

**NEW YORK STATE
DEPARTMENT OF HEALTH
AIDS INSTITUTE**

**STANDARDS
FOR
HIV/AIDS
CASE MANAGEMENT**

2006

ACKNOWLEDGEMENTS

CASE MANAGEMENT STANDARDS WORKGROUP

**JOANN BEASLEY
KAREN BOVELL
SHERRY CHOROST
CAROL DELAMARTER
TIM DOHERTY
LARRY KLEIN
PETER LAQUEUR
EUTHEMIA MATSOUKAS
JUDITH MAZZA**

**KYLE RESTINA
FELICIA SCHADY
NANCY SIMBOLI
MARC SLIFER
SUE STONE
LISA TACKLEY
TARA TATE
BARBARA WILLINGER
BETH WOOLSTON**

CASE MANAGEMENT STANDARDS GUIDANCE GROUP

**ALMA CANDELAS
BARBARA DEVORE
IRA FELDMAN
JAY FREEDMAN
ROBERTA GLAROS
GLORIA MAKI
MONA SCULLY
BARBARA WARREN**

ADDITIONAL THANKS TO

SONJA NORING, EDITING

SPECIAL THANKS TO

**HIV/AIDS CASE MANAGEMENT PROVIDERS
ACROSS NEW YORK STATE**

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1. INTENT

1. Intent

This document establishes universal core standards for HIV/AIDS case management services funded or administered by the New York State Department of Health AIDS Institute (AI). The standards set a minimum service level for programs providing HIV case management regardless of setting, size, or target population.

Universal core case management standards were developed to:

- Clearly define case management and describe models of case management service
- Clarify service expectations and required documentation across HIV/AIDS programs providing case management
- Simplify and streamline the case management process
- Encourage more efficient use of resources
- Promote quality of case management services

The overall intent of AIDS Institute Case Management Standards is to assist providers of case management services in understanding their case management responsibilities and those of their counterparts in other programs to promote cooperation and coordination of case management efforts.

Ongoing changes in the HIV/AIDS epidemic, the HIV/AIDS service environment, and the needs of HIV positive individuals over the late 1990's and into the twenty first century necessitated a re-examination of case management practice and standards. For over two years, an internal AIDS Institute workgroup, broadly representative of the diverse program types offering HIV/AIDS case management across New York State, met to develop a single set of standards. Case management providers from a variety of settings and locales provided initial input and ongoing feedback through focus groups, conference calls, and piloting.

The new case management standards describe two models of HIV/AIDS case management: **Supportive Case Management** and **Comprehensive Case Management**. Providers may be approved by the AIDS Institute to offer one or both models of service. The two models were established to respond to varied levels of client need, client readiness for case management services, and agency resources. Programs providing both models of case management have the added flexibility to vary the level of case management service while maintaining continuity of care by shifting a client from one model to another when the client's circumstances change.

Although these standards set minimum requirements for AIDS Institute-sponsored case management programs, individual bureaus within the AIDS Institute may establish additional requirements, modifying the standards to fit particular settings, objectives, target populations, and/or AIDS Institute initiatives.

2. SCOPE

2. Scope

The standards described in this document apply to the HIV/AIDS case management services funded by the AIDS Institute through state and/or federal grants. In addition, the standards apply to case management services reimbursed by Medicaid, either on a fee-for service basis or bundled with other services required for an enhanced Medicaid reimbursement rate. Services covered by these standards may be provided in a variety of settings, including community health centers, hospitals, or community-based organizations.

Case Management services provided under the following AIDS Institute initiatives are covered by these Case Management Standards:

- AIDS Day Health Care Program (ADHCP)
- Centers of Excellence in Pediatric HIV Care
- COBRA Community Follow-Up Program
- Community-Based HIV Primary Care and Prevention Services
- Community Service Programs (CSP)
- Designated AIDS Centers (DACs)
- Family-Centered Health Care Services
- HIV Primary Care and Prevention Services for Substance Users
- HIV Services for HIV-Infected Women and Their Families
- Multiple Service Agencies (MSA)
- Ryan White Title II Case Management Programs
- Supported Housing Programs
- Youth-Oriented Health Care Programs (Special Care Centers)

Exempt Programs

Exempt from the standards are programs funded by the AIDS Institute to provide HIV prevention case management (now known as Comprehensive Risk Counseling and Services), transitional planning (in criminal justice settings), transitional case management (Youth Access Programs), or supportive services (please see glossary for definition of terms).

