

MAKING THE CONNECTION

**Standards of Care for
Client-Centered Services:**

Case Management

**San Francisco EMA
Includes San Francisco City and County,
San Mateo County and Marin County**

Making the Connection:

Standards of Care for Client-Centered HIV Case Management

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San Mateo County and Marin County

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Dedication

Making the Connection: Standards of Practice for Client-Centered HIV Case Management is dedicated to the clients of the HIV Health Services System, to case managers who devote themselves to providing service to others, and to individuals who are both client and case manager in the San Francisco EMA.

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INTRODUCTION

These Standards of Practice for HIV Case Management represent the culmination of one year's work on the part of the HIV Planning Council, HIV Health Services staff and a Task Force comprised of members of the community of HIV service providers and consumers. The Standards are designed to develop consistency within case management practices throughout the San Francisco Eligible Metropolitan Area (EMA)¹, in terms of both quality and scope of services. The completion of these Standards fulfills Phase I of the Case Management Objectives for the HIV Health Services *Comprehensive Five Year Plan*, "A Client-Centered System of Care." The Plan calls for the development of a Case Management Services Plan, which includes "a working definition of HIV case management and principles, standards and guidelines for HIV case management practice." Each of these elements is contained in this document.

The central feature of this document is the Standards of Practice for each of the seven core activities that comprise HIV case management. These include:

1. Initial Interview and Intake
2. Comprehensive Assessment
3. Care Planning
4. Implementation of the Care Plan
5. Follow-Up and Monitoring
6. Reassessment
7. Transfer and Discharge

A guideline has been developed for each of these core activities. Each guideline specifies: 1) the purpose or goal of the activity; 2) the tasks to be accomplished; 3) the process involved; 4) the practical aspects of conducting the activity; 5) problems which might arise during the activity; and 6) "Practice Hints," which highlight some of the more complicated interpersonal and interagency dynamics which can arise during the course of case management.

In addition to the guidelines for conducting each component of case management, these Standards include more general criteria for: 1) the training and qualification of case managers, 2) case conferencing, 3) quality assurance monitoring, and 4) documentation and chart keeping.

This document also contains the *Client Acuity Scale*, located in Appendix A. It is a tool for estimating the level of case management involvement that a client is likely to need. It can also be used to help balance caseload intensity and size according to the needs of the clients entering the program.

In all aspects, these Standards are intended to reflect the "client-centered" philosophy that is the core intention of the *Comprehensive Five Year Plan*. By client-centered, it is meant that people with HIV disease, their caregivers and providers are and will continue to be involved in all aspects of program planning, implementation and evaluation. These Standards were developed with the input of individuals, both clients and providers of service who represent the diverse communities affected by HIV disease in the San Francisco EMA. They are oriented to the needs

¹ The San Francisco Eligible Metropolitan Area (EMA) consists of San Francisco, San Mateo, and Marin counties.

of the clients and to the service priorities identified by clients. These standards are not based on special agency interests or priorities, except when organizational needs conform with those of the clients.

The development of these Standards was guided by the philosophy that clients are full partners in their care management. These Standards encourage, and in many instances require, that the client be involved in all decisions affecting his or her choice of provider, the level or intensity of the services he or she receives, and in planning for the future disposition of his or her financial and legal affairs. The case manager has several interconnected roles as counselor and advocate for the client while assisting the client in navigating the service systems with the appropriate supports to help the client maintain his or her independence, and in achieving a comfortable, safe, and secure living situation. The case manager is a facilitator. The client's participation in case management is voluntary and the client can decline to participate in any or all parts of the program at any time. These precepts should be kept in mind by all participants in HIV case management programs.

It is a primary goal of the HIV Health Services *Comprehensive Five Year Plan* that all HIV related services be well coordinated. The application of uniform practice standards for case management will facilitate improved service coordination in a number of ways. The Standards of Practice actively encourage collaboration among providers through case conferences and the establishment of interdisciplinary teams. This will facilitate better communication among providers from all service sectors, including primary medical care, emotional and practical support, and other treatment programs, such as substance abuse and mental health. System-wide coordination of services across service categories is necessary to ensure that clients really do receive a continuum of service to meet their needs and to readily respond to changes in their service needs throughout the course of the disease. Because these Standards of Practice specify what activities are included in each core function of case management and provide case managers with an approximate length of time it should take to complete each task, they will facilitate the acquisition of both case management and referral services in a timely manner.

These Standards are intended to ensure that wherever clients enter the system, they can expect to receive the same services, when case management is requested. They are not meant to add to the regulatory and contractual constraints that restrict case managers in providing appropriate services to their clients. Rather they are meant to promote the flexibility that is needed to accommodate clients' changing needs and preferences and to promote the resources and services available in the community.

The following are basic principles on which this document is based:

- Case management is a client-centered service that respects the client's rights, values and preferences.
- Participation in the case management program is voluntary and the client can decline to participate in any or all parts of the program at any time.
- Case management coordinates any and all types of services and assistance to meet the client's identified needs.

- Case management requires a combination of clinical skills, competencies, and sensitivity to the client's cultural, linguistic, and lifestyle preferences.
- Case management is part of a comprehensive system of services that provides continuity of care for people with HIV throughout the course of their disease.

DEFINITION OF HIV CASE MANAGEMENT

Case management for people with HIV disease is a service that links and coordinates assistance from multiple agencies and caregivers who provide psychosocial, medical, and practical support. The purpose of case management is to encourage clients to obtain the highest level of independence and quality of life consistent with their functional capacity and preferences for care.

Case management is comprised of seven core activities defined in these Standards of Practice:

- 1) Initial Interview and Intake, which includes determination of whether case management is an appropriate service for the client and collecting basic eligibility information;
- 2) Comprehensive Assessment of psychosocial, medical/nursing, and practical support needs;
- 3) Individual Care Planning, based on the results of the Assessment and outlining goals, objectives, and activities to meet the client's needs and preferences for services and support;
- 4) Implementation of the Care Plan, which involves the step-by-step accomplishment of the goals and objectives laid out in the plan by the client and the case manager;
- 5) Follow-up and Monitoring, which involve regular in-person or telephone contact between the case manager and client to insure that the goals of the Care Plan are being achieved or are modified accordingly;
- 6) Reassessment, performed as needed to ensure that the Care Plan and services continue to be of high quality and appropriate for the client's condition, and that care among providers continues to be coordinated; and
- 7) Transfer and Discharge, when appropriate.

Case management for people with HIV disease is a client-centered, flexible, and quality-driven service. It is based on a trusting, working relationship between the client and the case manager. The client is an equal player in his or her care management. It is expected that, to the best of his or her ability, the client will participate in all decisions involving the choice of caregivers and services, and in securing benefits and entitlements. The client is informed of his or her rights and responsibilities at the beginning of the case management relationship when his or her informed consent to participate in the case management program is obtained. It is also understood that the client can decline to participate in all or part of the case management program at any time.

Case management is a quality-oriented, cost-conscious service, and promotes the efficient use of the HIV Services System. It is intended to enhance the appropriate use of the other services included in the HIV Continuum of Care. It also provides an extra layer of support for clients who may be dealing with multiple sources of stress, related to both the effects of the physical illness, and the secondary effects that HIV disease has on a person's emotional well-being, finances and social relationships.

BACKGROUND OF HIV CASE MANAGEMENT

The concept of case management for people requiring long term care has been developed in the social work and nursing fields for over two decades. HIV case management was initially derived from models of care for the elderly, mentally ill, and those with other chronic and degenerative diseases. It has since emerged as the prominent strategy to coordinate the wide range of health care, psychiatric, psychosocial and practical support needs of people with HIV disease. As therapeutic responses to HIV disease develop and life expectancy after diagnosis increased, AIDS has come to be viewed more as a long-term care challenge with episodes of acute illness becoming less frequent for the medically well-managed patient. Chronic care models of disease management have been employed both to maintain the independence and quality of life of the person with HIV disease, and in the belief that community based psychosocial support and nursing interventions would prove cost effective in the long run by reducing hospital admissions and length of stay. In particular, for the low income client and those who have been marginalized by virtue of dual or triple diagnoses of substance abuse or mental health problems, case managers have come to play an increasingly important role in dealing with access problems and crisis situations by serving as advocates and counselors for their clients.

HIV disease progresses differently in each individual that it affects. People with HIV disease do not necessarily experience a strictly linear decline in their health. After an episode of debilitating illness, an individual may recover his or her strength and health, and experience a period of enhanced functioning. Newly approved anti-retroviral drugs and widespread use of combination therapies promise to both extend the life expectancy of people with HIV disease and to reduce or forestall the effects of advancing disease. The disease also has varying psychological impacts, most prominently depression that can wax and wane over the course of the client's life. Therefore, clients who engage case managers may require periodic adjustments in the level of intensity of those services. Some clients who regain their health or financial or emotional stability may elect to discontinue case management services either temporarily or permanently.

WHO SHOULD USE THESE STANDARDS OF PRACTICE?

These Standards of Practice are intended for use by case managers, their supervisors, program administrators, clients and other service providers in the HIV Service System. They are intended to provide all users with a common understanding of the case management process and the quality standards expected by clients, providers and administrators of the HIV Service System. For case managers working within the context of the HIV Service System and for CARE funded programs, these Standards represent a minimum acceptable practice standard. These Standards will allow the individual case manager to look at his or her mode of practice and make an assessment of whether he or she complies with the minimum requirements considered acceptable

by his or her colleagues and clients. Case managers can self-regulate their practices accordingly. These Standards should clarify for all readers that case management comprises all seven core functions. Services such as Information and Referral or Client Advocacy may be included in the process of case management. However, when these activities are conducted independently of the processes of Intake, Assessment, Care Planning and Follow-Up, they do not in and of themselves constitute case management.

HOW TO USE THIS DOCUMENT

It is recommended that all case managers and case manager supervisors thoroughly familiarize themselves with the contents of this document. These standards provide clarity for what is expected of programs providing HIV case management services.

The document may be used as a manual. It is organized to take readers through the major steps of case management in the order in which they should occur. Issues relating to meaningful interaction between clients and providers are addressed throughout the document in the sections entitled: *Problems that Arise* and *Practice Hints*. These standards should be an integral part of any new case management staff's orientation. Staff currently providing case management services should read the document for any changes they may need to make in their practice. Additionally, all staff should note areas where program staff may need further assistance in achieving a desired level of skill.

While this document does address many issues, it is not meant to provide solutions for every situation. These standards are a first step in a multi-year process of studying and refining case management practice in San Francisco. This Plan is a living document and will continue to be updated as necessary changes are identified.

The reception of key concepts relating to client-centered practice (developing trust, obtaining client consent, creating partnerships with clients, etc.) throughout the document is intentional. If the document is read at one sitting, this repetition will accentuate the importance within these standards. If the document is read chapter by chapter at different sittings, the repetition ensures that at each reading, these concepts are understood to be an integral part of case management practice.

AGENCY AND SYSTEM-WIDE ISSUES

Effective use of these Standards by HIV case managers will require support by the agencies or programs in which they work. These Guidelines contain implications for the organizations, agencies and programs in which HIV case management is practiced. Agency issues that affect case management practice include: organizational ownership and structure, supervisory processes, administrative supports and staffing patterns, caseload size, qualifications for case managers, and management information systems to support case management activities.

System-wide issues include: 1) the ongoing training needs of case managers; 2) the development of interagency agreements regarding consultation, collaboration and referral; and 3) procedures that are undertaken when clients are utilizing the services of multiple case managers. In addition, the development of standards of practice for case management within the HIV Service System

sets the stage for similar work related to other service categories. Other services closely related to case management, such as client advocacy, need to be expanded in scope to encompass services and assistance that when undertaken alone do not constitute case management, but are nevertheless essential services for many clients.

HOW WILL THESE STANDARDS BE IMPLEMENTED?

During implementation, case management staff will be engaged in assessment and technical activities to acquaint them with application of these Standards to their program's practice. Individual program technical assistance will be provided in necessary areas. Additional workshops will be offered to case management staff related to topics such as psychosocial assessment and care planning. In a later phase of implementation, evaluation of these Standards will be carried out to determine: 1) the extent to which all components of case management are being carried out by programs; 2) the problems or obstacles programs encounter in trying to implement the standards; and 3) any flaws or inconsistencies that need to be corrected. During the first year of implementation, programs will not be penalized if they do not come into full compliance with the Standards, but all programs will be expected to apply the Standards to the fullest extent possible.

WHO NEEDS CASE MANAGEMENT?

Case management services are part of a continuum of care that is provided by the HIV Service System. Although anyone with HIV disease who resides in the San Francisco EMA and meets the financial eligibility criteria for a CARE funded program is eligible for case management, some individuals will benefit more than others from case management. These include individuals who have multiple issues in addition to HIV disease and those who lack adequate support from family or a social network to cope with their current or impending situations.

Not all people with HIV disease need case management. Many individuals have the personal resources to plan and coordinate their own care and treatment, at least until they enter the later stages of the disease. People who have had a high degree of social, psychological and physical functionality before becoming symptomatic with AIDS are most likely to be able to continue to function well, once they are diagnosed. Such individuals may never need case management services. They may make limited use of Information and Referral Service, Client Advocacy or any of the other services that comprise the HIV Continuum of Care. Other individuals may need only a minimum level of assistance until they face a severe decline in health status or approach the final stages of disease.

THE ROLE OF THE CASE MANAGER

The principal functions of the case manager are to: 1) thoroughly assess the client's need for services and support; 2) provide support and advocate for the client as appropriate; and 3) coordinate the services that the client receives from various service providers, making sure that the client receives the best mix of services and avoids unnecessary and expensive duplication of services. HIV case managers must be able to communicate effectively with their clients, their co-workers, and staff at other service agencies. They must be effective advocates for their clients with other social service agencies, hospitals, and governmental agencies. People with HIV disease are subject to precipitous changes in their health and functional status and may need their

case managers to assist them in acquiring rapid access to health and social services providers as new needs arise. Because the case manager keeps in touch with the client on an ongoing basis, he or she learns about changes in a client's physical or mental health, social support system, or finances as they occur. The case manager can intervene when emergency assistance is needed with finances, housing, or personal care services. The case manager can also alert other providers when a change in the type or intensity of treatment is indicated. When alterations are made in a timely fashion, the client is more likely to remain stable and avoid costly hospitalizations and dislocations.

