of care.
- Extra time spent on stabilizing a client in crisis.

3.4. Supervision. Programs shall provide appropriate supervision to case management staff, which includes, but is not limited to, the following:

- Staff and clients shall have access to supervisory levels of case management.
- Supervision that is observant and attentive to possible bias in treatment of clients because of their sexual preference, ethnicity, gender, substance use, etc.
- Individual supervision and clinical guidance that is available to case managers as needed.
- Multiple methods shall be used to evaluate case manager performance including: direct observation; chart reviews; and client feedback (e.g., through surveys, focus groups, complaint and grievance processes, etc.).

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- 3.5. Case Conferencing.** Formal or informal case conferencing shall occur when important client-specific issues arise that require a team or interdisciplinary approach or solution.

Standard	Measure
Case management staff receive initial and annual education regarding HIV/AIDS related issues/concerns	Training/education documentation on file including: <ul style="list-style-type: none">• Date, time, and location of the education• Education type• Name of the agency and case managers receiving education• Education outline, meeting agenda and/or minutes
Benefits counseling staff receive initial and annual education regarding community resources Recommended for case managers to receive initial and annual education regarding community resources	Training/education documentation on file including: <ul style="list-style-type: none">• Date, time, and location of the education• Education type• Name of the agency and case managers receiving education• Certificate of completion
Provider will ensure that staff have necessary licenses for the functions they perform. Staff performing intensive level case management shall have a Master's or nursing degree Staff performing moderate or basic level case management shall have a minimum of Bachelor's degree in a social service field or comparable case management experience	Documentation of licensure or degree on file
Staff shall have caseloads set at levels that allow them to conduct their activities adequately and competently (with assistance to include supervision and clinical guidance, formal or informal case conferencing, as well as case manager transition if needed)	Program managers shall conduct periodic assessments to see if caseload assignments allow for quality services and completion of job duties. (Documentation of periodic assessments on file.)

SECTION 4: CULTURAL AND LINGUISTIC COMPETENCE

Providers must participate in a process of training and education that increases cultural and linguistic competence and improves their ability to provide culturally and linguistically appropriate services to all persons living with HIV/AIDS. Although an individual's ethnicity is generally central to his/her identity, it is not the only factor. Other relevant factors include gender; language; disability; sexual orientation; the totality of socially transmitted behavior patterns, arts, beliefs, institutions and thought characteristic of a community or population. In

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providing culturally and linguistically competent services, it is important to acknowledge one's personal limits and treat one's client as the expert on their culture and relation to it.

Case managers shall be mindful of clients' literacy level and be able to accurately interpret and appropriately respond to a client's situation. If a case manager determines that he/she is not able to provide culturally or linguistically appropriate services, he/she must be willing to refer the client to another case manager or provider that can meet the client's needs.

Culturally and linguistically appropriate services:

- Respect, relate, and respond to a client's culture in a non-judgmental, respectful manner
- Match the needs and reflect the culture and language of the clients being served, including providing written materials in a language accessible to clients
- Recognize the significant power differential between provider and client, and work toward developing a more collaborative interaction
- Consider each client as an individual, not making assumptions based on perceived membership in any group or class

Standard	Measure
Providers will recruit a diverse staff that reflects the culture (including gender, sexual identity, and disability) of the community served	Providers have a written strategy on file
All staff (including administrative staff) will receive initial trainings within 60 days of hire and annual trainings to build cultural and linguistic competence	Training/education documentation on file including: <ul style="list-style-type: none">• Date, time, location, and provider of education• Education type• Name of staff receiving education• Certificate of training completion or education outline, meeting agenda, and/or minutes
Provider shall have posted and written materials in appropriate languages for the clients served	Site visit will ensure
Providers will maintain a physical environment that is non-offensive to the populations served	Site visit will ensure
Agency complies with American Disabilities Act (ADA) criteria	Completed form/certification on file
Services are accessible to community served	Site visit to review hours of operation, location, accessibility with public transportation

SECTION 5: CLIENT INTAKE

Intake is a time to gather registration information and provide basic information about case management and other HIV services. It is also a pivotal moment for establishment of trust and confidence in the care system. Case managers shall be careful to provide an appropriate level of information that is helpful and responsive to client need, but not overwhelming.

If a client is receiving multiple Ryan White services with the same provider, intake need only be conducted one time. It is acceptable to note that registration information discussed in this section was verified and exist; in another client service record at the same provider agency.