Designated AIDS Centers (DACs)

Designated AIDS Centers (DACs) are responsible for providing medical care coordination/ medical case management (see box below), as well as supportive case management. DACs are also responsible for referring patients assessed as needing comprehensive case management to community providers, unless recognized as providing comprehensive case management. Consult DAC-specific case management standards for additional information.

About Medical Care Coordination

Medical care coordination (or medical case management) is an essential component of HIV primary care. It is distinct from case management as defined in these standards, although overlap between the two roles often exists.

The medical care coordinator focuses on the clinical services of HIV primary care, and ensures that an HIV+ patient enrolled in primary care receives associated services such as nutritional assessments, substance use and mental health interventions, treatment adherence support, prevention education, and partner notification. Core functions include coordination of inpatient and outpatient care, referrals to specialists, follow-up for referrals and missed appointments, and conferencing between clinical and community-based case managers.

3. CASE MANAGEMENT DEFINITIONS

3. Case Management Definitions

Case Management

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

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

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

The goal of case management is to promote and support independence and self-sufficiency. As such, the case management process requires the consent and active participation of the client in decision-making, and supports a client's right to privacy, confidentiality, self-determination, dignity and respect, nondiscrimination, compassionate non-judgmental care, a culturally competent provider, and quality case management services.

For families caring for HIV infected or affected children, an additional goal of case management is to maintain and enhance the effective functioning of the family, and to support parents in their care-giving role. Case management services to children must be matched to their age and developmental level, enhance functioning and growth, and include children's participation in decision-making, as appropriate to their age and abilities.

The intended outcomes of HIV/AIDS case management for persons living with HIV/AIDS include:

- Early access to and maintenance of comprehensive health care and social services.
- Improved integration of services provided across a variety of settings.
- Enhanced continuity of care.
- Prevention of disease transmission and delay of HIV progression.
- Increased knowledge of HIV disease.
- Greater participation in and optimal use of the health and social service system.
- Reinforcement of positive health behaviors.
- Personal empowerment.
- An improved quality of life.

AIDS Institute Models of Case Management

Recognizing changes occurring in the HIV/AIDS epidemic and in the needs of persons living with HIV/AIDS, the AIDS Institute currently funds two models of case management service: **comprehensive case management** and **supportive case management**. These two models of case management may be provided in health care or social service settings, in large institutions or small community-based organizations. An agency or program may be approved by the AIDS Institute to provide one model exclusively, or both models, depending upon the specific AIDS Institute program requirements and formal arrangement with the AI.

Comprehensive Case Management

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

Central to the comprehensive model of case management is service planning, performed in conjunction with a comprehensive assessment and subsequent reassessments of the psychosocial and health care needs of the client and his/her family or close support system. Clients engaged in comprehensive case management will receive frequent contact, follow-up provided in the community and, in some programs, home visitation. Comprehensive case management services may be provided by a single case manager or by a case management team. Services may be supported by grant funds or Medicaid reimbursement, as approved by the AIDS Institute.

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

Supportive Case Management

The supportive case management model is responsive to the immediate needs of a person living with HIV/AIDS. Supportive case management is suitable for persons with discrete needs that can be addressed in the short term. Supportive case management is also an appropriate service for clients who have completed comprehensive case management but still require a maintenance level of periodic support from a case manager or case management team.

Supportive case management may also be provided to clients with multiple complex needs who may best be served by a comprehensive case management program, but who are not ready or willing at this time to engage in the level of participation required by the comprehensive case management model. In this case, supportive case management serves as a means of assisting an individual at his/her level of readiness, while encouraging the client to consider more comprehensive services.