Case managers are encouraged to work as part of an interdisciplinary team of caregivers. Optimally, and with the client's consent, each client has his or her own team. This may include the primary medical care provider, counselor, therapist or social worker, client advocate, and other caregivers, including home health aides, friends, and family. The case manager takes the lead position in communicating with each member of the client's team about the client's current or emergent needs for services and support, changes in health and psychosocial status, and problems that might have arisen with care and treatment. By consulting with other providers and caregivers and by convening case conferences, the case manager plays a lead role in assuring continuity of care and eliminating gaps in the client's service configuration. Working directly with clients, their families, and caregivers, case managers are in a unique position to represent the client with other service providers; to advocate for the client with legal, financial, and entitlement services; and to procure services that may be needed on an emergency basis such as housing, utilities, or transportation.

CLIENT INVOLVEMENT

The HIV Service System is committed to facilitating client involvement in all the decisions that affect their lives. Therefore, client involvement in planning and managing his or her care is seen as essential. Clients are encouraged to take the lead in determining the intensity and scope of services they need and in procuring those services to the extent that they are capable. Assessing client needs, developing and implementing the care plan, and refining and evaluating the case management relationship comprise interactive processes between the client and the case manager. The relationship between the case manager and the client emphasizes client participation and control over day-to-day activities, including treatment, the coordination of caregivers, and decisions to intensify or discontinue services. In many ways, the case manager acts as an agent for the client, carrying out tasks to fulfill the client's requests for services and treatment. For this reason, it is critically important that both the client and case manager keep in mind the voluntary nature of their relationship. The role of the case manager is to advocate, support, and educate the client so that the client is empowered to achieve the highest degree of self-management and autonomy possible, given the client's disease stage and the circumstances of his or her life.

WHERE IS CASE MANAGEMENT PRACTICED?

HIV case management in the San Francisco EMA is practiced in a range of settings, including community-based organizations, hospital outpatient clinics, freestanding primary care centers, and substance abuse treatment centers. The emphasis and range of services of HIV case management programs may vary according to the setting, ownership and professional specialty

of the sponsoring agency. Community-based organizations have developed their own responses to the HIV epidemic to meet the special needs of their target populations. Each affected community has unique needs with respect to cultural variables, such as language and social relations, access to existing health and social services, and financial resources. As such, case managers in each unique community setting should tailor Care Plans according to the availability of culturally appropriate services.

Many practice models exist for case management within the San Francisco HIV Service System. In some settings, case management services are brokered by agencies that provide no direct services. In other settings, including multipurpose social service agencies and visiting nurse programs, both case management and some, if not all, of the direct services associated with the AIDS continuum of care are provided by a single agency. There are also umbrella organizations or consortia of AIDS-related organizations that band together specifically for the purpose of coordinating care for people with HIV disease and providing case management, client advocacy, and home nursing and/or hospice care. Very often there is a combination of practice modalities and sponsoring agencies. There is great variation in substance and style, especially in regards to client assessment and follow-up, due to the broad spectrum of service agencies that practice case management. Because of this variation, standards of practice for HIV Case management are needed to guarantee high quality of care for all clients regardless of where they receive their case management services. Each of these factors, along with professional nursing and social work standards for client assessment and care, plays a role in determining standards of practice for case management.

QUALIFICATIONS OF CASE MANAGERS

In the San Francisco HIV Health Services System, case managers come from a variety of backgrounds in terms of their education and work experience. Historically, case managers have most often been social workers or nurses. More recently, community trained workers and other paraprofessionals have begun performing the functions of case managers. Encompassing issues relating to both academically and community trained staff, this sections outlines qualifications required for case managers and case manager supervisors.

As members of client-centered organizations, case management providers depend on their staff's abilities to form relationships, intervene effectively, and provide continuity of care for their clients. Community organizations are also increasingly committed to providing services that are culturally appropriate for their target population. This often means making a special effort to recruit quality staff that reflects the ethnic, racial, or cultural background of the clients served by the program. These Standards for the qualifications and training of case managers are designed to assist programs to provide culturally competent care. They are based on the need to achieve a good cultural match between case manager and client as well as between specific levels of educational and experiential background.

Academic Background

In the San Francisco EMA, there is agreement among providers that those with different levels of academic background can effectively carry out the job of case manager. It is important to focus on the person's experience and skills, not on the degree. Proponents of graduate education for

case managers argue that professionally trained staff is better able to work autonomously and to deal with the complex issues of finding and allocating scarce resources and providing differential support. Whatever their level of training, case managers in the HIV Service System must possess or be trained in the analytic skills and knowledge base necessary for carrying out the complex tasks involved in the job. They also must possess a high level of interpersonal sensitivity, cultural awareness and knowledge of the health and social service system.

Ongoing training is necessary if HIV case managers are to keep up with the many changes taking place in HIV services in particular and in the organization of health services in general. Case management programs are required to provide at least 16 hours per year of on-the-job or community training for their case management staff.

Paraprofessional or Community-Trained Case Managers

Case managers who have not been academically/formally trained may have adequate preparation for performing most case management tasks including intake, preliminary assessment, and giving immediate referrals. However, additional training on comprehensive psychosocial assessments and care planning may be necessary. If case managers do not have appropriate training for performing a comprehensive psychosocial assessment, supervisory personnel or consultants must be employed to complete those aspects of the assessment.

Case Manager Qualifications

Three options are allowed for the hiring of new case managers: 1) a masters degree in social work, counseling, nursing or other appropriate field, including clinical training; 2) a Bachelor's degree plus appropriate experience in human services; or 3) a high school degree or GED plus three years experience in human services, which may include work as an intern or volunteer.

Case Manager Supervisor Requirements

Case manager supervisors must have either: 1) masters level training in nursing, social work or a related discipline plus two years of progressively responsible work experience; or 2) four years of case management experience including two years of supervisory experience.

Agencies may wish to hire a person who does not meet these standards but who has a combination of skills and experience that in the judgment of the hiring committee prepares the individual for the tasks and responsibilities of case management work. In this situation, an individual training plan must be developed and implemented at the time of hiring. This ensures that all case management staff has appropriate training to carry out the duties necessary for quality case management. Documentation of the training plan and its completion must be included in personnel files.

If neither the case manager nor the supervisor has the training necessary to administer a complete psychosocial needs assessment, then the agency must employ such a person to assist in the assessment or have a consultancy agreement with another agency that can provide such services. (See section on Consultation for more on this issue.)

CORE ACTIVITIES

CORE ACTIVITY #1: INITIAL INTERVIEW AND INTAKE

Overview

The Initial Interview and formal Intake are the first encounters that the client will have with the case management program. They provide an opportunity to inform the client about the scope of services available through case management and of the full spectrum of services available through the HIV Services System.

The Initial Interview includes both formal and informal interactions that help the client and the case manager determine whether case management services are appropriate for the client at this time. The Initial Interview also presents the first opportunity for the case manager to determine whether the client has any crisis situations that require immediate attention.

Intake is the formal process of collecting information to determine the client's eligibility for services and his/her immediate service needs. During the Intake, the client should be informed that the HIV service system is intended to be client-centered in all aspects and that case management services in particular are intended to assist the client in maintaining his or her well being and independence. The information collected during the Intake process provides the basis for obtaining an informed consent for service and for conducting the comprehensive needs assessment, which will follow.

Goals of the Initial Interview and Intake

1. To begin to establish rapport and trust between the client and case manager;
2. To determine the immediate needs of the client and connect the client to the appropriate resources;
3. To determine whether the client's needs for social and practical support can be well served by the particular agency. This includes considering whether the case management program is culturally and otherwise appropriately matched to the client;
4. To inform the client of the scope of services offered by the case management program, including the program's benefits and limitations;
5. To inform the client of his or her rights and responsibilities as a participant in the program;
6. To obtain the client's informed consent to participate in the program;
7. To make a mutually agreed upon decision between the client and case manager to go forward with the client's enrollment in the program.

Purpose of Initial Interview

The Initial Interview is necessary to determine whether the client is in a crisis situation or requires immediate direct service referral. It provides the case manager with important first impressions about the client and his/her needs. And it also allows the client to interact with the case manager and to consider the ramifications of his or her participation in the program. With this information the case manager can choose to 1) provide immediate assistance through the resources of the agency, 2) refer the client to another agency, or 3) continue the enrollment process by conducting the client Intake. This first contact between the client and case manager also establishes the basis for the development of rapport and trust, which are essential elements in a successful case management relationship.

Purpose of Intake

Enrollment into a case management program may often be the client's first encounter with the HIV Services System, outside of primary medical care. During the Intake, all the information necessary to register the client into the wider HIV Service System must be collected.

During the Intake process, the client also will be informed of his/her rights and responsibilities as a participant in the program. The client's informed consent to participate in the case management program should be obtained at this time. In the process of acquiring the client's informed consent, it is important to ensure that the client understands the grievance procedure as well as the right to refuse any or all services. This right can be exercised by the client at any point during his participation in the case management program.

The client will be provided with a clear explanation of the range of services offered by the case management program and of the role of the case manager. Questions that the client or his/her caretakers might have about the program and about how involved the case manager will be with the client may arise at this time. It is also important for the case manager to make the client aware of the limitations of the program as well as its offerings. This information must be provided during the Intake in order to avoid problems that inappropriate expectations can cause the client and the agency later on.

Once the Initial Interview and Intake are completed, both the case manager and the client have the information needed to determine whether case management is the appropriate service for the client. Because resources are limited, case managers are encouraged to refer clients who are successfully self-managed or who have less intensive needs to mental health, advocacy, and other social and practical support programs. Individuals who are most likely to benefit from case management include those who have multiple service needs that require coordination.

Practical Aspects of Conducting an Intake

- ***Who Performs the Initial Interview and Intake?***

The Initial Interview and Intake are commonly performed by a variety of trained personnel. These include case managers, caseworkers, intake workers, and other agency support staff. Those conducting the Initial Interview and Intake should be prepared to handle crisis situations as they arise.

Since conducting the Intake involves making a preliminary assessment of the client's needs and functional abilities, it is strongly suggested that Intake be performed either by a case manager or other staff member working closely with the case manager. The intake worker must have the ability to communicate effectively with clients about how the case management program operates. He or she must also have the skills necessary to assess the client's immediate needs for services or assistance. It is also the responsibility of the intake worker to obtain the client's informed consent to participate in the program.

- ***How Are the Initial Interview and Intake Conducted?***

The Initial Interview is sometimes initiated with a telephone encounter and completed in person where answers to questions are verified. Intake is most often conducted during a face-to-face meeting with the client. This should be done in a place that is mutually agreed upon to be safe and confidential. Such sites can include the case manager's office, the client's home or hospital room, or at another program site. Face-to-face contact is necessary for the case manager to obtain an initial impression of the client and his or her overall mental and physical status.

- ***How Long Does it Take to Complete the Initial Interview and Intake?***

In most cases, the entire process of Interview and Intake can be completed within two hours. In some circumstances the Interview may require multiple contacts with the client. Intakes that include all or part of an initial psychosocial and medical assessment also may take longer to complete. Complex Intakes may require more than one encounter.

Information Collected During Client Intake

The information collected during the Intake provides the basis for determining program eligibility and for conducting the comprehensive client Assessment that follows. This information includes the verification of the client's HIV status and county address.

Case management programs are encouraged to develop Intake and Assessment forms that could be adapted to on-line use as computerized data collection and management become the norm. It is a long term goal to develop forms that are sufficiently standardized to produce comparable data across agencies.

Registration Information

Basic information on client characteristics is collected during the Intake. This information is expected to become part of the "REGGIE" system of client registration for the HIV Service System. REGGIE is a uniform registration system that is in development for use by all programs receiving CARE funding. Once a client registers through REGGIE, the registration process does not have to be repeated. Therefore, case managers and intake workers should check to see whether a client has been previously registered through REGGIE. REGGIE is being implemented in phases from 1996 through 1999 and will not be operating at all HIV service sites when these Standards go into effect.

The following client information is required by all programs for registration into the HIV Services System:

1. Client's name
2. Address
3. Date of birth
4. Gender
5. Confirmation and date of initial AIDS diagnosis or of first positive HIV antibody test
6. Racial or ethnic identification
7. Consent to participate
8. Verification of residency/address
9. Statement of income
10. Living situation
11. Number of people in client's household
12. Annual household income
13. Health insurance status
14. Health disease stage

Special Note

The following information is required by REGGIE for all clients enrolling in the HIV Service System through either primary medical care or case management agencies:

1. Homelessness status
2. Active substance use (optional for case management)
3. Active psychiatric illness (optional for case management)
4. Primary health care source
5. HIV positive year
6. CD4 count at time of entry (can accept self-reporting)
7. Date of CD4 count (optional for case management)
8. Source of CD4 count (optional for case management)
9. Source of exposure to HIV
10. TB Status
11. TB Treatment Status
12. Is client anergic?
13. Results of Last PPD
14. Date of Last PPD

Most clients will not have all of this information readily available. It is the job of the case manager to assist the clients in obtaining the necessary documentation.

It is strongly recommended that case management Intake forms include this information in a form that is compatible with REGGIE's data collection protocols.

Additional Information to be Collected During Intake

In addition to the required Registration data, the following information should be routinely collected during the Intake. This information is necessary to allow case managers to make an initial determination of need and to prepare a comprehensive assessment of client need.

1. Demographic information, including:
 - a. Primary language spoken by client
 - b. Highest level of education completed by client
2. Financial information, including:
 - a. Gross monthly income
 - b. Sources of income
3. Information on the client's practical situation, including:
 - a. Transportation resources
 - b. Food resources
4. Emergency contact information
5. Presenting problem
 - a. Reason for initial request for service
 - b. Initial assessment of whether client is appropriate for case management

Process

The Initial Interview and Intake are the first encounters that the client will have with the case management program. It is extremely important that the process of building trust and understanding between the client and the case manager begin during this process. The acquisition of a complete set of data is secondary to the development of a comfortable rapport with the client. Balance is needed between the collection of data and the need for the Interview to remain client-focused. Case managers should allow the interaction with the client to evolve in such a way that the client feels free to express his or her needs openly and for those needs to be acknowledged by the case manager.

During the Intake process clients should be given a clear understanding of what is to follow in terms of their integration into the case management program. Dates and times should be set for the complete assessment to be completed, referral information should be provided to the client to meet immediate service needs and the client should be told how to contact the case manager. Each program will have a different protocol for accomplishing these tasks, but a reasonable timeframe should be established so that the client knows when his or her care plan will be completed and when he or she will begin to receive needed support services.