If a client has been referred by another Ryan White provider to receive services, it is acceptable to note that registration information discussed in this section was verified and exists at the referring Ryan White provider. Registration information may be sent from the referring provider to the provider receiving the referral so that the provider receiving the referral may enter information for the Ryan White Services Report. Provision of information regarding *Client Rights and Responsibilities* and *Client Grievance Process* may be conducted one-time at the referring provider agency. To document the provision of this information, the referring provider may send the provider receiving the referral a signed document indicating that they have provided this information to the client.

The case manager shall conduct the client intake with respect and compassion. The following describe components of intake:

- 5.1. Timeframe.** Intake shall take place as soon as possible, at minimum within five days of referral or initial client contact. If there is an indication that the client may be facing imminent loss of medication or is facing other forms of medical crisis, the intake process shall be expedited and appropriate intervention may take place prior to formal intake.
- 5.2. Registration Information.** The provider shall obtain information to complete registration as required for the Ryan White Services Report. This includes, but is not limited to, information regarding demographics, and risk factors.
- 5.3. Provision of Information.** The case manager shall clearly explain what case management entails and provide information to the client. The case manager shall provide adequate information about the availability of various services or resources within the agency and in the community. The case manager shall also provide the client with information about resources, care, and treatment available in Orange County this may include the county-wide HIV Client Handbook.
- 5.4. Required Documentation.** The provider shall develop the following forms in accordance with state and local guidelines. The following forms shall be signed and dated by each client.
 - **ARIES Consent:** Clients shall be informed of the AIDS Regional Information and Evaluation System (ARIES). The ARIES consent must be signed at intake prior to entry into the ARIES database and every three years thereafter. The signed consent form shall indicate (1) whether the client agrees to the use of ARIES in recording and

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tracking their demographic, eligibility and service information and (2) whether the client agrees to share select information contained in ARIES with other agencies in the Ryan White system of care.

- **Confidentiality and Release of Information:** When discussing client confidentiality, it is important *not* to assume that the client's family or partner knows the HIV-positive status of the client. Part of the discussion about client confidentiality shall include inquiry about how the client wants to be contacted (at home, at work, by mail, by phone, etc). If there is a need to disclose information about a client to a third party, including family members, clients shall be asked to sign a Release of Information form, authorizing such disclosure. Clients receiving medical case management shall strongly be encouraged to sign a Release of Information authorizing their case manager to speak to their medical provider so that the case manager can better assist the client in coordinating care for the client. A Release of Information form describes the situations under which a client's information can be released and includes the name of the agency and/or person with whom information will be shared, the specific information to be shared, duration of the release consent, and the client's signature. This form may be signed at intake prior to the actual need for disclosure. Releases of information may be cancelled or modified by the client at any time. For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), the Release of Information must be a HIPAA-compliant disclosure.
- **Consent for Services:** Signed by the client, agreeing to receive case management services.

The following forms shall be signed and dated by each client receiving case management services and posted in a location that is accessible to clients receiving client advocacy services. For documents available in the HIV Client Handbook, completed forms may indicate that the client has received the HIV Client Handbook.

- **Notice of Privacy Practices (NPP):** Clients shall be informed of the provider's policy regarding privacy rights based on the provider's confidentiality policy. For agencies and information covered by HIPAA, providers shall comply with HIPAA guidelines and regulations for confidentiality.
- **Client Rights and Responsibilities:** Clients shall be informed of their rights and responsibilities (included in the HIV Client Handbook).
- **Client Grievance Process:** Clients shall be informed of the grievance process. The HCA's Grievance Process is included in the HIV Client Handbook.

Standard	Measure
Intake process began within five business days of referral or initial contact with client	Intake tool is completed and in client service record
Registration information is obtained	Client's service record includes data required for Ryan White Services Report
ARIES Consent signed and completed prior to entry into ARIES	Signed and dated based on ARIES consent form guidelines by client and in client service record

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Standard	Measure
Release of Information is discussed and completed as needed	Signed and dated by client and in client service record as needed
Consent for Services completed	Signed and dated by client and in client service record
Client is informed of Notice of Privacy Practices	<p>For clients receiving case management: Signed and dated by client and in client file</p> <p>For clients receiving client advocacy: One of the following (based on provider policy):</p> <ol style="list-style-type: none"> 1) Posted in a location that is accessible to clients; or 2) Signed and dated by client and in client service record; or 3) Other (based on provider policy)
Client is informed of Rights and Responsibilities	<p>For clients receiving case management: Signed and dated by client and in client file</p> <p>For clients receiving client advocacy: One of the following:</p> <ol style="list-style-type: none"> 1) Posted in a location that is accessible to clients; 2) Signed and dated by client and in client service record; or 3) Client's service record includes signed referral form indicating provision of information
Client is informed of Grievance Procedures	<p>For clients receiving case management: Signed and dated by client and in client file</p> <p>For clients receiving client advocacy: One of the following:</p> <ol style="list-style-type: none"> 1) Posted in a location that is accessible to clients; 2) Signed and dated by client and in client service record; or 3) Client's service record includes signed referral form indicating provision of information