Central to the supportive case management model is follow-up by the case manager or team to ensure that arranged services have been received and to determine whether more services are needed. Clients in

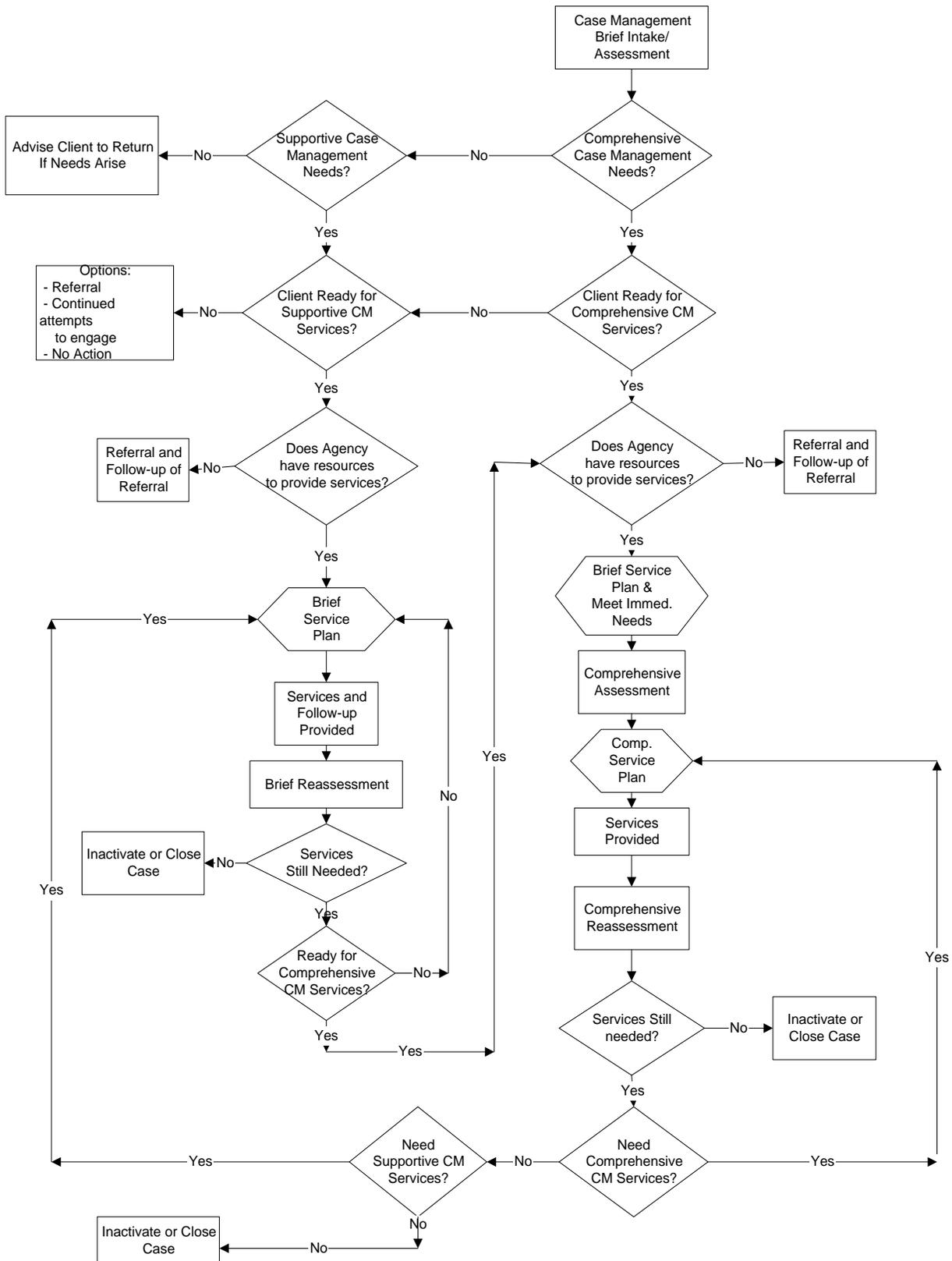
supportive case management experiencing a repeat cycle of the same crisis or problem should be encouraged to enroll in comprehensive case management services, either onsite or offsite, and assisted in attaining these services.