Once eligibility has been established and the client has made the decision to enroll into the case management program, the case manager must inform the client that the next step in the case management program is a comprehensive Assessment of the client's needs.

Problems and Issues That Arise During Intake

1. At some sites, clients must re-enroll on a regular basis. At many agencies, different clinics or programs may require separate registration or Intake processes. For the purpose of streamlining services and avoiding unnecessary duplication of effort, it is important for providers participating in the HIV Services System to develop methods of sharing baseline client data, including eligibility and registration data and periodic updates of that information. The REGGIE system should help facilitate this sharing of registration information, but will not eliminate the need for additional assessment information.

2. Ideally, HIV case management should be used to provide the right balance of social and practical support and care coordination to assist clients to maintain independent lives in the community. However, much of HIV case management takes place on a crisis control basis. Clients who request or are referred to HIV case management programs often have multiple problems and have not been able to manage either their HIV-related care or their other needs. Clients may present for case management services when they have lost or are about to lose their source of income and/or housing, or they have become symptomatic with HIV disease and are struggling with mental health or substance abuse problems. The needs of such clients can be overwhelming to both the case manager and to other program staff. Case managers and their supervisors are encouraged to balance client caseloads to the extent that is possible so that the needs of low and moderate maintenance clients are not overlooked in favor of responding to clients in more extreme crisis situations.

Practice Hints

1. Don't be disappointed if the client is somewhat resistant to sharing openly with you at the first few meetings. A deeper level of trust may develop as the client becomes more confident that you can and will help him/her.
2. Listening carefully to the client during the initial contact is critically important to developing a relationship of trust. Patient listening will help the client feel safe enough with the case manager to disclose necessary information about his/her life situation and needs. Do not bombard the client with a barrage of questions during this first encounter. Instead, encourage the client to talk about his/her needs and problems, ask questions, and let a natural dialog develop.
3. The client may not have a letter of HIV diagnosis or proof of local residency. If this is the case, the case manager should document the reasons that eligibility cannot be confirmed at the time of Intake and initiate the process to obtain the required documents. Lack of documentation should not become a barrier to the acquisition of service. Necessary service referrals should be made on the basis of presumptive eligibility.

CORE ACTIVITY #2: CLIENT ASSESSMENT

Overview

Once the Initial Interview and Intake are completed, a comprehensive Assessment is made to determine: 1) the client's needs for treatment and support services, 2) the client's current capacity to meet those needs, and 3) the areas in which the client requires assistance in securing services. Once these needs are identified and documented, case managers should work with their clients to prioritize service and support needs in the form of the written Care Plan.

Some programs conduct the Intake and Assessment together in one combined session. For those programs, the guidelines and data elements outlined in this section should be combined with the Initial Interview and Intake guideline.

Purpose and Goals

The Purpose of the Assessment is to determine:

1. The extent and nature of the client's service needs;
2. The ability of the client to meet his or her personal needs;
3. The ability of those in the client's social support network to help meet the client's needs;
4. The extent to which other service agencies, including the client's primary medical provider, other treatment centers and other case management programs are involved in the client's treatment or care;
5. The relative time commitment the client will require from the case management program, given the client's current needs and functional abilities;
6. The need for education or other support to reduce HIV transmission risk.

After completing the Assessment, case managers should be able to answer basic questions about the new client, his or her care needs, and the client's potential relationship to the case management program. The information collected during the Assessment should be used as a baseline from which to update as the client's health status and service needs change over time.

Practical Aspects of Conducting an Assessment

- ***When Does the Assessment Occur?***

An Assessment should be conducted as soon as possible after the client Intake has been completed. Intake and Assessment can be conducted during the same client encounter.

- ***Who Performs the Assessment?***

It is strongly recommended that the Assessment be performed by a case manager trained to identify the signs, symptoms and range of needs characteristically associated with HIV disease (See supervision guidelines regarding staffing). The case manager should be someone who is fluent in the language and understands the culture and values of the client.

- ***How is an Assessment Conducted?***

The Assessment is conducted during an in-person encounter with the client, usually at the case management agency. Sometimes it may be necessary to augment the information obtained during the in-person Assessment interview with information collected over the phone. The Assessment must take place in a confidential, private, safe place where few interruptions will occur. If the client is hospitalized or otherwise not ambulatory, the case manager may make arrangements for the Assessment to be conducted at home or in the hospital.

- ***How Long Does it Take to Complete an Assessment?***

The Assessment will usually take one to two hours to complete. Some Assessments may require more time depending on the complexity of the client's situation. Programs that combine the Intake with the Assessment might require additional time to complete both activities. Because of the importance of this activity to successful case management, the case manager should provide ample opportunity for the client to ask questions about the services offered by the program and the case manager's supportive role. Every effort should be made to complete the Assessment during a single session with the client, so that the Care Plan can be completed and appropriate referrals made without undue delay.

Information Collected During an Assessment

The information collected during the Assessment is important for establishing a baseline profile for each client. This information is used to develop a Care Plan for the client and to make initial service referrals. Comparing this baseline profile with information collected during Follow-Up and Reassessment visits will allow case managers to assess the client's continuing need for services and support.

Some of the information collected during the Assessment may supplement or complement the information collected during the Initial Interview and Intake. For example, during the client Intake session the case manager may note the client's living situation in terms of type of housing and other people living in the client's household. The Assessment process may require more detailed information about ease of access, safety, and adequacy of kitchen and bathroom facilities.

The Assessment also provides an opportunity to collect information on the client's satisfaction with various aspects of his or her current medical treatment, housing, and social and psychological support systems. The case manager can also ask questions of the client to determine whether the client is willing and able to follow through on medical treatment, goals for drug or alcohol treatment, or home care regimens.

The following information is collected and evaluated during the Assessment:

1. Basic client data:
 - a. Update and verification of data collected during the Intake
 - b. Financial data, including current income
 - c. Insurance coverage, including co-pay requirements and eligibility status for SSI, SSDI, Medi-Cal, Medicare, and CMSP

- d. Current basic needs, including needs first identified by client during Intake, e.g., food, transportation, housing, health care, or clothing
 - e. Benefits: Are they in place or does the client require benefits counseling?
- 2. Medical information:
 - a. Update and/or verification of data collected during the Intake, including:
 - i. Name of primary care physician or clinic
 - ii. Original and current letter of diagnosis
 - b. Medical insurance information
 - c. Medical history, including current medications and alternative treatments
- 3. Living situation:
 - a. Update of information collected during the Intake
 - b. Information on whether client's HIV status is known to other members of his or her household
 - c. Information on basic housing situation, including adequacy of kitchen and bath facilities, telephone, utilities, safety issues
 - d. Food preparation and eating habits
 - e. Whether there are pets on the premises
 - f. Transportation availability
- 4. Personal History and Situation:
 - a. Family history
 - b. Education (highest grade completed) and literacy level
 - c. Occupational/work history and status
 - d. Children/other dependents
 - e. Cultural identity issues
 - f. Special circumstances, including history of physical or sexual abuse
- 5. Relationships and Social Support:
 - a. Social networks
 - b. Spiritual practices/religious affiliation
 - c. Relationship status (single/domestic partnership)
- 6. Health Education:
 - a. Sexuality
 - i. Sexual orientation
 - ii. Sexual partners
 - iii. Secondary prevention practices
 - b. Substance Use
 - i. Current substances used (type and frequency)
 - ii. History of substance use
 - iii. History of treatment
 - c. Nutrition
 - i. Nutritional status
 - ii. Adequacy of food preparation

7. Psychosocial functioning and mental health status²:
 - a. Mental health status, including indicators of affect, mood appearance, behavior, suicidal ideation, etc.
 - b. Neurological signs
 - c. Coping mechanisms/skills
 - d. Mental health treatment history
 - e. Mental health provider
8. Functional Status:
 - a. Ability of client to perform activities of daily living (ADL)
9. Service Needs and Issues:
 - a. Assess client satisfaction with current services and providers
 - b. Identify other agencies client has worked or is currently working with to receive HIV related services
 - c. Determine whether client currently is receiving other case management services
 - d. Determine client's immediate needs for services
 - e. Prioritize other remaining service needs
 - f. Need to refer to other program components within agency
10. Legal Issues:
 - a. Determination of legal services needs
 - b. Status of wills, living wills
 - c. Power of attorney, medical power of attorney
 - d. Guardianships, foster care for children
 - e. Legal status: documented/undocumented, have a conservator, are on probation

Formats for Collecting and Recording Assessment Information

Case management programs are expected to use a formal instrument for recording Assessment information. Many different Assessment forms currently are in use by programs throughout the HIV Services System. Some Assessment forms are a single page. Others are many pages in length and incorporate multiple choice formats for the answers to common questions as well as free form formats to record answers to open-ended questions or the case manager's impressions. Agencies are encouraged to collaborate to develop common forms that will collect comparable client data for all case management programs.

A typical Assessment form will follow the order in which case managers typically address the issues covered in the Assessment. The form should be constructed to minimize the amount of writing the case manager must do and to standardize the responses. Use of multiple choice, checklist format, or scales is encouraged. The medical/health Assessment and the psychosocial Assessment are often separated into two documents and may be completed by different staff in programs where case managers work in interdisciplinary teams. In addition to the psychosocial and medical/health status and history information, Assessment forms should include space to assess client strengths and to identify client problems and needs for each of the areas described above. The case manager should acquire relevant information from any previously conducted

² Case managers who do not have the training necessary to conduct a complete psychosocial assessment should be trained to recognize key indicators of mental health problems that would require follow-up by a licensed mental health practitioner.

Assessments of the client's health status and service needs that could contribute to the development of the Care Plan.

Process

1. Developing Trust

Trust is a key element in the ability of case managers to work successfully with clients. In cultivating a trusting relationship, it is important for the case manager to strike a balance between the empathic role—utilizing active listening skills, developing a rapport, and providing emotional support—and the objective role which requires engaging and encouraging the client toward concrete actions to achieve a desired goal. Developing and maintaining boundaries and clear expectations for activities by both the case manager and the client will facilitate development of trust by both parties.

The issues of confidentiality and informed consent add complexity to the development of a trusting relationship between the client and the case manager. The client may need reassurance about the informed consent he or she gave during the Intake. The case manager may need to reiterate that consent to participate in all or part of the case management contract can be withdrawn by the client at any time. Furthermore, it is important that the client understand that the information provided during the Intake and Assessment may be used by the case manager to communicate with other providers about the client's service needs. The goal is for the client to feel comfortable about the sharing of necessary information and the purposes for which it is used. Clients should be made aware of the method(s) of communication (fax, phone, modem, mail, case conference) that your program uses to share information. There are situations in which the case manager may act without client consent—instances of medical emergency, child abuse, elder abuse, danger to oneself or another, etc. The client should be made aware of this possibility early in the Assessment process. While this knowledge may affect the development of trust, it is important in establishing boundaries within the relationship.

2. Client Participation

Case management in the HIV Service System is intended to involve the active participation of the client in determining service needs, evaluating the options for treatment and care, and for making decisions about personal, financial, legal and family affairs as the client's disease progresses. Case managers are urged to work interactively with clients, utilizing a problem-solving and client-centered approach that empowers the client. For their part, clients must understand that participation in their care management is a responsibility as well as a right. The emphasis overall should be on developing a broad based support system for the client that 1) makes resources available as they are needed through the different stages of the disease, and 2) encourages client independence to the degree that is appropriate, given the client's current condition.

3. Collaboration

Collaboration among service providers is also necessary if continuity and coordination of care are to be achieved. It is especially important for the service providers who are directly involved in the client's care and treatment, including physicians, nurses, and social workers, to communicate on an as needed basis about the client's treatment or Care Plan. Collaboration can take place through case conferences, conference calls, interdisciplinary team meetings and

periodic record reviews. The client must give informed consent for this process to occur. If the client does agree to the sharing of information among his/her various service providers, a signed consent form must be placed in the client file.

4. Establishing Time Frames

As part of the process of developing a working relationship between case manager and client, it is important to have clear expectations on both sides about when particular tasks and activities will be accomplished and when the client can expect to begin receiving direct services. It is recommended that each program develop its own standards regarding the maximum amount of time that can lapse between 1) the completion of the Intake and conducting the Assessment; 2) the completion of the Assessment and the completion of the Care Plan; and 3) Follow-up and Reassessments. If the agency maintains a waiting list or if services are unavailable, this wait list process should be explained to the client.

Problems and Issues that Arise during the Assessment

1. Boundaries

One of the toughest issues to resolve between the client and the case manager is that of establishing clear boundaries around the case manager's role. The client may indicate his or her neediness by imploring the case manager to take a more active role in his or her day-to-day affairs. The client may also expect the case manager to do much of the work involved in making connections with referral agencies that provide direct services. In order for the client/case manager relationship to succeed, the case manager must make clear to the client what the limits of his or her involvement with the client will be as well as the client's responsibility for carrying out elements of the Care Plan. Each case management program should establish clear parameters of the extent to which the case manager is permitted to get involved in providing direct assistance to the client on a daily basis.

2. Gatekeeping

The mission of HIV case managers is to be "gate openers" or facilitators for their clients with the broader health and social service systems. However, the case manager often has to function as a gatekeeper between the client and service programs that may restrict eligibility or operate with resource limitations. Pressure can be placed on the case manager by referral agencies to limit either the number or type of clients referred. Reimbursement mechanisms may also restrict the case manager's referral options for a particular client. "Gate opening" requires special skills and sensitivity on the part of the case manager who must broker effectively with outside agencies, while maintaining the client's trust that he/she is doing everything possible to help the client acquire requested services.

3. Referring the Client to the Appropriate Provider

Occasionally clients who do not fit an agency's target population profile will be referred or will self-refer to its case management program. A lack of fit can be defined by a cultural or language incompatibility, a service need that is not emphasized (such as substance abuse treatment), or by a difference in the level of acuity in terms of how the client presents and what the program is equipped to handle (early intervention versus care for clients in more advanced stages of HIV disease). The organization has an obligation to assess its strengths and weaknesses in conjunction with the agency's mission and resources and to develop relationships with complementary programs to facilitate referral of clients to appropriate agencies. Clients must be consulted with in regards to their comfort level with the referral based on past history and culture. In cases where the case manager determines there is a lack of fit, it is important to identify the source of the incompatibility and make a timely referral to another agency that is better equipped to provide services to this particular client.