SECTION 6: COMPREHENSIVE ASSESSMENT

Proper assessment of client need is fundamental to case management. A comprehensive assessment is required for all persons receiving case management. Assessments shall be

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provided by staff with the appropriate level of education and experience. Assessments are conducted to determine:

- The client's need for case management services and other treatment and support services,
- Current capacity to meet those needs,
- Ability of the client's social support network to help meet client need,
- Extent to which other agencies are involved in client's care,
- Areas in which the client requires assistance in securing services.

Case management shall target individuals assessed as needing support in accessing and maintaining regular medical care. Individuals who are assessed as self-sufficient and not needing periodic follow-up may not need case management services and may receive services under Client Advocacy.

6.1. Initial Assessment. The case manager shall conduct an in-depth assessment of the client's current and potential needs. The assessment process shall start within one week of client intake and completed within thirty (30) days. A strengths assessment consisting of past accomplishments is recommended to identify clients' skills and abilities in order to successfully follow through with their medical care visits, support a positive, trusting relationship with case manager or accessing other services, and other goals. In addition, a comprehensive assessment must be completed annually thereafter. Case managers shall use the Acuity Scale (see Appendix A for the Acuity Scale) to document general findings of the assessment and periodic reassessments of client need. **The Acuity Scale is not an assessment tool in and of itself.**

6.2. Reassessment. Reassessments (which may be more focused and less comprehensive) shall be conducted whenever health and situational changes make it helpful and necessary to do so. Notwithstanding situational changes, reassessments shall be conducted at intervals determined by the level of client's acuity and type of case management.

The following *minimum* standards for reassessments have been set based upon general categorization of client acuity:

- Basic: face-to-face reassessment every six months
- Moderate: face-to-face reassessment every three months
- Intensive: face-to-face reassessment every two months

Reassessments shall include a review of all pertinent issues. This may be accomplished by reviewing recent comprehensive assessments with the client and focusing only on areas of need. They can also, if appropriate, invite clients to use a form or checklist to self-assess their needs.

6.3. Assessments shall include the following:

Medical (HIV and non-HIV) Need
<ul style="list-style-type: none">○ Understanding of health issues related to HIV○ Resources for medical/dental care○ Continuity and regularity of medical/dental care○ Quality of and adequacy of medical/dental care

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<ul style="list-style-type: none">◦ Access to, and compliance with, HIV treatment◦ Need for assistance with activities of daily living and available support◦ Use of herbs, folk medicine, and alternative therapies
Understanding of, and Response to, HIV Transmission Factors
<ul style="list-style-type: none">◦ Knowledge, attitudes, and behaviors associated with risk reduction techniques◦ Need for partner education and notification services◦ Need for extended HIV testing and counseling
Substance Use
<ul style="list-style-type: none">◦ History and extent of current substance use◦ Resources for substance use issues, if applicable
Mental Health Issues
<ul style="list-style-type: none">◦ History of and current mental health issues◦ Resources for mental health issues, if applicable
Financial Needs
<ul style="list-style-type: none">◦ Income◦ Employment issues◦ Public benefits eligibility◦ Health insurance◦ AIDS Drug Assistance Program (ADAP)
Nutritional Needs
<ul style="list-style-type: none">◦ Dietary restrictions◦ Access to food◦ Need for supplements
Housing and Living Situation
<ul style="list-style-type: none">◦ Current housing situation◦ Ability to maintain stable housing
Social and Emotional Support
<ul style="list-style-type: none">◦ The extent and availability of family and other support networks◦ Disclosure issues◦ Current or past history of domestic violence
Legal Issues
<ul style="list-style-type: none">◦ Ability to access eligible benefits◦ Criminal offenses, parole, or probation status◦ Citizenship◦ Guardianship
Transportation
<ul style="list-style-type: none">◦ Ability to access services through public or private modes of transportation
Education and Employment
<ul style="list-style-type: none">◦ Level of education◦ Literacy◦ Current employment◦ Employment issues
Spirituality

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- Current beliefs

Standard	Measure
Initial assessment shall be completed within thirty (30) days of intake and annually thereafter	Completed assessment, signed and dated by case manager and in client file to include: <ul style="list-style-type: none">• Medical (HIV and non-HIV) Need• Understanding of, and Response to, HIV Transmission Factors• Substance Use• Mental health Issues• Financial Needs• Nutritional Needs• Housing and Living Situation• Social and Emotional Support• Legal Issues• Transportation• Education and Employment• Spirituality
Reassessment conducted at intervals determined by the level of client's acuity and type of case management	Progress notes and/or new assessment demonstrating reassessment in client file
Acuity Scale with scores updated at intervals determined by the level of the client's acuity	Signed and dated Acuity Scale in client file

SECTION 7: SERVICE MANAGMENT

Once client intake has been conducted, the provider may provide the appropriate range of services to the client. Service management shall be consistent with the following principles.