The goal of supportive case management is to meet the immediate health and psychosocial needs of the client at their level of readiness in order to restore or sustain client stability, and to establish a supportive relationship that can lead to enrollment in more comprehensive case management services, if needed.

Case Management Flow Chart

The Case Management Flow Chart, on the following page, is meant to provide a visual overview of the flow of activities and services within and between the two models of case management described above. The flow chart maps out in broad strokes the service system intended by the case management standards.

Case Management Flow Chart



4. CASE MANAGEMENT STANDARDS

4. Case Management Standards

The standards required for case management processes are presented in this section. The definition and purpose of each process is presented first, followed by a chart stating the standard and time frame along with the criteria that will be used to determine if the standard has been met. Exceptions to the standard, best practices, and additional resources follow where relevant.

The processes of case management described here are:

- I.** Brief intake/assessment process
- II.** Selection of case management model and placement
- III.** Brief Service plan
- IV.** Initial comprehensive assessment
- V.** Initial comprehensive service plan development
- VI.** Service plan implementation, including client contact, monitoring and follow-up
- VII.** Reassessment
- VIII.** Service plan update
- IX.** Case coordination and case conferencing
- X.** Crisis intervention
- XI.** Case closure

The standards presented in this section, in addition to the Requirements for All Case Management Programs in Section 5 (Policies and Procedures, Caseloads, Staff Qualifications) comprise the AIDS Institute Case Management Standards. For a quick summary of both please refer to the AI Case Management Standards “At-A-Glance” chart in Section 7.

I. Brief Intake/Assessment Process

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

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

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

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

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

<i>Standard</i>	<i>Criteria</i>
<p>Key information concerning the client, family, caregivers and informal supports is collected and documented to determine client enrollment eligibility, need for ongoing case management services, and appropriate level of case management service.</p> <p>In AIDS Day Health Care Program (ADHCP) Not applicable</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Time requirement: Due within 15 days of referral. Where HIV positive persons are entering services for HIV medical care, due by completion of initial comprehensive medical visit(s).</p> </div>	<ol style="list-style-type: none"> 1. Immediate needs are identified during the Brief Intake/Assessment process. 2. Immediate needs are addressed promptly. 3. Brief Intake/Assessment documentation includes, at minimum: <ol style="list-style-type: none"> a) Basic information <ul style="list-style-type: none"> • presenting problem • contact and identifying information (name, address, phone, birth date, etc.) • language spoken • demographics • emergency contact • confidentiality concerns • household members • insurance status • proof of HIV status • other current health care and social service providers, including other case management providers b) Brief overview of status and needs regarding <ul style="list-style-type: none"> • food/clothing • finances/benefits • housing • transportation • legal services • substance use • mental health • domestic violence • support system • HIV disease, other medical concerns, access to and engagement in health care services

<i>Standard</i>	<i>Criteria</i>
	<ul style="list-style-type: none"> • prevention of HIV/AIDS transmission • prevention of HIV disease progression <p>4. Documentation includes appropriate releases, including Authorization for the Release of HIV Confidential Information in accordance with Article 27F, and other releases for information as required by applicable law.</p> <p>5. Client is assessed for program eligibility and meets eligibility criteria.</p> <p>6. Case Management Policies and Procedures contain guidelines for conducting the Brief Intake/Assessment including staff responsible for and supervisory oversight.</p>

Exceptions

Where HIV positive persons are entering services for HIV medical care, a Brief Intake/Assessment is required by the end of the initial comprehensive medical visit to screen for case management needs. In some medical settings this may involve multiple visits.

A client’s acute needs and/or crises are paramount. If the presenting problem requires immediate attention, the Brief Intake/Assessment may be postponed or abbreviated, but should be completed as soon as possible.