Practice Hints

1. Utilizing the Concept of Triage or Categorizing Clients by Intensity of Need

HIV service agencies in large urban areas are characterized by a chronic feeling of crisis. Agencies are strapped for resources and are often understaffed. Clients often present themselves while in a personal crisis; this heightens the sense that the agency in general, and the case manager in particular, must respond first to those in most dire need. This crisis orientation often results in agencies having little time to spend on clients requiring low to moderate levels of maintenance and to agency staff feelings of stress resulting from having to function in an environment where crisis demands immediate intense response.

Triage could work well to bring some semblance of order to this crisis environment. Triage criteria are identified in the *Client Acuity Scale*, (see Appendix A) would enable program staff to categorize clients into those requiring low, moderate, or high maintenance or crisis intervention. Criteria should be based on levels of acuity for the specific conditions presented by an agency's clients. These criteria should be developed by agency staff working together. Some of the criteria that could be considered to determine whether a client is likely to require a high, moderate, or low level of care include: 1) medical diagnosis/stage of illness; 2) the availability of informal and formal social support; 3) current level of functioning; and 4) history of program or treatment compliance. Since client status will change over time, client assignment to categories will also have to be periodically reassessed.

In programs that employ more than one case manager, the implementation of the *Client Acuity Scale*, with its four level of need categories, allows clients to be assigned to case managers in a balanced manner. With more balanced caseloads, case managers should be able to plan their casework hours to include adequate time for those in less need as well as for those in crisis or emergency situations. Each case management program may have to tailor its response to triage needs to ensure that clients with low and moderate needs do not become lost in the climate of crisis.

2. Lengthy Assessment Sessions

During a lengthy Assessment session, it is important to check in with the client to gauge his/her ability to continue. It is important to validate the difficulty of the experience and frame the session in the context of the case management experience. Part of this check-in should also include inquiries regarding the client's need to take a break, have some refreshment, or use the bathroom facilities.

More Practice Hints

3. Consider Culture as an Important Factor when Matching Clients to Case Managers

Some clients may prefer to work with a case manager who is similar in race, nationality, age, gender, sexual orientation, religion, and/or who has experience in a specific area such as substance abuse or mental health. Other clients may prefer to work with someone from a different cultural background. Therefore, in programs with more than one case manager, clients should be informed of their options of available case management staff and every effort should be made to accommodate the client's request.

4. Reading Between the Lines is Important

Reading between the lines is important during this process. Take notice of the client's affect and body language to determine whether information given by the client is consistent with the case manager's perceptions. The case manager should share his/her perceptions and feelings about the Assessment process with the client in order to validate information and to help avoid misunderstandings later on.

5. Communication is Key to Developing a Successful Case Management Relationship

Use the Assessment as an opportunity to establish two-way communication with the client. The Assessment is best thought of as an in-depth conversation between the client and the case manager. Avoid interrogating the client with a lot of questions. Encourage the client to discuss his/her concerns about his/her health, living situation, finances and overall care and treatment.

Providing Prevention Education

Although the principal function of the HIV case manager is to help the client obtain needed social and practical support services, the case manager also has an important role to play in prevention of secondary HIV transmission. As part of the Assessment process, the case manager should assess the client's knowledge, attitudes, and behaviors toward safe sex, alcohol and drug use. Based on the results of this Assessment, the case manager should provide appropriate information and support to help the client avoid risky behaviors that can lead to further HIV transmission. The potentially ongoing relationship with the client gives the case manager an opportunity to encourage any behavior change that the client has identified as problematic. The client's Care Plan may also address these issues.

CORE ACTIVITY #3: DEVELOPMENT OF THE CARE PLAN

Overview

The Care Plan constitutes the core of the case management effort. The development of the Care Plan is the culmination of the comprehensive Assessment. It consists of the translation of the information acquired during Intake and Assessment into short-term and long-term objectives for the maintenance of the health and independence of the client. The Care Plan includes:

1. Identification of all services currently needed by the client, as well as resources readily available to assist the client;
2. Identification of agencies that have the capacity to provide needed services to the client;
3. Specification of how the client will acquire those services;
4. Specification of the procedure that will be followed to assure the client has successfully procured needed services;
5. A plan for how the various services the client receives will be coordinated, specifically defining the role of the case manager; and
6. Development of a list of problems, symptoms and issues.

Client participation in the development of the Care Plan, especially regarding the choice of providers, is encouraged to the fullest extent possible. In particular, client feedback should be obtained on each element of the Care Plan before it is implemented. Once the Care Plan is completed, the case manager's relationship with the client changes, because other direct service providers become involved with the client's service needs through brokerage and referral. When more than one agency is involved in coordinating the care of the client, the service plan should include any agreements made by the providers regarding who is responsible for the various components of care.

In some cases, case management responsibility for a client will be shared among different programs or will shift from one agency to another over time. This could occur with a multiple diagnosed client who receives substance abuse treatment as well as HIV-related social or medical services. This also could occur as a client progresses through the various stages of HIV disease, first requiring social support services, then nursing, and finally hospice care. In such cases, the Care Plan should include documentation regarding the transfer or assumption of primary case management responsibility from one agency to another, the time at which the change occurred, and the primary personnel involved with the client. In particular, each agency involved in the client's care should have a clear understanding of who is the primary case manager. This information should be recorded in the Care Plan.

The Care Plan must be documented well. Should the assigned case manager leave the program or the client be transferred from one agency to another, the Care Plan is the one document that will facilitate continuity of care.

Purpose

The Purpose of the Care Plan is to:

1. Document and organize/plan for comprehensive support services and to ensure continuity of care at a level that is desirable to the client.

2. Demonstrate a relationship between actions and the wants, needs, strengths and limitations of the client as documented in the Assessment.
3. Ensure the Care Plan is a realistic reflection of what the client and the case manager can accomplish together for the benefit of the client.

Care Plan Goals

The Care Plan reflects the needs that were identified by the client and the case manager during the Assessment. It should include:

1. Prioritizing Client Goals

It is common for case management services to be initiated during a time of crisis for the client. In identifying client goals, the case manager must ask, “What needs to be done to stabilize the client’s life or situation at this time?”

Both short-term and long-term goals will be identified in the Care Plan. Short-term goals address immediate needs, especially those required to stabilize the client or to deal with a crisis situation. The Care Plan documents the resources readily available to help the client make immediate improvements in his/her situation.

Longer terms goals reflect the standards that the client wishes to achieve for independence, supportive care and overall quality of life, given the status of his or her HIV diagnosis. Long-term goals should include provisions for assisted living, legal power of attorney and financial management. These topics should be introduced early in the case management relationship, to ensure that the client has chances to consider important decisions that will affect his/her course of treatment and life during the later stages of disease.

Goals must be realistically defined by the client and the case manager. A realistic goal may be for a client who can no longer work to become financially more stable through the procurement of disability benefits and other entitlements. In contrast, the goal of living independently may be an unrealistic goal for a client whose physical condition has deteriorated to the point where he/she needs assistance with basic activities of daily living.

In the event that there is disagreement between the client and case manager on long or short-term goals and/or the tasks needed to accomplish those goals, the concerns of both parties should be documented. It is strongly encouraged that the case manager and client identify mutually agreed upon short term goals and objectives, while any disagreements or disputes about longer term objectives are worked out.

Tips for Prioritizing Goals and Objectives for the Care Plan:

1. Ask the client to identify his/her priorities for improving or maintaining his/her quality of life.
2. Provide feedback to the client on his/her priorities.
3. Identify areas where you and the client agree and disagree on priorities and on activities needed to accomplish goals.
4. Starting with the areas of agreement, work with the client to develop mutually agreed upon short-term goals.
5. Identify long term goals, to be further developed with the client, once his/her short-term needs are met.

2. Creating Realistic Objectives

When identifying objectives, the case manager must always keep in mind the major goals of the Care Plan and be flexible in his/her interpretation of those goals.

Objectives should be concrete and obtainable within a realistic time frame. For example, realistic objectives intended to meet the goal of financial stability could include: obtaining certification for state and federal disability programs and for Medicare and Medi-Cal. A realistic objective for stabilizing the living situation of the client in a state of physical decline would be to obtain in-home practical support.

3. Estimating a Time Frame for Accomplishment of the Objectives

A timeline for the accomplishment of goals and objectives and activities of the Care Plan needs to be developed with the client and his or her caregivers. Timelines should be realistic and reflect the fact that objectives and activities can only be accomplished one by one. As each objective is accomplished, the timeline should be modified to reflect its successful completion. Conversely, if activities and objectives are not successfully completed, the timelines should be adjusted or modified to meet more realistic goals. The timeline should not be used as a marker of failure for either the client or the case manager. Rather it should be used to help both parties achieve the desired goals and to reassess whether the accomplishment of those goals is realistic.

4. Taking Action to Meet Objectives

A variety of actions and activities will be necessary to meet the objectives outlined in the Care Plan. These may include: 1) referrals to outside agencies for specified services; 2) timely follow-up on those referrals to ensure the client is receiving needed services; 3) advocating on behalf of the client for entitlements, resolution of legal problems, or for gaining access to scarce resources, such as housing or drug or alcohol treatment or mental health services; and 4) regular or periodic contact with the client to provide social and emotional support.

Process of Creating the Care Plan

The development of the Care Plan is an interactive process that takes place between the client and the case manager. It is a process that whenever possible, encourages the client to actively participate in the decision making process related to his/her care, support, and treatment.

Practical Aspects of Creating the Care Plan

1. The case manager's knowledge of community resources and resourcefulness in "working the system" become critically important when developing the Care Plan. The case manager must use his/her knowledge of community programs and networking skills to effectively piece together a personalized care system for the client. The case manager needs to be aware of average waiting times for specific programs and how services offered by various agencies differ in terms of quality and cultural orientation.
2. Using the information obtained during the Intake and Assessment and any subsequent contact with the client, the case manager determines the client's level of case management need; i.e., does the client qualify as a low, moderate, or high maintenance client for the purposes of resource allocation?
3. The Care Plan needs to be a dynamic document which is modified as necessary, depending on the client's current condition and/or need for services. The case manager must be alert to signs of change warranting modification of the Care Plan and the array of services and treatments requested. Other changes might be precipitated by changes in the client's financial situation or in the resources available in the community.
4. In the event that the client transfers from one case management program to another, the Care Plan must be written clearly so that it can be understood by staff at other agencies. Case managers must obtain the client's consent before sharing information with other providers.
5. The Care Plan should clearly indicate who is responsible for implementing its various objectives and activities. In particular, the client should participate in choosing the elements of the Plan for which he or she will take responsibility.

Using REGGIE as a Referral Resource

Case Managers may use a variety of resources to keep up-to-date with current services. As part of REGGIE, each CARE-funded agency in the EMA has access to information about local, national, and international services as well as medical information through an Internet connection. The REGGIE Home Page on the World Wide Web can be accessed through the San Francisco Public Library database. This database has been developed and is updated from the San Francisco AIDS Foundation Resource Guide and UCSF's HIV-related Home Page which provides medical information. The REGGIE website address is <http://www.reggie.org>.

Documenting the Care Plan

At a minimum, the written Care Plan should incorporate five elements. These include:

1. Prioritized, long range and short range goals. Ideally, these goals will have been initially identified in the Assessment.
2. At least two short-term objectives linked to each goal that can be achieved through the concrete action of either the client or the case manager. It is important that the client achieve success in the accomplishment of at least one short-term objective. Defining at least two short-term, easily obtainable objectives will help the client move toward accomplishment of his or her longer-term goals.
3. The specification of the actions that need to be taken to accomplish each objective. Actions include tasks accomplished by both the case manager and the client to improve the client's quality of life and/or to procure the services needed by the client.
4. Responsibility for the accomplishment of each objective and activity should be clearly documented in the Plan. The client, the case manager, caregivers, and friends/family of the client might all share in the responsibility for accomplishing the goals of the Plan.
5. A date for the accomplishment of each element of the Care Plan: goals, objectives, and activities. The Plan should be periodically reviewed to ensure that goals and objectives are being met within a reasonable amount of time or to determine whether dates need to be modified.

It is recommended that the Care Plan be organized into sections corresponding to the functional domains of the client's life, such as housing, psychosocial support, practical support, mental health, or substance abuse treatment, etc.

Problems That Can Arise During Care Planning and Beyond

1. Bottlenecking

The case management process often stalls after completing the assessment and before development of the Care Plan. This is partly due to high caseload sizes that prevent case managers from developing or implementing the Care Plan in a timely fashion. Delays in service acquisition can result that may frustrate or anger the client and contribute to a deterioration in the client's overall well being. Each program should establish optimal caseload sizes that reflect the level of acuity of its client population. Use of the *Client Acuity Scale* can help individual case managers estimate the impact that an individual client is likely to make on his/her time and resources. Balancing caseloads and adhering to caseload size limitations can help facilitate the timely completion of the Care Plan and its Implementation.

2. Lack of Coordination

Staff from other agencies working without the case management Care Plan as a guide can duplicate services or provide inadequate or inappropriate service. Case conferences and other forms of care coordination can help ensure that all providers involved in a client's care and treatment work together to achieve the best service mix and avoid duplication of effort.

3. Insufficient Client Involvement

If clients are not sufficiently involved in the development of the Care Plan, client adherence to the goals and objectives of the Plan may not be achieved. Client participation should be encouraged and will likely result in the client taking an appropriate amount of responsibility for carrying out its objectives.

4. Services are Not Available

Sometimes reasonable goals and objective are identified by the client and case manager, but appropriate services are not available to meet those goals. Housing and substance abuse treatment are examples of two services that are not always readily available. In such situations, the case manager must be creative in designing interim solutions or configuring available services in a way that compensates for services or slots that are unavailable.

Practice Hints

1. Begin the process of Care Plan development by focusing on the more concrete needs of the client. For example, basic needs such as those for food and shelter should be addressed before planning for more complex needs for psychosocial support and advocacy services.
2. There will be both immediate and long term repercussions of the case management Care Plan on the client's life and lifestyle. The case manager should allow plenty of opportunity for the client to express his/her feelings about the implications of the Care Plan on his/her relative dependency and independence.
3. Clients and case managers may not always agree on the goals and objectives of the Care Plan. For example, the case manager may have determined that the client's housing situation is unstable or otherwise inappropriate to meet the client's needs. The client may not want to change his/her living situation at the present time. In such circumstances, the case manager and the client need to find a mutually acceptable short term objective for improving the client's current housing situation and establish a long term goal for making a more substantial change in living situation.
4. The case manager must be honest and candid in evaluating the client's personal goals and providing the client with feedback on how realistic those goals are. At the same time, the case manager must be flexible in formulating solutions to problems that retain the client's autonomy and choices, whenever possible. If the client has neurological impairment or is otherwise impaired by substance use or by psychological crisis, the case manager may have to work with other designated representatives of the client to develop the Care Plan.