7.1. Service Delivery

- Services shall be delivered in a manner that promotes continuity of care. Newly diagnosed clients shall be assessed for barriers that prevent linkage to medical care. To address these barriers, as recommended by the strengths-based case management model, skills and abilities shall be identified to assist clients to successfully access medical care and maintain a positive relationship with the care coordinator.
- Providers shall refer clients to other providers if they cannot provide a level of service that is medically, culturally, linguistically, or otherwise appropriate for the needs of the clients.
- Changes in client-case manager assignment shall be to see the same case manager over time, as this is a desirable arrangement that helps develop trust. However, the program may consider changing client-case manager assignments if a client expresses his/her wish to do so based on negative experience or lack of trust.

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7.2. Confidentiality

- Provider agencies shall have a policy regarding informing clients of privacy rights, including use of Notice of Privacy Practices. For agencies and information covered by HIPAA, providers shall comply with HIPAA guidelines and regulations for confidentiality.

7.3. Service Planning

- Where service provision options are substantially equivalent, the least costly alternative shall be used in meeting the needs of clients.
- Services shall be planned, managed, and monitored to avoid the need for urgent or emergency services, the interruption of services, and need for emergency or unplanned appropriations of funding to continue services during contract periods.

7.4. Documentation and Data Collection

- Program and administrative staff shall provide adequate data collection in a timely manner and documentation of all services provided for accounting, reporting compliance, and evaluation purposes.
- Program data shall be entered into ARIES between two (2) to five (5) business days as specified in contract or scope of work.
- Providers shall document and keep accurate records of units of services for use in reporting units of service for reimbursement and community planning.
- Providers shall gather and document data (e.g. demographic, and risk factor information) for the Ryan White Services Report.

7.5. Compliance with Standards and Laws

- Service directors and managers shall ensure compliance with all relevant laws, regulations, policies, procedures, and other requirements designed to enforce service standards and quality.
- Services shall be consistent with standards set forth in this document.

Standard	Measure
Provider shall have procedure to address walk-ins, telephone triage, and emergencies and after-hour care	Written procedure in place
Provider shall have procedure for making referrals to offsite services	Written procedure in place
Staff shall be aware of HIPAA and Notice of Privacy Practices regulations via training upon employment and annually thereafter	Documentation of HIPAA and Notice of Privacy Practices education or training on file
Provider shall ensure client information is in a secured location	Site visit will ensure
Provider shall screen clients to ensure the least costly case management service is used as appropriate to client needs; screening shall occur at minimum when client is accessing a new service and periodically as the client's needs change	<ul style="list-style-type: none">• Written procedure in place• Documentation of client screening and determination on file• Site visit will ensure

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Provider shall regularly review client charts to ensure proper documentation including progress notes	Written procedure in place
Providers shall document and keep accurate records of units of services	Site visit and/or audit will ensure
Service directors and managers shall ensure compliance with all relevant laws, regulations, policies, procedures, and other requirements designed to enforce service standards and quality	Site visit and/or audit will ensure

SECTION 8: INDIVIDUAL SERVICE PLAN

Once client needs have been assessed, case managers together with clients shall prioritize care, support needs, and identify activities to address them. This process is documented on the Individual Service Plan (ISP). The plan provides a map for both the client and case manager on how to address needs in a manner that promotes self-sufficiency of the client. The ISP shall be completed within thirty (30) days of intake and revised as necessary, but not less than every six (6) months. Discernment is required on the part of case managers to provide enough support to assist clients in meeting needs, while fostering client ability and responsibility for self-care. Often this requires an approach that is heavier in initial support, which includes a transition over time to increased client responsibility. Good communication regarding roles and expectations is essential from the beginning of the client-case manager relationship because it is necessary to respectfully and successfully navigate the process of establishing and modifying the ISP. The ISP must be developed in collaboration with the client, taking into account his/her priorities and perception of needs.