In the **ADHCP** the Screening/Intake process serves the purpose of the Brief Intake/Assessment and provides information for determining appropriateness of admission to the program and identification of immediate service needs. A case manager assigned to the client within the first week of admission is responsible for addressing immediate needs.

Best Practices

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

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

Additional Resources

Sample forms including Brief Intake/Assessment and Screening Questions to Determine Need and Level of Case Management Services are available on the New York State Department of Health web site at <http://www.nyhealth.gov/diseases/aids/index.htm> under the category “Clinical Guidelines, Standards, and Quality of Care.”

II. Selection of Case Management Model and Placement

The **Supportive** and **Comprehensive** models of case management provide different levels of service geared to the needs and readiness of the client.

Supportive case management is designed for clients who need short term service, for those who require continued maintenance support following comprehensive case management, or for those not yet willing to participate in comprehensive case management.

Comprehensive case management is intended for people with multiple, complex needs who require intensive, longer term service.

For case management programs approved to provide both models of service, the ability of clients to shift from one model to another within the same program provides flexibility and enhances continuity of service as client needs evolve.

<i>Standard</i>	<i>Criteria</i>
<p>Clients are enrolled in a Supportive or Comprehensive case management program that provides a level of service that meets the needs identified in the Brief Intake/Assessment and in which the client is ready and willing to participate.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Time requirement: At completion of Brief Intake/Assessment.</p> </div>	<ol style="list-style-type: none"> 1. Case management model most appropriate for client needs is determined. <ul style="list-style-type: none"> • Acuity of client needs is ascertained. • Case management services are explained. • Readiness and interest in case management is assessed. • Client is enrolled in model most suited to their needs regardless of agency enrollment needs. 2. Program capacity is evaluated. <ul style="list-style-type: none"> • Program's service level and staff qualifications and/or expertise meet clients' needs. • Program has caseload capacity. • Program has capacity to meet clients' cultural and linguistic needs. 3. Clients are enrolled in Supportive or Comprehensive Case Management within agency. <ul style="list-style-type: none"> • Consent for case management services is obtained where required by initiative. • All required forms authorizing the release of HIV confidential information and other protected information are signed by clients as required by applicable law. 4. For clients at agencies which are not able to provide level or type of case management services necessary: <ul style="list-style-type: none"> • Agency refers the clients to another case management program. • Referral to another case management program occurs within 15 days after the determination of appropriate level of care. • Referring agency follows up and verifies with client that placement was appropriate and client is receiving services. 5. Agency has referral arrangements with local case management providers to ensure diverse needs of clients are met. 6. For agencies providing both Supportive and Comprehensive Case management models of service: <ul style="list-style-type: none"> • Agencies are able to identify which clients receive Supportive or Comprehensive case management at any point in time, and to report total number of clients being served in each model. • Policies and Procedures describe the process to move clients between models.

Exceptions

In some circumstances clients with extensive needs may be unwilling to accept or participate in Comprehensive Case Management but will agree to a supportive level of services. In these instances Supportive Case Management may be provided to meet immediate and crisis needs. With a continued cycle of crises, efforts should be made to encourage clients towards engagement in Comprehensive Case Management.

Clients enrolled in an ADHCP automatically receive Comprehensive Case Management services.

Best Practices

Agencies that coordinate with a variety of service providers and hold multiple reciprocal service agreements can best meet diverse client needs.

The most effective agencies are culturally competent and employ staff who culturally and linguistically represent the community served.

When clients are referred for case management services elsewhere, case notes include documentation of follow-up and level of client satisfaction with placement.

III. Brief Service Plan

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

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

Standard	Criteria
<p>Needs identified in the Brief Intake/Assessment are prioritized and translated into a Brief Service Plan.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Time requirement: At completion of Brief Intake/Assessment.</p> </div>	<ol style="list-style-type: none"> 1. A Brief Service Plan is developed and includes: <ul style="list-style-type: none"> • Goal(s) • Activities (work plan, action to be taken, follow up tasks) • Individuals responsible for the activity (case manager or team member, client, family member, agency representative) • Anticipated time frame for each activity • Client signature and date, signifying agreement • Supervisor’s signature and date, indicating review and approval (if required by AIDS Institute initiative, or agency/program Policies and Procedures). 2. Documentation includes: <ul style="list-style-type: none"> • Service plan format developed by the program including the above information • Progress notes recording activities on behalf of the client to implement the service plan • Actual outcomes of case management goals and activities. 3. Agency has an ongoing monitoring process to assess the client’s ability and motivation to complete service plan activities and to address any other barriers to achieving goals. (For example if client is unable to perform specific activities alternative approaches to meet goal are explored such as skills development or staging of activities.)