CORE ACTIVITY #4: IMPLEMENTATION OF THE CARE PLAN

Overview

Implementation of the Care Plan involves several interrelated elements: 1) service referral, 2) brokerage of services with other providers, 3) advocacy for clients with other providers and institutions, 4) coordination or linkage of services, and 5) monitoring the accomplishment of the Plan's goals. When obstacles arise that prevent the accomplishment of goals, it is the responsibility of the case manager to determine what those obstacles are and how to overcome them.

Tasks Involved in Implementation

1. Service referral, brokerage, and linkage. In order to implement the Care Plan, a number of steps need to be undertaken to assure that service referral is completed and clients receive the needed services identified in the Assessment. Each of these activities should take place only after client consent is obtained. Effective communications skills are required for the case manager to accomplish these steps:
 - a. Contacting other providers to make arrangements for client referral. In some cases, the case manager may need to do the front-end work of making initial contact with service providers to pave the way for effective referral for their clients.
 - b. Making arrangements, if necessary, for the client to get to the service referral site, e.g., arranging transportation.
 - c. Contacting the client to determine that the referral appointments have taken place and that services have been procured; troubleshooting if the referral did not take place as planned.
 - d. Making arrangements (brokering) directly with other direct service programs to provide services to the client, especially those who may need to come to the client's home, such as home health or visiting nurse care, food delivery, etc.
 - e. Sometimes service arrangement may include letter writing on the client's behalf, escorting the client to appointments where the client anticipates a difficult encounter, and "coaching" the client when necessary so that he or she can act as a better advocate for him or herself.
2. Encouraging the client to act on his or her own behalf. An important aspect of the case manager's work is to support and encourage the client to take action on his or her own behalf whenever possible. Both the client and the case manager must contribute time and energy to implementing the Care Plan. As each component of the Care Plan is discussed, the case manager and client will decide together what actions to take to accomplish each objective. The case manager will work closely with the client to determine which aspects of the Care Plan the client can carry out on his or her own and for the case manager to provide support and encouragement for the client to do so. It is also important for the case manager and client to work together to determine when the client should be "unlinked" from a particular service to avoid prolonged dependence.
3. Monitoring the progress of the Care Plan. Follow-up and implementation are inseparable. It is through systematic follow-up that the case manager and client discover whether the

Plan is working and when it needs revision. The Care Plan should be regularly reviewed to determine whether any changes in the client's situation warrant a change in the Plan and also to determine whether the goals and objectives of the Plan are being met in a timely fashion and, if not, what are the reasons.

4. Advocating for the client, when necessary. Sometimes it is necessary for the case manager to advocate for the client with a service agency or a benefits program to assist the client in receiving necessary services. The case manager should consult with the client before doing this. It is important that the case manager be truthful with the referral agency about the client's problems and not minimize the client's needs. Advocating for the client involves providing the referral agency with information and insights about the client, in order to facilitate the client's initial contact with that provider. Effective advocacy requires that the case manager familiarize him or herself with the different program "styles" and with stated and implicit admissions or eligibility criteria. Knowledge of funding sources is also important in order for the case manager to maximize use of resources for the client.
5. Monitoring the client for changes in physical and mental health and social, economic and functional status. Implementation of the Care Plan requires that the case manager and client (and/or client's caregiver) communicate regularly regarding changes in health and functional status to determine whether any status changes warrant a revision of the goals and objectives of the Care Plan or its timeline for implementation.
6. Communicate periodically with the client, either in person or by telephone to assess whether an appropriate and desired level of service is being rendered. Periodic contact between the case manager and the client in person or by telephone is necessary for the case management relationship to be maintained and to ensure that services are being delivered. The case manager must listen to and ask questions of the client to make sure the client's concerns and most urgent needs are being met. The frequency and intensity of these contacts should be determined by joint agreement between the case manager and the client.

Process of Implementation

Implementation, like all other aspects of HIV case management, requires the case manager and the client to work closely together to achieve the goals and objectives of the Care Plan. Providing social support and encouragement to the client is as much a part of Implementation as the actual brokerage and coordination of services. In order to make a Care Plan work, the case manager and client need to determine how much autonomy the client can exercise on his or her own behalf and how much assistance he or she needs in order to acquire the needed assistance. The *Client Acuity Scale* (see Appendix A) and other similar tools can be used by the case manager to determine how much assistance the client is likely to need in implementing the Care Plan.

Documenting Implementation

Implementation of the Care Plan includes careful documentation in the Progress Notes of each encounter with the client, his or her caregivers, and other providers involved with the client's care. Dates of contact, information on who initiated contact, and any action that resulted from the contact should be included in the documentation. All documentation should be signed by the case manager.

The following questions should be answered by the case manager during the process of Implementation and documented in the Progress Notes.

1. Are the goals and objectives of the Care Plan being met in a timely fashion?
2. What are the obstacles or problems the client faces in acquiring services, or in the appropriateness of the services or benefits being received?
3. Is the client satisfied with the services and benefits that he or she is receiving and the manner in which they are being rendered? If not, what are the problems that the client has with service providers or the level of benefits?
4. Are there any changes or modifications to the Care Plan that should be made to better accommodate the client's strengths and weaknesses, or to address any emergent service or support needs?
5. Should the frequency of contact between case manager and client be increased to provide adequate social support and encouragement, or decreased to encourage more client autonomy?

Problems That Can Arise During Implementation

1. Because HIV is a life threatening and debilitating disease, the client, the case manager and the client's caregivers will be subject to strong feelings and judgments about what is best for the client during his/her course of care and treatment. The case manager needs to be alert to problems of mutual expectations and attachment that can develop between client and case manager. The case manager needs to remember to focus on what is most helpful and appropriate for the client. A case manager may identify an issue as problematic when the client does not. The case manager needs to be aware that sometimes his or her own judgment about what is needed or best for the client may differ from the client's own point of view. Remember that it is always the right of the client to refuse to participate in programs or to receive services that he/she feels are inappropriate or unnecessary. Regular case conferences, and peer and supervisor review of the Care Plan and its revisions, can be helpful in troubleshooting these problems as they arise.
2. The case manager may become aware that the client has varying ability to follow through on aspects of the Care Plan. If the case manager senses that the client may have a low ability in one activity area, a higher level of assistance from the case manager should be incorporated into the Care Plan. Implementation of the Plan with a lower functioning client will involve more effort from the case manager to provide some direction for the

client. Experience working with the client may warrant the case manager to re-categorize the client's maintenance needs from low to moderate or moderate to high.

3. Unfortunately, even among agencies serving people with HIV disease, a certain amount of client selection takes place that may leave clients with the most complex situations or behavioral problems unable to secure appropriate care. If the case manager finds that such a client has been unable to obtain care at an agency to which he/she was referred, it is the case manager's responsibility to intervene and advocate on the client's behalf. Case conferences, supervisory support and peer support should be used by the case manager as a means of problem solving for the client when such problems arise. Client consent should be obtained before engaging in these efforts.

Practice Hints

1. Encourage the client to acknowledge problems that the case manager has identified, but that the client does not necessarily see or denies. Education, support and confrontation are tactics that can be employed effectively and sensitively by the case manager. While the Care Plan may describe the goals and objectives that the client and case manager would ideally like to accomplish, successful implementation of the Plan often requires day-to-day assessment of whether the case manager should be taking a more active role in helping the client acknowledge his or her problems and support in fulfilling his or her obligations to the Care Plan.
2. Implement the Care Plan incrementally, allowing for the fullest participation of the client. Aim to accomplish one objective at a time while acknowledging the next tasks to be accomplished.
3. Whenever possible, include people who provide the client's informal social and practical support into the implementation of the Care Plan.
4. Take the opportunity to create multi-disciplinary case conferences involving the client's other providers, including primary care physician or nurse practitioner, residential treatment staff, and counselors or therapists. Use the case conference to discuss any service inequities or unethical practices that have come to your attention and that may be ameliorated through collective action. Once again, client consent should be obtained before these activities are begun.
5. Don't forget that the Care Plan is the most important instrument for helping the client to escape a crisis mode of coping with his or her problems and service needs. HIV Case managers and clients often get used to responding to a constant sense of crisis. With proper support and encouragement from the case manager many clients are able to increase their coping skills and stabilize their life situations to avoid the cycle of moving from one crisis to another.
6. Find ways to celebrate successes with clients. Acknowledgement of the hard work and effort that goes into achieving an objective or goal adds to the development of the client/case manager relationship and may boost the motivation level of both case manager and clients.

CORE ACTIVITY #5: FOLLOW-UP AND MONITORING

Overview

Regular Follow-Up by the case manager must be conducted in order to determine whether the goals and objectives of the Care Plan are being met. In addition, Follow-Up and Monitoring are necessary in order to determine whether any changes in the client's condition or circumstances warrant a change in the array of services that the client is receiving.

Case manager initiated Follow-Up and Monitoring should occur on a regular basis unless client requests for services or intervention by the case manager make additional contact unnecessary. Follow-Up and Monitoring should occur frequently enough so that emergent needs can be anticipated before a crisis is precipitated.

Follow-Up and Monitoring are related to Reassessment. Follow-Up and Monitoring should include an informal reassessment every time the client and case manager have contact. The case manager will encourage the client to take primary responsibility for his/her own care. If the client is unable to do so, the case manager will play a more active role in Follow-Up and Monitoring with the client and other care providers.

Follow-Up and Monitoring Goals

The overall goals of Follow-Up and Monitoring are to:

1. Review the Care Plan with the client to determine its relevance, adequacy, and timeliness to meet client service needs;
2. Make sure the treatment and support the client receives from different providers are being coordinated to avoid needless duplication of or gaps in services;
3. Address, as appropriate, any changes that have emerged in the client's condition or circumstances in order to avoid crisis situations; or conversely, address any changes that create opportunities for transition toward autonomy and independence;
4. Maintain client and case manager contact on a regular basis in order to build communication, trust, and rapport with the client.

Practical Aspects of Follow-Up and Monitoring

- ***When does Follow-Up Occur?***

Follow-Up and Monitoring occur in two different ways:

1. When the client initiates contact with the case manager in order to request a service or for help solving a problem, and
2. When the case manager initiates contact with the client to determine whether the goals and objectives of the Care Plan are being met.

- ***Frequency of Follow-Up?***

Frequency of Follow-Up varies from setting to setting and according to the acuity of client need.

Case manager initiated Follow-Up should occur monthly, unless special circumstances dictate a different arrangement. If the client is severely disabled, psychologically or physically, more frequent Follow-Up may be required. If the client can achieve the goals and objectives of the Care Plan with minimum assistance of the case manager, then less frequent Follow-Up can be arranged, in consultation with the supervising Case Manager. The Client Acuity Scale (see

Appendix A) can be used to help determine the frequency and intensity with which clients should be monitored. At the end of each contact with the client, the case manager should establish when the next encounter will occur.

- **Who Initiates Follow-Up?**

Follow-Up can be initiated by either the case manager or the client. Clients should be encouraged to contact the case manager when changes occur in their physical condition or in their social and practical support systems. Careful planning by the client and the case manager can help determine how frequently the client needs contact with the case manager in order to avoid crisis situations.

Some clients initiate contact with case managers only when a crisis has occurred or is about to occur. The case manager can try to avoid this situation by reviewing the objectives of the Care Plan with the client to make sure that the planned frequency of contact with the case manager meets the client's anticipated needs.

- **Where Does Follow-Up Occur?**

Follow-Up is most effective when done in person so that the case manager can provide emotional support to the client and assess the client's overall affect and physical condition. Follow-Up can occur in the case manager's office, at the client's home or temporary residence, in the hospital, or at the site of another service program in which the client is enrolled. Sometimes Follow-Up contact with a client occurs over the telephone, but this practice is discouraged.

- **How Long Does It Take to Conduct a Follow-Up Visit?**

The length of time for a Follow-Up encounter with a client may vary from 15 minutes to one hour or more, depending on whether Follow-Up is being performed for routine contact with the client or whether there are emergent needs with which the client needs assistance.

Information Collected During Follow-Up and Monitoring

The case manager should keep careful notes of the Follow-Up encounter. It is strongly suggested that case management programs employ preformatted progress notes for Follow-Up encounters. Progress notes should include both subjective impressions and objective measures of the client's condition at the time of Follow-Up. In particular, the items listed in the *Client Acuity Scale* (see Appendix A) should be reviewed to determine whether there has been a change in the client's level of acuity since the last contact.

Each time the case manager meets with the client, changes that have occurred in any of the following areas should be recorded:

Basic Needs

1. Food
2. Housing
3. Transportation
4. Clothing
5. Income

6. Social and practical support systems

Physical Health and Health Care

1. Change in HIV disease status since last encounter
2. Other health care or medical problems
3. Frequency/adequacy of contact with primary medical provider

Mental Health

1. Change in mental health status
2. Adequacy of mental health care

Substance Abuse

1. Status of any new or ongoing substance use problems
2. Adequacy of current treatment or need for new treatment

In addition, at each Follow-Up encounter, the client and the case manager should review the objectives that had been outlined in the Care Plan and evaluate the progress that has been made toward accomplishing them. The client and the case manager should discuss any obstacles that have impeded accomplishment of the goals of the Care Plan and identify actions that each of them can take to overcome those obstacles. If certain goals or objectives have proved to be unrealistic, the case manager should work with the client to review the Care Plan accordingly. Any changes made to the Care Plan should be recorded in the Progress Notes.

Process

A mechanism should be in place to enable case managers to determine which clients have not been seen within the last three months. Regular review of client charts will enable the case manager to determine how often the client should be contacted and for what purpose.

Follow-Up and Monitoring require that the case manager be in contact with other providers and programs from which the client receives services. Follow-Up and Monitoring provide important opportunities for the case manager to facilitate the coordination of client care among all providers, including medical, social service and practical support personnel. The client's ongoing consent to participate in case management activities, including all aspects of care coordination, also should be confirmed during Follow-Up visits.