The ISP shall include:

- Needs and goals of the client
- Specific actions that need to be taken to address them
- Timeframes for such actions
- The responsible parties for each activity
- Signature by client or reason for inability to sign

The ISP shall also include the following as they relate to medical care:

- Cases where a client is not adherent with medical care
- Specific actions that need to be taken to promote adherence

Standard	Measure
ISPs must be finalized within thirty (30) days of the completion of the Comprehensive Assessment	Completed ISP, signed and dated by case manager and in client file to include: <ul style="list-style-type: none"> • Needs and goals of the client • Specific actions that need to be taken to address them • Timeframes for such actions • The responsible parties for each activity

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	<ul style="list-style-type: none">• Individual Service Plan signed by the client or reason for inability to sign• The ISP shall also describe cases where a client is not compliant with medical care, known reasons for non-compliance and specific actions that need to be taken to promote compliance
Review and revise ISP as necessary, but not less than once every 6 months	Documentation of updated ISP in client file

SECTION 9: IMPLEMENTATION OF THE INDIVIDUAL SERVICE PLAN (ISP)

Implementation, monitoring and follow up involve ongoing contact and interventions with (or on behalf of) the client to achieve the goals detailed on the ISP, evaluate whether services are consistent with the ISP and determine any changes in the client's status that require updates to the ISP. These activities ensure that referrals are completed and services are obtained in a timely, coordinated fashion. In implementing the ISP, case managers are responsible for the following:

- 9.1. Client Education.** Based on the client's assessed needs and goals stated in their ISP, case managers shall provide clients with information and education about basic health care, prevention, available resources, and the application process for available resources.
- 9.2. Referrals/Linkages/Coordination of Care.** Case managers shall make appropriate and complete referrals to medical and support services offered within the agency or in the community. Case managers shall build strong relationships with health care providers and have a referral network they are comfortable with referring their clients to. After the referral, the case manager shall make contacts with the client and/or the agency to which he or she was referred to make sure linkages were established. This must be done even when the client has been the one to initiate the referral. To ensure that appropriate and complete referrals are made, the following are required:
 - Information about resources shall be readily and continually available to all clients.
 - As appropriate, case managers shall facilitate referrals by obtaining releases of information to permit provision of information about the client's needs and other important information to the service provider.
 - Case managers are encouraged to help clients access services on their own (advocacy). Advocacy is a form of empowerment and may help the client to take control of his or her own care. However, case managers must first assess the client's ability to do so, and shall actively facilitate referrals when the likelihood is high that a client will be unable to follow through on his or her own. Examples of these situations include: minimal English language ability; impairment in cognitive functioning, developmental delays, lack of client understanding of, or experience with, the system to be able to negotiate access to care; an unstable living situation; fragile health; drug, alcohol or substance use that interferes with the client's ability to follow through; emotional burden from a new diagnosis; mental health issues; cultural or other reasons that cause the client to be apprehensive about approaching a

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service providers. In such cases, case managers must take an active role in making and following up on the referral.

- It is important that the client is satisfied with the referral since they will be more likely to attend the appointment. If the client shows a sense of resignation or lack of motivation, he or she is not likely to seek needed care and services. In such cases, the case manager shall take an active role in making the referral, and an assessment shall be done to determine the basis for the client's behavior. In particular the need for a medical evaluation and/or mental health assessment may be in order.
- Whenever appropriate, case managers shall assure ongoing coordination of services between providers of care for the client. Case managers shall follow up with clients and providers of services to make sure clients are staying in care, making progress toward their individual service plans, and to see if there are changes in their living situation or if there are any problems that need to be addressed. This may be done on a one-on-one basis or through case conferencing.

9.3. Follow-Up and Monitoring. Case management is to be an ongoing "management" process, not simply initial or occasional assessments and referrals. Individuals who are self-sufficient and do not need periodic follow-up may not need case management services. Case management shall target individuals needing support in accessing and maintaining regular care. Follow-up contact by case managers shall be appropriate to the needs of the client rather than at predetermined intervals (e.g., once every one, three, or six months). To that end:

- Case managers shall respond in a timely and appropriate manner to client requests for assistance and to client needs identified by other providers. In general, case managers are expected to respond to clients and provider within one working day.
- Even when a case manager has not become aware of any care-related problems or situational issues, he or she shall contact the client periodically in case the client has hesitated contacting the case manager about his or her needs or issues regarding services. Such contacts can serve as opportunities for reassessment of the client's needs and living situation. Frequency of these contacts shall be determined by the case manager's assessment of the client's situation.
- For newly diagnosed clients, case managers may want to meet more frequently during the initial intake process to link clients into care within ninety (90) days.
- The following table is provided as a guide for the minimum frequency of assessments and contacts:

Level of Case Management	Client Acuity Level	Minimum Face-to-Face Reassessment Frequency	Minimum Contact Frequency
Basic (Non-Medical)	Basic	6 months	3 months
Moderate (Medical)	Moderate	3 months	1 month
Intensive (Medical)	Intensive	2 months	1 month

- These follow-up contacts need not all be face-to-face; telephone contacts would be adequate. However, periodic face-to-face contact is highly desirable, as it provides

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the chance for development of relationship and trust between the client and the case manager. Case managers shall acknowledge clients' successes and appreciate their commitment as progress is made throughout the individual service plan. With positive feedback, clients will be confident and empowered in committing to their service plans.