Exceptions

If the Brief Intake/Assessment process determines the client has no presenting issues to be addressed, no service plan is required.

Clients enrolled in an ADHC do not receive a Brief Service Plan. Instead, a comprehensive care plan is completed immediately following completion of a Comprehensive Case Management Assessment 30 days after enrollment.

In **Supportive Case Management** programs, supervisory review and signoff on the Brief Service Plan can provide proactive monitoring for quality and ensure identified needs are prioritized and activities well planned. In **Comprehensive Case Management**, where an Initial Comprehensive Assessment and Comprehensive Service Plan are performed, supervisory review and signoff on the Brief Service Plan may not be necessary. For both **Supportive** and **Comprehensive** case management programs, each AIDS Institute program type will determine whether a supervisor must review and signoff on the Brief Service Plan. Individual program practices will be described in the Policies and Procedures manual of that program.

Best Practices

Service plans developed during face-to-face meetings and negotiated between client and case manager encourage a client's active participation and empowerment. A copy of the service plan offered to the client emphasizes the partnership necessary in the case management process.

Measurable goals and activities, taking into consideration cognitive and physical abilities, available resources, support networks, and client interest, result in a more realistic, client-specific plan. Although client signature denotes acceptance of a plan, a client may decline all or any portion of a service plan.

Documenting changes or updates to a service plan as well as actual outcomes provides a simple method of tracking client progress.

Family members and collaterals may assist in ensuring a client receives needed service. They can be included in the service plan to carry out activities.

Additional Resources

Sample Brief Service Plan form is available on the New York State Department of Health web site at <http://www.nyhealth.gov/diseases/aids/index.htm> "Clinical Guidelines, Standards, and Quality of Care."

IV. Initial Comprehensive Assessment

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

The 60 days completion time permits the initiation of case management activities to meet immediate needs, and allows for a more thorough collection of assessment information.

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

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

<i>Standard</i>	<i>Criteria</i>
<p>An Initial Comprehensive Assessment describes in detail the client's medical, physical and psychosocial condition and needs. It identifies service needs being addressed and by whom; services that have not been provided; barriers to service access; and services not adequately coordinated.</p> <p>The assessment also evaluates the client's resources and strengths, including family and other close supports, which can be utilized during service planning.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Time requirement: Comprehensive Case Management Due within 60 days from completion of a Brief Intake/Assessment</p> </div>	<p>1. Initial Comprehensive Assessment includes at minimum:</p> <ol style="list-style-type: none"> a. Client health history, health status, and health-related needs, including but not limited to: <ul style="list-style-type: none"> • HIV disease progression • tuberculosis • hepatitis • sexually transmitted diseases • other medical conditions • OB/GYN, including current pregnancy status • medications and adherence • allergies to medications • dental care • vision care • home care • current health care providers; engagement in and barriers to care • clinical trials • complementary therapy. b. Client's status and needs related to: <ul style="list-style-type: none"> • nutrition • financial resources and entitlements • housing (including results of home visit to assess living situation) • transportation • support systems • identification of children and separate assessment of children's needs • identification of collaterals • determination of collaterals needing case management assessment and services • parenting needs • partner notification needs • HIV disclosure status/issues • alcohol/drug use/smoking history and current status • mental health • domestic violence