Problems and Issues that Arise During Follow-Up

1. Loss to Follow-Up

Loss to Follow-Up is the most severe impediment to managing client care. Loss to Follow-Up can occur when a client leaves the area, lacks a permanent residence, is reluctant to participate in the program, or from inadequate Follow-Up on the part of the case manager.

The case manager can positively affect client retention by providing consistent support and monitoring of the client's progress in achieving the goals of the Care Plan. While the frequency of Follow-Up contacts should be agreed upon between the client and the case manager, it is

incumbent on the case manager to be consistent and predictable in performing his/her Follow-Up activities.

Every effort should be made to avoid client loss related to inadequate Follow-Up. Case managers need to determine on a case-by-case basis whether more frequent contact with a particular client is needed in order to avoid potential drop out.

If, after reasonable effort, the case manager has not been able to contact the client for three months or more, the client's case can be closed or inactivated and another client can be added to the case manager's caseload.

2. Frequency of Contact

Frequency of contact with clients for Follow-Up purposes will differ from program to program and according to acuity of client need. Frequency of Follow-Up with clients who are dually-diagnosed with mental health and substance problems will necessarily be greater than for clients in other ambulatory care or primary care settings, where many clients may be capable of self-management with occasional help from case managers when problems arise. Generally the Follow-Up interval is longer in case management programs linked to ambulatory care than it is for clients in intensive substance abuse treatment or mental health programs. In ambulatory care settings, case management Follow-Up is also more likely to be accomplished when clients come in for routine care than by case manager initiated contact.

3. Multiple Case Managers

Follow-Up provides an opportunity for the case manager to find out if the client is utilizing other case management programs. Clients may seek assistance from multiple case managers in their effort to find the most effective assistance in obtaining essential support services or benefits. Whenever possible, case management services for a client should be consolidated within a single agency in order to avoid unnecessary duplication of services. When this is not possible, the case manager should take the initiative to contact other case managers involved with the client's care or treatment. Case managers are strongly urged to resolve who will be the primary case manager and to delineate the roles of staff from other support programs. Clients should be assured by the case manager that they can continue to receive services from outside agencies, regardless of whether they continue to use multiple case managers. *(Please see section on Multiple Case Managers for more on this issue.)*

Practice Hints

1. Case managers should do whatever they can to involve clients in advocating for themselves and managing their own care. Case managers have a role to play in assisting with client self-care and management. Whenever possible, clients should be encouraged to make phone calls and write letters on their own behalf. Case managers should support clients by helping with difficult tasks such as letter writing, working out transportation plans and setting up daily schedules for in-home support.
2. The case manager has a role to play in assisting the clients with solving the problems of day-to-day living. By helping the client work out the details of daily life, the case manager will help maximize the client's ability to keep their lives organized, keep appointments, and, more broadly, to achieve the Goals outlined in the Care Plan.
3. Client contact with case managers often occurs on an ad hoc or drop-in basis. This is especially true in outpatient clinic settings. Case management programs at such settings are encouraged to develop multidisciplinary teams within their agencies. These teams should be comprised of medical, social services, and other personnel that play a role in the client's overall care. The existence of such patient care management teams will ensure that whenever a client drops in and requires case management intervention, someone familiar with the client's condition and treatment plan will be available to help.

CORE ACTIVITY #6: REASSESSMENT

Overview

Clients will need to be periodically reassessed to determine whether the appropriate level of care is being delivered as a client's situation changes over time. Reassessment should be a regularly scheduled activity. It is an important opportunity to reevaluate the client's condition and to make appropriate adjustments to the level and intensity of services being delivered. A Comprehensive Reassessment of the client's medical, psychosocial, and financial condition and service needs should be conducted at least once every six months.

Reassessment Goals

The purpose of the Reassessment is to take stock of the client's entire situation and to determine what further actions need to be undertaken on the client's behalf. The Reassessment presents an ideal opportunity to make legal and other arrangements for the time when the client will not be able to manage his/her own affairs or to make complicated decisions. In particular, the Reassessment is a good time for the client and case manager to discuss provisions for hospice care, guardianship, and power of attorney. If the client has dependent children, the case manager is urged to discuss foster care arrangements with the client during the Reassessment. These topics may be difficult for the client to contemplate during the early months of case management. However, at the time of Reassessment, approximately six months after beginning the case management program, a sufficiently trusting and comfortable relationship should exist between the client and case manager to support the discussion of these issues.

Reassessment should provide answers to the following questions:

1. What changes, if any, have occurred in the client's physical, mental, and psychosocial status since the last formal Assessment was conducted?
2. To what extent were the goals of the Care Plan achieved in the period since the previous assessment was conducted?
3. What were the barriers or obstacles that prevented the goals of the previous Care Plan from being accomplished?
4. Is the client satisfied with the level of care and services that he or she has been receiving?
5. Are there new services that the client should be receiving that were not included in the previous Care Plan? Are there services the client currently is receiving that he or she no longer needs and should be discontinued?
6. Do changes in the client's condition, or new knowledge about barriers or problems the client faces, warrant an increase or decrease in the intensity of case management services the client receives?

Practical Aspects of Conducting a Reassessment

- ***When Should Reassessment Occur?***

At a minimum, Reassessment should occur at six-month intervals. For clients whose physical, mental health, or social status is undergoing rapid change, Reassessment should be conducted more frequently as part of ongoing Follow-Up and Monitoring.

- **Who Should Conduct the Reassessment?**

It is strongly recommended that the formal Reassessment be conducted by a case manager trained to work with clients with HIV disease. It is preferable that the assessment be conducted by the client's regular case manager.

Information Collected During Reassessment

The information collected during the initial client Assessment should be reviewed at the time of the Reassessment. Any changes in client status that have occurred since the last Follow-Up visit should be noted in the Progress Notes. Information collected during the Reassessment should emphasize the client's ability to continue to function with the degree of independence that he/she has previously been exercising. The case manager should be especially alert to any changes in physical, mental and emotional status that would indicate a need for enhanced support.

Health Status, Social Support System, and Functional Ability

The following indicators of the client's condition must be included in the Reassessment documentation:

1. Disease stage as determined by T-cell count and the first occurrence or reoccurrence of any of the AIDS defining opportunistic infections, neoplasms, or other conditions associated with advanced stages of HIV disease, including evidence of dementia or AIDS-related wasting;
2. Physical condition and ability to perform activities of daily living;
3. Mental health status, including indicators of depression;
4. Adequacy of social support network, including information on adequacy of caregiver support, ability of caregivers to provide needed psychosocial and practical support in light of any changes in client's condition;
5. Changes in client's financial status or benefits that could destabilize client's ability to meet his or her expenses.

Legal and Financial Arrangements

The Reassessment should either include copies of the following documents or a status report on the client's wishes regarding each of the following:

1. Durable Power of Attorney
2. Living Will
3. Arrangements for guardianship of children/dependents

Other Arrangements

During the Reassessment, the case manager should also determine the client's need for such services as housing, transportation, food, etc. Reassessment forms should include information on whether the client:

1. Is currently receiving the following services;
2. Has applied to receive these services and the status of the application; or
3. Has declined to apply or enroll for these services:
 - a. Housing/CHIPS
 - b. Visiting nurse and home health care
 - c. Hospice

- d. Programs offering transportation services
- e. Programs offering food services
- f. Other programs offering practical support for daily living

Format For Collecting and Storing Information

If a formal instrument is used for the initial comprehensive client assessment, it is recommended that it be modified for use as the reassessment instrument. The information should be recorded in a format that is easily used and understood by social workers, nurses, and community-trained case managers. In the event the client's case management is transferred from one agency to another, it is important that the client's needs assessment be easily read and understood by staff at any outside agency to facilitate continuity of care.

Process

The Reassessment should build on previous work done by the case manager during the initial formal Assessment. It should result in a modified Care Plan that takes into account the changes in the client's condition since the last assessment was conducted.

The client's consent to continue to participate in the case management program should be confirmed at this time along with any consent to share information among the agencies involved in the client's care and treatment.

During the Reassessment the client and case manager should review all aspects of the client's care, treatment and living situation. The case manager and the client should discuss the client's level of satisfaction with his/her current service configuration and providers and make plans for any needed changes. The Reassessment is also an appropriate time for the case manager to contact other service providers involved in the client's care to:

1. Determine whether care and services being delivered in different settings are coordinated and unnecessary duplication is eliminated;
2. Assess whether client participation in other programs continues to be appropriate to meet the client's (changing) needs; and
3. Obtain other providers' assessments of any special needs or problems the client might have that would require assistance from the case manager.

Reassessment also provides an opportunity for the case manager to work with the client to solve service-related problems. The client is, of course, the best source of information about whether or not the current Care Plan is working well to fill his or her service and support needs. Client input on changes in intensity or scope of services should be given the greatest weight when changes to the Care Plan are made.

Informal Reassessment should occur as part of every interaction between client and case manager, but such informal Reassessment is different from the structured process that should take place at least once every six months. Informal Reassessment involves systematically reviewing all aspects of a client's condition, care, and treatment. Case managers should look upon reassessment as an opportunity to "fine tune" the service structure for clients whose needs

have not changed or to make changes in the configuration of services for clients whose conditions have changed.

Problems and Issues that May Arise During Reassessment

1. If the client has not been in regular contact with the case manager in the period since the initial Care Plan was completed, it may be difficult to contact the client for the purposes of Reassessment. If reasonable efforts have been made to contact the client for the purpose of Reassessment and all efforts have failed, then the case manager should consider inactivating the client's file. The decision to discharge or inactivate a client's case should only be made in conformance with the case management agency's discharge criteria.
2. The Reassessment provides a structured time for the case manager and client to discuss the client's success in achieving the goals and objectives of the Care Plan. If the client had previously agreed to take certain actions or to participate in certain programs, such as a drug treatment program or vocational rehabilitation program, but has not done so, then those arrangements must be revised. The case manager and the client should consider the substitution of more modest goals that the client can realistically achieve. Client success in meeting the goals he or she develops with the case manager is important for strengthening the client's sense of personal effectiveness in managing his or her disease.

Practice Hints

1. The Reassessment is an opportunity to reevaluate whether each aspect of the client's care plan is still working to the client's benefit. It is important to involve the client's other caregivers and members of the client's support network in conducting the Reassessment. After a period of time, caregivers may tire and need respite care. Other caregivers may no longer be in a position to provide assistance or support to the client, but may need the help of the case manager to communicate effectively with the client about making such changes. Client consent to share information with or involve other caregivers in the Reassessment should be confirmed.
2. Reassessment for clients with HIV disease should take into account that, over the course of the disease, clients will experience periods of relatively high functioning interspersed with periods where the effects of the disease impede effective functioning. In particular, the debilitation that results from acute or chronic infections, the weakness and frailty that results from wasting in the later stages of disease, and the sometimes subtle cognitive deficits that are associated with AIDS-related dementia, will impede the client's ability to carry out activities of daily living or to cope with the challenges of daily life.
3. The effects of the disease also have varying psychological impacts, most prominently depression that can wax and wane over the course of the client's life. HIV disease can also behave in paradoxical ways and often does not lead to a consistent decline in health. After a period of debilitating illness, many clients recover their strength and health, and experience periods of enhanced functioning that require less intensive intervention by case managers.
4. Communication is key to developing a successful case management relationship. Use the Reassessment as an opportunity to establish two-way communication with the client. The Reassessment is best thought of as an in-depth conversation between the client and the case manager. Avoid interrogating the client with a lot of questions. Encourage the client to discuss his/her concerns about health, living situation, finances and overall care and treatment.

CORE ACTIVITY #7: TRANSFER AND DISCHARGE

Overview

Transfer or Discharge from HIV case management programs occurs when the client dies, moves out of the area, transfers case management responsibility to another service program, or refuses further participation in the program. On rare occasions, it is appropriate for the case manager to initiate Discharge when the client has exhibited threatening or dangerous behavior toward program staff.

Transfer and Discharge can be difficult procedures for the case manager and the client to carry out because of the emotional implications. These procedures involve the severing of formal ties between the client and the case manager. Whereas Discharge often results from death of the client, Transfer frequently occurs because the client has entered a more advanced stage of disease requiring more intensive care and management, such as that offered by a hospice program. In either case, or when Transfer happens for other reasons, it is important to ensure that Transfer and Discharge are not carried out in an abrupt or disruptive manner, but result from a planned and progressive process which takes into account the needs and desires of the client and his or her caregivers, family, and support network.

Transfer and Discharge Guidelines

These guidelines are intended to assist the case manager in making the decision to terminate or transfer a client from the active caseload. Before undertaking to transfer or discharge a client from case management services, the following steps should be taken:

1. The case manager must be convinced that his/her agency or program is no longer able to meet the case management needs of the client and has consulted with the supervisor or other members of the case management team about plans to discharge or transfer the client.
2. The case manager discusses with the client and his or her caregivers the decision to discharge the client from the case management program.
3. The client has been informed of other agencies that might better meet his or her needs for care and treatment. Arrangements are made to refer the client to another agency of this type.
4. Reasons for the planned transfer or discharge are well documented in the client's file as well as records of conversations with the client about planned transfer or discharge.
5. A reasonable timetable has been set for discharge or transfer that allows sufficient time for the client or his or her caregivers to make other arrangements for care or treatment.

Transfer can also occur when responsibility for the client is transferred to another case manager within the same agency. There are a variety of circumstances that would warrant an intra-agency transfer. These include: language or cultural barriers, client or case manager preference, or the need of the case manager to balance his/her caseload.

Practical Aspects of Transfer and Discharge

- ***When Do Transfer and Discharge Occur?***

Transfer and Discharge occur when the case management program no longer serves the needs of the client. This could occur when the client has progressed to a more advanced stage of disease and needs more intensive care management or when the client has moved out of the area.

After a client dies, cases are closed only after an appropriate period is observed where case management support is offered to the client's family, friends and caregivers. Each program should develop a written policy regarding the length of time of these extended services.

Client Initiated Transfer

Client-initiated requests for transfer or discharge from the program or client "drop out" from the program may result from client perceptions that the program no longer meets his or her needs adequately. The client may feel that he or she is incompatible with the particular case manager or with the program. The client may feel that program rules or guidelines are too rigid or that his or her expectations for what the case manager can accomplish are not being met. The client may also feel renewed confidence, after a period of successful program participation, to manage his or her own care or treatment without case management. Sometimes, after client initiated discharge or termination, outreach efforts on the part of the case manager can bring the client back into the program. Programs should be flexible enough to keep open the option of reactivating a case if renewed contact with the client warrants this.