- The Acuity Scale shall be used to support the general categorization of client acuity; however, this categorization shall *not* be used as the primary determinant of frequency of contact; *need* shall be the determining factor. In addition, the category of client acuity (basic, moderate or intensive) shall not be based upon total acuity score. Instead, severity of need in any area(s) of the scale will indicate the low, moderate or intensive need for acuity. For example, a client may have a low total acuity score, but may have a high acuity score in one area that requires frequent contacts to ensure he or she stays in medical care or adheres to the treatment plan. Temporary loss of housing or transportation, for example, may make it difficult for a patient to comply with the medication regimen or to keep medical appointments. The case manager *must adequately note* the determining factors that indicate the need to override a client's acuity.
- To foster self-sufficiency, clients shall be encouraged to initiate contact with the case manager when changes occur in their health condition, living situation or support systems.

SECTION 10: COORDINATION OF MEDICAL CARE

Beyond simply educating the client about medical care, the case manager shall make the following efforts to support and coordinate the continuity of medical care:

10.1. Assess Medical Care Access. Case managers shall regularly assess client's access to medical care and any barriers to care. Case managers shall make an effort to identify barriers to adherence in each case (housing instability, alcohol and drug use, mental health issues, financial factors, attitudes toward medicines, etc.).

10.2. Monitor Medication Adherence. Case managers shall monitor client medication adherence. Client self-reports, pill counts, electronic pill bottle caps, diaries, adherence watches and other reminder systems, lab reports, etc., are used to assist with adherence. The case manager needs to be able to determine which method may be more helpful for a particular client. As needed, the case manager shall find out who has the primary responsibility for giving medication and shall provide HIV and adherence education to family members or caregivers. Case managers shall refer clients to additional treatment adherence services as needed.

- Case managers shall communicate any adherence barriers to client medical care providers.

Standard	Measure
Case managers shall regularly assess client's access to medical care and any barriers to care	Documentation on progress note will ensure
Case managers shall monitor client medication adherence	Documentation on progress note will ensure

SECTION 11: CASE MANAGEMENT SERVICE CLOSURE

Case management is considered a critical component in assuring access to medical care and other critical services. Discharge from case management services may affect the client's ability to receive and stay compliant with medical care. As such, discharge from case management must be carefully considered and reasonable steps must be taken to assure clients who need assistance in accessing care are maintained in case management programs.

A client may be discharged from case management services due to the following conditions:

- The client has died.
- The client has become ineligible for services (e.g., due to relocation outside Orange County or other eligibility requirements).
- The client no longer demonstrates need for case management due to his/her own ability to effectively advocate for his/her needs.
- The client chooses to terminate services.
- The client's needs would be better served by another agency.
- The client is being discharged from the correctional facility at which he/she is receiving jail case management services.
- The client demonstrates pervasive unacceptable behavior that violates client rights and responsibilities.
- The client cannot be located after documented multiple and extensive attempts for a period no less than three months.

The following describe components of discharge planning:

11.1. Efforts to Find Client. Providers and the County shall periodically query data systems to identify clients who appear to be lost to follow-up. It is recommended, but not mandatory, that at least three attempts to contact the client are made over a period of three months. However, termination shall not be assumed after a predetermined number of unsuccessful attempts at reaching the client at their documented address or phone number. Efforts shall be made to locate and contact a client who has not shown up for appointments or responded to case manager's phone calls. These efforts shall include contacting last known medical provider and other providers for which releases have previously obtained. *Within the constraints of previously signed releases of information*, speaking to other individuals who have been included on a signed release or staff at other programs, asking program's outreach workers for help, consulting the County's public records, making inquiries at shelters and charities may be examples of what can be done to locate the client. Clients who cannot be located after extensive attempts shall be referred to available outreach services so that they may be linked back into the care system.