- ***What Circumstances Warrant Termination of a Client From Case Management?***

As a general policy, case management programs may suspend or terminate a client if the client has threatened violent behavior or bodily harm to the case manager or to any member of the agency's staff. Clients can also be terminated from programs if they have made fraudulent claims about their HIV diagnosis or have falsified documentation. Clients with substance abuse problems must not be terminated from non-residential HIV case management programs solely for active drug use.

Some case management programs may employ a suspension program that allows a client who has been terminated for violent or threatening behavior to re-enroll in the program after a period of time. This period can range from one month to one year, depending on the client's condition and the degree to which the client has successfully improved his or her behavior.

Information Collected During Transfer and Discharge

It is important to carefully document the reasons the client is being transferred or discharged and the process that was undertaken to accomplish the transfer or discharge. This documentation should include information on the nature of the relationship between the case manager and the client. For instance, has communication and cooperation between the case manager and client been satisfactory as far as both parties are concerned? Documentation should also indicate:

1. The steps in case management process that have been completed at the time of discharge or transfer;

2. All options to either continue in the current program or transfer to another program have been discussed with the client;
3. The case manager's supervisor as well as other members of the client's care management team have been consulted about the plans to discharge or transfer;
4. Discussion with the client about the decision to discharge or transfer has taken place;
5. The client's plans for further care or treatment management;
6. Any plans for follow-up or re-contract once the discharge has taken place; and,
7. Whether in the best judgment of the case manager, transfer or discharge engenders any risk to the client's health and safety.

All of this information should be summarized in the Discharge Summary in the Progress Notes. There is no need to create a separate form for documentation of Transfer and Discharge procedures.

Process

The process of Transfer and Discharge involves good communication, thorough documentation and reasonable follow-up to ensure that the client has successfully transferred to another system of care, when appropriate. The decision to transfer or discharge a client must involve consideration of the client's current level of functioning, the problems that inhibit the client from managing his or her self care and an assessment of whether another program could better help the client cope with his or her HIV disease and related problems. Transfer and Discharge should never be undertaken without consultation with other caregivers involved in the client's care. Transfer to either more or less intensive programs should be considered. In cases where the client is being discharged because of behavior that is unacceptable to the case management program (that is, in cases where the client has exhibited threatening or violent behavior) the reasons for discharge should be carefully documented.

The case manager should do whatever he or she can to prepare the client for transfer or discharge. If transfer to another program has been planned, the case manager should do whatever he or she can to facilitate entry of the client into the other program, including making sure that all the necessary paperwork accompanies the client or is sent to the appropriate personnel at the new program.

When a client has died, the case is not immediately closed. The case manager and, when appropriate, other members of the agency staff, have an important role to play in supporting the client's family and caregivers in their time of grieving. Each agency should develop its own process, appropriate to the culture of its client population.

Problems and Issues Related to Transfer or Discharge of a Client

1. *Coping with the death of a client is a difficult task for all services workers.* Agency procedures will help the case manager close a case, but the case manager and other co-workers who have dealt with the client may still be left with feelings of grief and sadness. Case management staff may sometimes feel remorse and anger that more could not have been done to improve the quality of a client's life or to sustain the client's life for a while longer. The grieving process is further complicated by the ongoing high pressures of the

case manager's job. Case management programs are strongly encouraged to develop bereavement policies and procedures that allow case managers and their co-workers an appropriate vehicle for expression of their feelings of loss when a client has died.

2. *Case management is usually viewed as a long-term relationship between the client and case manager.* Therefore, guidelines for case management tend to focus more on the issue of client retention and not on termination or discharge. Sometimes resource allocation constraints necessitate the evaluation of the appropriateness of retaining certain clients whose needs could best be served by other agencies or programs. At other times clients with HIV disease may experience an improvement in their overall condition that warrants either discharge from the active caseload or reassignment to a less intensive program. Case management options for people with HIV disease are varied depending on the constellations of symptoms and conditions that the client presents. Planned referral to less intensive case management or other programs should be considered as an alternative to retention when the situation warrants.
3. *Case management programs are intended to foster client autonomy and self care, whenever possible.* The case manager should be aware and should make the client aware that the client always can exercise the right to separate from the program without any recrimination. Case managers should be adequately trained to deal with the interpersonal relationship issues that arise from Transfer and Discharge. In particular, case managers should always be prepared to deal with separation from the client in a way that does not jeopardize the client's self-determination of self-reliance.

ISSUES RELATED TO COMMUNICATION AND COORDINATION

Case Conferences

In order to promote better care coordination and to encourage collaboration among providers, case managers should make maximum use of case conferences. Case conferences are designed to provide case managers with a forum of peers in which to solve problems related to individual cases and to devise ways to better coordinate care among multiple providers. Case conferences are the primary mechanism for building a multidisciplinary team approach to case management and care coordination for clients in the HIV Services System.

Active cases must be reviewed regularly among a group of case managers and other social services and health care staff to ensure that all options have been considered to meet the client's identified needs. Additionally, case conferences may also be used to determine if elements of the Care Plan are being carried out in a timely fashion. Client consent must be obtained for case conferences to occur.

Case conferences can include case management staff from different agencies and programs. Precedent exists for interagency case conferences to be held among providers who provide clients with different services and forms of care. Whenever possible, case conferences should include the primary health care provider, case manager, and providers of other critical care and treatment services such as substance abuse, home care, and mental health. Nonprofessional caregivers, including family members, friends, and lovers, should also be encouraged to participate in case conferences when appropriate.

Consultation

Consultation is the process of interacting with other case managers, supervisors, and community health workers to ensure that the client receives the highest quality of care and the most appropriate array of services. There are times when even the most highly skilled care manager will not be able to determine the best course for the client. In such situations, case managers can receive critical support from consultation and case conferences with their peers.

In programs where the case manager or case manager supervisor do not yet have the appropriate knowledge to conduct all seven core activities, two options are available: 1) hire a consultant who has the appropriate experience to ensure that all activities are provided on an ongoing and regular basis, and 2) form a collaborative relationship with another program to conduct the activities in question (e.g., psychosocial assessments). Simultaneous training should be conducted for case management staff in the activities for which they lack experience.

Client Pressure for Care

What should a case manager do when his/her judgment regarding a decision affecting the client conflicts with the preferences and values of the client and/or family and caregivers? Case managers may also have to mediate between the wishes of clients and the wishes of their caregivers. Mediation and negotiation are intrinsic elements of effective case management. Conflict will occur as part of the ongoing process of case management work. Conflicts and tensions that arise between case manager and client need to be resolved on a case-by-case basis and cannot be addressed by specific guidelines. The importance of clinical skills and experience

are made clear when conflict arises. These issues also emphasize the need for adequate peer support and supervision and for training to enable case managers to effectively respond to tensions and conflicts that inevitably arise in the course of this work. Case managers should be encouraged to ask for assistance from supervisors in arbitrating conflicts with their clients. Client consent must be obtained in order for another person to become involved in the client's case.

Multiple Case Managers

It is strongly urged that clients who enroll in HIV case management programs choose a single agency and a single case manager to be their primary care coordinator at the time of enrollment. Case managers should discuss the benefits and liabilities of having multiple case managers with their clients. With the client's consent, the case manager should contact any other providers involved in coordinating care or procuring services for the client. When other programs or agencies remain involved in providing and/or coordinating a client's care, the case manager should work with the client and other providers to designate a primary case manager. The primary case manager will have the responsibility of maintaining a complete set of patient files, including intake, assessment and care planning documents. The results of the assessment and the goals and objectives of the care plan should be shared with the other providers. In cases where the client or the other caregivers and providers think that it is best for the client to continue using the services of multiple providers, case conferences should be called to share information, to avoid duplication of work whenever possible, and to remove obstacles preventing the client from receiving needed services.

Clients have expressed their point of view on the subject of multiple case managers. They have persuasively pointed out that, in situations where they have not been able to get satisfactory assistance from case managers in the past, they have turned to other service providers for help. Clients who have developed sophisticated methods of "working the system" have learned not to take no for an answer and to keep searching for a provider who will help them get the services or the benefit they want. Such clients should be encouraged to continue to be resourceful in getting their needs met. However, these clients should be made aware of the benefits of having a primary case manager who could work with other case managers to better coordinate services and care. Case managers should provide all possible support for clients when they act on their own behalf to meet their service and care needs.

The lack of a single definition for case management and the rather loose use of the term in the past, may have led clients to believe that they were enrolled in a case management program or were being followed by a case manager when in fact they were not. These guidelines strive to clarify the role that case managers play in the client's life, especially the ongoing commitment to work with the client that is made by the case manager and the program. Hopefully, standardizing the functions that case managers perform will contribute to eliminating the confusion that has led many clients to seek the help of multiple providers to accomplish the same tasks.

PROGRAM DESIGN ISSUES

Quality Assurance for Case Management Programs

Case management requires a commitment to providing and procuring the highest quality services for the client. Quality Assurance must be a component of each case management program in the San Francisco HIV Service System. It must be routinely carried out following a specified protocol that is developed by program staff to review and improve the quality of case management services provided to clients.

Quality assurance review should be conducted by a committee composed of program administrators, case management supervisors, case managers, and clients. Larger institutions and programs may select a random sample of charges to review clients' cases and the completeness with which case management objectives and components of care are accomplished. Smaller programs may review the progress of each client's case as part of its quality review process. Programs are encouraged to develop their own protocols and data collection tools for quality assurance purposes. Documentation of all case management activities must be complete and up-to-date if quality assurance activities are to be effective.

Case management has a dual focus: providing direct services and support to the client and procuring services from other community agencies. Therefore, quality assessment involves not only monitoring the direct provision of services by the case manager but also the process of acquisition and quality of care provided by the other involved agencies. Case management should meet standards of quality related to structure, process, and outcome criteria as defined in these standards. Case management quality assurance must also include a mechanism to ensure the overall quality and appropriateness of all services provided to the client.

The following indicators of quality care need to be considered in implementing the Standards of Practice for HIV Case Management. They include dimensions related to appropriateness of service type and intensity, availability of case manager and of other services, timeliness with which services are rendered, reliability of service providers and case managers and cultural competency to provide care to individuals from different target populations.

1. Frequency of Contact with the Client

In some case management programs, client contact is initiated by the client; in others, standards are set for minimum client contact initiated by the case manager. Frequency of contact also will depend on the type of service program, the level of care required by the client, client preferences regarding the frequency of contact, and caseload size. Some clients prefer to initiate contact with their case managers themselves, rather than have the case managers contact them on a regular basis, so that their privacy is not interrupted if they are not in need of services at the time. At a minimum, the case manager and client should have contact once a month.

2. Mode of Client Contact

Depending on client needs and program goals, different modes of client contact may be appropriate. In-person contact with the client is strongly encouraged whenever possible. In some programs that focus on brokering services for their clients, an initial face-to-face intake and assessment will be conducted; most subsequent client contact takes place over the telephone,

when possible and appropriate. Since in-person contact with the client is desired, case managers in brokerage type programs are encouraged to make in-person contact with their clients at least once per month. Clients often come to the site of the case management program to obtain assistance with applications for entitlement programs or to acquire such items as transportation vouchers. This provides one opportunity for in-person contact. While telephone contact may suffice for making referrals, in-person contact may play the dual function of providing the client with social and emotional support while providing the case manager with the opportunity of informally reassessing the client's psychosocial and physical health status. When case management programs are situated within larger HIV service programs, client contact with the case manager at the service site may take place as a natural extension of participation in other program components, such as social support groups, adult day health, or substance abuse treatment.

3. Caseload Size

Establishing optimal caseload size and preventing caseloads from growing too large are challenges most HIV case management programs face. In programs offering comprehensive case management, caseloads of 35-50 clients per case manager have been suggested by local providers. However, growth occurs rapidly in most HIV case management programs. While trying to accommodate the demand for services, some case management programs have had to put a cap on new enrollments in order to preserve quality. High caseloads arise, at least in part, from lack of adequate triage policies. In the absence of a formal triage system, case managers devote more time and effort to the most needy clients. Triage protocols need to be developed that target clients in such a way as to allocate program resources according to specific level of need.

4. Tasks Performed by Case Managers

It is expected that each of the seven core functions of case management will be undertaken and performed in a timely fashion for each client enrolled in a case management program. However, since HIV case management is an emerging field, and health and social services providers from multiple disciplines are involved, the tasks performed by case managers are not always the same. These Standards of Practice are intended to promote more uniformity in the range of tasks that case managers perform. Since case managers in the HIV Service System come from many educational and experiential backgrounds, there will be some variation in the tasks performed. When case managers do not have the expertise to perform certain tasks, such as comprehensive psychosocial or nursing care assessment, they will bring supervisory personnel or a consultant to support and complete the work of the individual case manager.

5. Client and Provider Satisfaction

In evaluating the success of case management, quality assurance refers to parameters affecting both client and staff satisfaction with the service program and the conditions under which services are delivered. Any quality assurance protocols or guidelines should take both these factors into account.

6. Client Empowerment

The HIV Service System is committed to a "Client-Centered System of Care." Therefore, quality assurance activities should be designed to empower clients to have an active role in the quality

and provision of services they receive. Case management programs are encouraged to have clients serve on their advisory boards and on quality assurance committees. Clients should be encouraged at all levels to participate in the care planning process and to make choices about their care. Clients should be educated about their rights and responsibilities in participating in the case management program. There should be a formalized process for receiving grievances from clients and for notifying case managers and other service providers about client complaints. Clients should be directly involved in the evaluation of the services they receive.

Defining Successful Outcomes for HIV Case Management

Case management is a complex and highly personalized service for people requiring long term care. It poses difficult challenges for those attempting to define specific outcomes that result from this service. Case management for people with HIV disease is further complicated by the progressive nature of the disease. Clients often first request case management services when they are in more advanced stages of disease and their overall health and functional abilities are in decline.

Outcomes for HIV case management should focus on the effects that case management has on improving the client's quality of life and/or achieving a higher level of stability for the client in his or her housing situation, practical and emotional support, and care and treatment. In particular, the type of outcomes that can be measured include: 1) overall client satisfaction with the case management program and with his or her system of care; 2) timeliness of service provision; 3) appropriateness and cultural competency of care received; and 4) specific outcomes or improvements that have resulted from the care delivered. These outcomes relate to the overall quality and effectiveness of care, not exclusively to case management. These outcome measures are applicable not only to the case management program, but to all the other services that contribute to the client's overall well being, including in-home and community based support services. It may be impossible to isolate the specific contribution of case management to the client's overall well being.

Potential sources of information for outcome measurement are those that are also used for quality assurance. They include client satisfaction surveys, review of the client's chart, and provider and caregiver satisfaction surveys or interviews. Client satisfaction surveys should be designed to include both the client's and the informal caregiver's opinions and perceptions with the quality of care given, the timeliness of care, the relationship with the case manager, and how well the case management program functions to support the work of the case manager. The provider and caregiver satisfaction surveys or interviews are important for obtaining their perspective on their ability to meet the client's needs, while being forced to allocate limited resources among many clients who may have competing needs. Case managers should also be surveyed to determine their relative ability to make successful referrals, where clients sought services upon the case manager's recommendation and received them.

In evaluating outcomes, it is important to remember the overall goals of HIV case management: 1) to maintain or improve the client's ability to remain independent in his or her home environment and 2) to maintain or improve quality of life for the client during the course of his or her illness. In order to accomplish these goals, successful case management ensures that: 1)

the client actually receives the services for which he or she is referred; 2) periodic reassessments of the client's status are conducted to update the care plan; and 3) adjustments in the configuration of services are made to accommodate changes in health or social status. Evaluation of case management services must include measures of the successful accomplishment of these components.

Documentation

At this time no standardized data collection instruments have been developed for use with these Standards of Practice. Case management programs are expected to have data collection instruments that all case managers within that program use to record the information collected while they carry out each component activity of case management. As the HIV Service System becomes more integrated through the implementation of "REGGIE," the centralized and coordinated client registration system, there will be a greater incentive to standardize the data collected by case management programs. It is expected that standardized tools for case management data collection will be developed during the implementation of these Standards.

Case management providers have developed a variety of different intake and assessment forms and other tools to record client information. Intake forms often have common elements to establish eligibility, enroll the client in the program and determine immediate service needs. Assessment forms often have common elements to establish functional and cognitive capacity and limitations, determine other service needs, and assess strengths, abilities and resources. Many forms and tools also have unique elements related to different services provided or the special needs of their client population.

At a minimum, documentation of case management services should include: 1) an initial intake or registration form, used at the time of first client contact; 2) the request for services form, signed by the client; 3) an initial assessment of client status and service needs; and 4) the initial care plan, specifying the services to which the client is being referred and the manner in which the referral will take place. Documentation should include the name of the case manager and, if relevant, indication of whether other case managers, working out of other service sites, are involved with the client. When multiple case managers are involved, the care plan should indicate how coordination of efforts will take place. Documentation should include: 1) the date of encounter with the client, 2) date of service referral, 3) date of service delivery, 4) name of person or agency providing the referred service, and 5) information indicating whether the service requested was received.

As patient caseloads grow, agencies that coordinate the care of persons with HIV disease are turning to computerized database management systems to keep track of patient flow into and out of the programs. The need for reliable data is heightened by the requirements of the federal government and other funding agencies. CARE-funded programs are required to produce aggregate data that describe the volume and type of services on a program-by-program level for the entire service system. The collection of system-wide, client level data would allow planners and evaluators as well as program managers to gain an accurate picture of program utilization, including the distribution of clients among service programs.

Contracting for Case Management Services

Units of Service

A case management unit of service is counted as an hour of service provided to or on behalf of the client in the following activities:

- Assessment
- Coordination of services
- Intake
- Reassessment
- Service planning
- Referral and arranging of services
- Informing clients of service options
- Individual client advocacy (action to ensure access to a service)
- Phone contacts with client of referral agency (service monitoring)
- Assistance with concrete survival (food or housing, etc.)
- Case review within the agency
- Coordinating/conveying information with collaborating agencies and client's support system
- Crisis counseling
- All client related telephone calls
- Discussions with other staff regarding client needs
- Client education
- Assisting clients to complete forms or application processes
- Decision-making counseling
- Interpreting eligibility requirements of a referring agency to clients
- Representing clients in efforts to gain access for a client to a particular service
- Arranging for practical support

The following activities may be conducted as part of the provision of services, but cannot be counted as units of service:

- Outreach (Note: The time spent conducting intakes, counseling, etc. with clients in the field may be counted as a UOS.)
- Transportation for client to and from a service
- Volunteer recruitment, training, and placement
- Charting
- Staff travel to conduct home visits
- Staff training

Answers to questions regarding what activities a specific program counts as a unit of service may be found in the program contract document. All contracts are public documents and should be made available to staff as part of program orientation.

Evaluation

Evaluation of case management programs must take place at both the agency and system-wide levels. Evaluation should reflect the same client-centered approach that was taken in developing

these standards. The primary goal of evaluation of AIDS case management programs should be to determine how well the program is functioning for the client. From the point of view of the client, the most important aspects of a case management program is that the case manager acts decisively and effectively on his or her behalf. Clients have expressed frustration with a fragmented health and social service system for people with HIV disease. They desire assistance from case managers to help them obtain the benefits they are eligible for, find appropriate housing, secure child-care, etc. Building rapport and trust between the case manager and client is also essential to making the case manager/client relationship work. Process oriented outcome measures can be used to evaluate the effectiveness of case managers in helping clients achieve these goals. Experimental designs for process evaluation could focus on determining the factors related to achieving trust and rapport and facilitating the successful accomplishment of case management goals.

Other evaluation activities focus on the measurement of outcomes related to successful case management. These include client satisfaction surveys, random sampling and review of client charts, review of case manager activity logs, caregiver satisfaction surveys, and client retention rates. Experimental studies built into outcome evaluation can be structured to determine whether variations in clinical practice patterns, such as caseload size or frequency of client contact, are related to the successful accomplishment of specific landmark tasks or quality of life improvement.

APPENDIX A: ACUITY SCALE

An Acuity Scale has been developed to assist case managers in determining the overall functioning of the client and the intensity of services that the client requires. It can be used by case managers as a time management tool and to help them achieve a balanced caseload. It can be used by case manager supervisors to allocate the distribution of new clients into caseloads of manageable sizes and intensity. It can also be used to help case management programs determine optimal caseload sizes for individual case managers, based on a balance of low, moderate, and high need clients. The use of the Acuity Scale is voluntary at this time but is strongly encouraged. System-wide use of the Acuity Scale will facilitate more equitable distribution of clients to programs throughout the City and will provide valuable data about the overall level of need with which clients present themselves for services.

The Acuity Scale is a measurement tool that rates clients on the basis of their level of need in eleven “Life Areas.” It is recommended that the Acuity Scale be used after the Assessment is completed. For each of these Life Areas, four possible stages exist, ranging from Stage 1 representing a low level of need, to Stage 4, or Crisis. Points are given in each Life Area based on the client’s assessed level of need. The cumulative scores provide case managers with a guide to how intensely and how frequently follow-up contact with a client should be pursued. Each case manager’s client caseload can then be totaled to determine its overall “weight” in terms of intensity of client need. New cases can then be assigned to case managers with the lowest acuity totals. Using this process can help identify case managers with a disproportionate number of high acuity clients. Balancing caseloads can help ensure consistent quality of service for each client. It also supports the case manager’s ability to more quickly reassess clients and provides more proactive support to clients as their needs change.

A client with a crisis situation in one or more Life Areas requires immediate attention to his or her needs. Clients with low or intermediate scores are likely to have relatively low demand on case manager time and resources. However, such clients should not be neglected in favor of clients who present themselves to case management programs in more acute need or in crisis. The Acuity Scale can be used by individual case managers to allocate their time in such a way that low and moderate need clients are taken through the case management process from Initial Interview and Intake to Implementation of the Care Plan in a timely manner. If a case manager finds that clients in crisis or in acute need of care are preventing them from attending to the needs of low and moderate level clients, then a reallocation or transfer of cases is warranted.

Data collected from the Acuity Scale are useful for planning and resource allocation on both the agency and system-wide levels. Use of data from the Acuity Scale can provide the AIDS Office with information that can be used to determine whether case management clients are distributed among programs in a balanced way or if certain programs tend to attract an unbalanced client caseload, heavily weighted toward clients in crisis or with acute level needs. To some extent the distribution of clients by intensity of need is a function of the mission and target population of the individual case management program. It should also be acknowledged that many clients first request case management services when a crisis hovers or when the stability of their life situation or health status suddenly changed. However, in some cases, where case managers provide services to a cross-section of clients, the Acuity Scale can be used to adjust imbalances in client

intensity. This can be done through interagency referral or by reallocating cases among case managers at a single agency or at affiliated agencies.

Aggregate data from the Acuity Scale can also provide system-wide planners and program administrators with useful information on the dynamics of client need, i.e., how long individual clients tend to remain within a particular stage, whether clients in crisis tend to experience a transition into more manageable life situations, and what proportion of clients enrolled in case management are in crisis at any one time. This information is also useful in determining the contribution that case management makes in stabilizing clients who first request services in emergent or crisis situations. With this information, AIDS Office statisticians can predict the behavior of clients in terms of where they tend to go to seek services, at what stage of disease they first request case management services, and the length of time clients tend to remain in each stage of need.

The Acuity Scale is a useful tool for documenting the relationship between client acuity and the amount of time required for case managers to provide adequate assistance. Clearly, clients in crisis or with emergent crises situations or with a high level of need for assistance will need more of the case manager's time than clients with low or moderate need.

Although case management is seen as an essential service in the prevention of crisis situations, it doesn't always succeed. The Acuity Scale also will provide comparable information on low and moderate need clients. It is a useful tool for isolating the variables in a client's life that are subject to change and which factors contribute to a client's stability.

There are limitations to the use of the Acuity Scale. In smaller programs where there is just one case manager, it cannot be used to distribute cases in a balanced fashion among case managers. However, it remains useful as a way to obtain information on the intensity of the client caseload that the program attracts. The Acuity Scale can also be used as an indicator for programs that may need to establish collaborative relationships with other case management programs in order to achieve a desired balance in client intensity.

CLIENT ACUITY SCALE WORKSHEET

Life Area	Stage 1 (1 point)	Stage 2 (2 points)	Stage 3 (3 points)	Crisis (4 points)
Basic Needs _____ Score	Food, clothing, and other sustenance items available through client's own means; accessing food assistance programs; able to perform all necessary activities of daily living (ADLs).	Sustenance needs met on regular basis with some periods of lapse; partial access to assistance programs for food and household items; ranging from able to perform ADLs on own to needing ≤10 hours weekly in-home ADL assistance.	Needs information/help with accessing assistance programs; past difficulties accessing assistance programs; often without food & clothing; needs > 10 hours in-home ADL assistance.	Has no access to food, without basic needs; unable to perform ADL — no home to receive assistance with ADL.
HIV Disease Progression _____ Score	Asymptomatic; in early intervention program.	Symptomatic; one or more opportunistic infections; ranging from fair to poor health.	Debilitating HIV disease	Medical emergency related to HIV. Client is rapidly approaching terminal stages of the disease/and is close to death.
Other Medical Needs _____ Score	Stable health, no current need for other medical care. Chronic condition under control with medication/ treatment.	Some need for treatment/medication of non-HIV related symptoms.	Poor health.	Medical emergency not related to HIV. Client is rapidly approaching death.
Support System _____ Score	Dependable emotional and physical availability of numerous relatives and friends to help client.	Gaps exist in support system; family and/or significant others periodically available when crises occur.	No stable support system accessible; only supports are provided by professional caregivers.	Acute situation where client is unable to cope without professional support within a particular situation/ time frame.
Living Situation _____ Score	Clean habitable apartment or house that is not in jeopardy due to poor upkeep and/or financial strain.	Needs short-term assistance with rent/utilities to remain in habitable dwelling; housing in jeopardy due to projected financial strain or housing is uninhabitable. Formerly independent person temporarily residing with friends or relatives.	Imminent eviction; home completely uninhabitable due to health and/or safety hazards; living in shelter.	Homeless; evicted; no place to stay; arrangements to stay with friends have fallen through; client has been evicted from residential program.
Substance Abuse _____ Score	No current or past difficulties with alcohol or other drugs.	Problems with alcohol or drugs; less than one-year sobriety; immediate family member with alcohol/drug problem; expresses desire for help in overcoming drug abuse.	Major impairment of client/ family member; extensive tx of life problems from c.d.; relapse; indifference regarding consequences of use; disconnected from or unmotivated to seek tx.	Current relapse/binge.
Mental Health _____ Score	No history of mental illness, psychological disorders, or psychotropic medications; no need for counseling referrals.	History of disorders/treatment in client and/or family; expected level of client/family stress regarding HIV counseling is high.	Incapacitating stress or family crisis re: HIV; no mental health care.	Danger to self or others; needs psychiatric intervention.
Financial/Benefits _____ Score	Steady source of income which is not in jeopardy; has significant savings/resources; able to meet monthly financial obligations.	Has steady source of income that is in jeopardy; occasional need for financial assistance or awaiting outcome of benefits application; has short-term benefits.	No income and no previous application for benefits; benefits denied; unfamiliar with application process and/or unable to apply without guidance.	Immediate need for emergency financial assistance.
Transportation _____ Score	Has own or other's means of transportation consistently available; can drive self; can afford private or public transportation.	Has occasional to minimal access to private transportation; needs occasional assistance with finances for transportation.	No means via self/others; in area not served by public transportation; unaware of or needs help accessing transportation programs.	Lack of transportation is a serious contributing factor to current crisis.
Legal _____ Score	No recent or current legal problems, all pertinent legal documents completed.	Wants assistance completing standard legal documents; possible recent or current legal problems.	Involvement in civil or criminal matters; incarcerated; unaware of standard documents, i.e., living wills; undocumented immigrant.	Crisis involving legal matters, e.g., legal altercation with landlord/employer, etc.
Culture/Language _____ Score	Understands service system; language is not a barrier to accessing other services.	Needs interpretation services/ understands service system; family needs education/ interpretation to provide support.	Culturally appropriate interpretation services are needed for client to access other services (language & cultural issues); family's lack of understanding is barrier to care.	Lack of understanding of service system/language creates state of fear/anxiety and distrust in client and/or family; crisis intervention is necessary.