- 11.2. Closure Due to Unacceptable Behavior.** If closure is due to pervasive unacceptable behavior that violates client rights and responsibilities including excessive missed appointments, the provider shall notify the client that his/her services are being terminated and the reason for termination. Within the limits of client's authorization to receive mail, notification of closure shall be mailed to the client. A copy of the notification shall be placed in the client's chart. If the client has no known address or the provider is not authorized to send mail to the client, the provider shall document other types of notification of closure (e.g. phone calls, visit) or attempts to notify the client of closure. If the client does not agree with the reason for closure, he/she shall be informed of the provider's grievance procedure.
- 11.3. Case Management Service Closure Summary.** A discharge summary shall be documented in the client's record. The case management service closure summary shall include the following:
- Circumstances and reasons for closure
 - Summary of service provided
 - Goals completed during case management
 - Diagnosis at closure
 - Referrals and linkages provided at closure
- 11.4. Data Collection Closeout.** The provider shall close out the client in the data collection system (ARIES) as soon as possible, but no later than thirty (30) days of mental health service closure. For clients receiving services other than mental health services at the same provider agency, the provider shall coordinate efforts between services to ensure that data collection closeout occurs no later than thirty (30) days of closure from all Ryan White services at that provider agency.
- 11.5. Transfer.** A client may be closed if his/her needs would be better served by another agency. If the client is transferring to another case management provider, case management service closure shall be preceded by a transition plan. To ensure a smooth transition, relevant documents shall be forwarded to the new service provider with authorization from client. Case Management providers from the two agencies shall work together to provide a smooth transition for the client and ensure that all critical services are maintained. Clients may be anxious to attend the first appointment with the new provider. Introducing the new case manager or staff with whom they will be working with may assist in the transfer process.
- 11.6. Jail Case Management.** If a jail case management client is being released from a correctional (or other institutional) setting, case closure shall be preceded by discharge planning. To ensure a smooth transition, provide a discharge plan to the new service provider as soon as possible, however no greater than thirty (30) days. Intense case management efforts may be needed prior to and immediately following a person's release/discharge. Since a person may leave custody of a correctional facility with only a few days' worth of medication, case managers shall plan ahead and help the client qualify for AIDS Drug Assistance Program (ADAP) or other programs to ensure continued access to medication. Also, a person leaving a correctional facility may have immediate

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problems in finding employment, housing, substance abuse treatment, etc. Social support systems may also be absent. Instability in living situation may interfere with the person's ability to access care and supportive services. Therefore, case managers shall plan ahead and try to help the person access public assistance or link him/her with community resources that could bring some stability to that person's situation. If possible, attend the initial appointments with clients.

Standard	Measure
Follow up will be provided to clients who have dropped out of case management without notice	Signed and dated note to document attempt to contact in client service record
Notify client regarding closure if due to pervasive unacceptable behavior violating client rights and responsibilities	Copy of notification in client service record If client has no known address or is unable to receive mail, documentation of other types of notification or attempt at notification in client service record
A case management service closure summary shall be completed for each client who has terminated case management	Client service record will include signed and dated case management service closure summary to include: <ul style="list-style-type: none"> • Circumstances and reasons for closure • Summary of service provided • Goals completed during case management • Referrals and linkages provided at closure
Closeout of data collection shall be completed for each client who has been closed from all Ryan White services at that provider agency	Data collection system (ARIES) will indicate client's closure no later than thirty (30) days of service closure
A client may be closed due to transfer if his/her needs would be better served by another agency	Client service record will include signed and dated case management progress note or other documentation that the client was closed due to a transfer and shall include: <ul style="list-style-type: none"> • authorization from client • transition plan • documentation that relevant documents have been forwarded to the new service provider
Case closure for jail case management shall be preceded by discharge planning To ensure a smooth transition, provide a discharge plan to the new service provider as soon as possible, however no greater than thirty (30) days	Client service record will include signed and dated case management progress note or other documentation that the client was closed due to release from a correctional (or other institutional) setting

APPENDIX A

Orange County Ryan White Act-Funded Services Case Management Acuity Scale

Name: _____ Chart Number: _____

This acuity scale is designed to assess one's need for case management. It is not intended to assess one's overall needs. Case managers are to use their skills and best judgment in scoring the client's acuity. Each area is to be assessed and scored in the column that best fits the client's current level of functioning. Score each item with a number of one through four in the date column after writing in the date that acuity is scored. Total the score at the end of page three to determine acuity level. Client's chart must have documentation of acuity assessment based on Standards of Care periodicity requirements.

Area of Assessment	One	Two	Three	Four	Date	Date	Date	Date	Date	Date
Medical	Asymptomatic. Linked to medical care and adherent to medical treatment.	Recent diagnosis or symptomatic. Needs linkage to medical treatment.	One or more active medical conditions. Poor adherence to medical treatment.	Debilitating disease and/or approaching terminal stages of illness.						
Substance Abuse	No current or past issues with substance use. Over 5 years sobriety.	Less than 5 years sobriety. Intermittent abuse of substances that does not interfere with daily functioning. Vulnerable to substance use triggers.	Periodic/current substance abuse that interferes with daily functioning.	Chronic or acute substance abuse/dependence causing major impairments in daily functioning.						
Mental Health	No history of mental illness, psychological disorders, or psychotropic medications. No need for counseling referrals.	History of disorders/treatment in client or family. Moderate level of stress. Needs mental health services.	Clinical diagnoses. Poor adherence to mental health treatment.	Frequent mental health crisis. Danger to self or others. Need crisis/psychiatric intervention.						
Support System	Dependable and available support.	Needs linkage to appropriate support.	Needs support but is not accessing it.	No support system. Unable to cope without intervention.						
Transportation	Has means of transportation consistently available.	Needs linkage to transportation services.	Unable to access transportation without continued assistance and coordination.	Not applicable						
Education	Understands HIV disease. Avoids risk behaviors.	Initial and/or intermittent need for education and support.	Ongoing need for education. May engage in high-risk behavior.	Frequently engaging in high-risk behavior. Continual need for treatment adherence support.						

Appendix A Continued: Case Management Acuity Scale

Client Name: _____

Chart Number: _____

Area of Assessment	One	Two	Three	Four	Date	Date	Date	Date	Date	Date
Legal	No current or recent legal problems.	Needs linkage to legal services.	Crisis involving civil matters.	Active in the criminal justice system.						
Basic Needs	Food, clothing, and other sustenance items available through own means. Able to perform activities of daily living (ADL).	Sustenance needs met regularly with some periods of relapse. Access assistance programs for food and household items. Able to perform ADL.	Often needs help with accessing assistance programs. Often without food or clothing. Needs some ADL assistance.	Chronic nutritional deficit due to inability to access food programs. ADL assistance required.						
Primary Relationships	Supportive family environment. Family provides emotional and financial support when needed.	Limited support within family structure. Occasional verbal conflicts.	Some family members have substance abuse and/or mental health issues. Sporadic verbal and/or physical conflicts among family members on a regular basis.	Frequent verbal, physical, and/or sexual abuse in family members on a regular basis. Active disruptive Family mental health and/or substance abuse issues.						
Living Situation	Stable and adequate housing	Needs short term assistance, rent or utilities to remain in adequate housing.	Residing in overcrowded or substandard living conditions. Imminent or recent eviction. Living in a shelter or transitional housing.	Homeless. Chronic housing placement issues.						
Financial/ Benefits	Steady source of income not in jeopardy.	Occasional need for financial assistance and/or benefits counseling.	No steady income/financial resources.	No income or financial resources.						
Culture	Culture is not a barrier to accessing services.	Occasional need for education for client/family.	Culture barriers interferes with ability to access care.	Unable to access care due to cultural barriers.						
Language	Language is not a barrier to accessing services.	Occasional need for interpretation/ translation services.	Limited English proficiency is a continual barrier to care.	Not Applicable						
Self Determination	Understands service system. Ability to access resources without assistance.	Able to use own initiative to identify and access resources given some assistance and guidance.	Unable to identify and access resources without sustained assistance.	Not Applicable						

Appendix A Continued: Case Management Acuity Scale

Client Name: _____

Chart Number: _____

Date	Total Score	Level of CM	Justification of Score Over-ride (if applicable)	Referral Made	CD4/VLoad	Case Manager Name	Signature

NOTES:

ACUITY GUIDE		
Level of Case Management	Total Score	Acuity Determination Conditions
INTENSIVE (Medical Case Management)		
Minimum face-to-face acuity reassessment every two months Minimum contact every month	29-56	Score with threes in medical, mental health and/or substance abuse
	Any	Score with fours in medical, mental health and/or substance abuse
MODERATE (Medical Case Management)		
Minimum face-to-face acuity reassessment every three months Minimum contact every month	16-28	Score with two in medical or three in mental health and/or substance abuse
	29-54	Score with three or four in any category except Med, MH or SA
BASIC (Non-Medical Case Management)		
Minimum face-to-face acuity reassessment every six months Minimum contact every three months	16-28	Score with three or four in any category except Med, MH or SA
	19-28	No scores of two in medical and no scores of three or four in any other category
NO NEED FOR CASE MANAGEMENT - Make appropriate referrals under CLIENT ADVOCACY		
	14-18	No scores of two in medical and no scores of three or four in any other category