<i>Standard</i>	<i>Criteria</i>
<div data-bbox="110 254 443 430" style="border: 1px solid black; padding: 5px;"> <p>Time requirement: AIDS Day Health Care Program (ADHCP) Due 30 days from enrollment</p> </div> <div data-bbox="110 520 443 688" style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Time requirement: Supportive Case Management Not required</p> </div>	<ul style="list-style-type: none"> • legal needs (e.g. health care proxy, living will, guardianship arrangements, parole/probation status, landlord/tenant disputes) • activities of daily living • knowledge, attitudes, and beliefs about HIV disease; current risk behaviors; and prevention of transmission • employment/education. <p>c. Additional information:</p> <ul style="list-style-type: none"> • client strengths and resources • other agencies serving client and collaterals • brief narrative summary • name of person completing assessment and date of completion • supervisor signature and date, signifying review and approval. <p>2. The case manager has primary responsibility for the Initial Comprehensive Assessment and meets face-to-face with the client at least once during the assessment process.</p> <p>3. Unless exempt, programs providing Comprehensive Case Management conduct a home visit during the assessment process.</p> <p>4. The Initial Comprehensive Assessment is documented in the case record on forms developed or approved by the AIDS Institute.</p>

Exceptions

In the **Supportive Case Management Model**, the Initial Comprehensive Assessment is not required. Case management services are provided based on information gathered for the Brief Intake/Assessment and Brief Service Plan and updated throughout service provision and reassessment.

In specified **Comprehensive Case Management** initiatives, home visitation, assessment of and services to the client’s children and collaterals are not required.

When case management is being provided in a medical setting, client health information listed under Criteria 1.a. may be omitted from the case management record if it is documented elsewhere on site and easily accessible to the case manager.

ADHCP’s are not required to use forms developed or approved by the AIDS Institute.

Best Practices

In programs incorporating a team model, team members other than the case manager assist in gathering information and completing portions of the assessment document. However, the case manager takes full responsibility for the process and for the completed documentation.

A comprehensive assessment performed over time rather than in one sitting is often more complete and less intrusive and tiring for a client. Information is gathered from client self report and (with client release) a variety of sources, including providers serving the client and the client’s collaterals.

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

Additional Resources

Sample AIDS Institute-approved Initial Comprehensive Assessment form is available on the New York State Department of Health web site at <http://www.nyhealth.gov/diseases/aids/index.htm> under the category “Clinical Guidelines, Standards, and Quality of Care.”

V. Initial Comprehensive Service Plan Development

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

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

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

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

<i>Standard</i>	<i>Criteria</i>
<p>Client needs identified at Initial Comprehensive Assessment are prioritized and translated into an Initial Comprehensive Service Plan, which defines specific goals, objectives, and activities to meet those needs.</p> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <p>Time requirement: <i>Comprehensive Case Management</i></p> <p>Due at completion of Initial Comprehensive Assessment, 60 days from completion of Brief Intake/Assessment</p> </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <p>Time requirement: <i>Supportive Case Management</i></p> <p>Not required</p> </div> <div style="border: 1px solid black; padding: 5px;"> <p>Time requirement: <i>AIDS Day Health Care Program (ADHCP)</i></p> <p>Due at completion of Initial Comprehensive Assessment, 30 days from enrollment.</p> </div>	<ol style="list-style-type: none"> 1. Initial Comprehensive Service Plan includes at the minimum: <ul style="list-style-type: none"> • Goal(s) • Activities (work plan, action to be taken, follow up tasks) • Individuals responsible for the activity (case manager or team member, client, family member, agency representative) • Anticipated time frame for each activity • Client signature and date, signifying agreement • Supervisor's signature and date, indicating review and approval. 2. The case manager has primary responsibility for development of the service plan. 3. The Initial Comprehensive Service Plan is included in the case record and completed on forms developed or approved by the AIDS Institute. 4. The Initial Comprehensive Service Plan is updated with outcomes and revised or amended in response to changes in client life circumstances or goals.

Exceptions

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

In specified **Comprehensive Case Management** program initiatives, when assessment of the children and collaterals is not required, addressing their needs is optional within the client's Initial Comprehensive Service Plan.

AIDS Day Health Care Programs are not required to use forms developed or approved by the AIDS Institute.

Best Practices

Service plans developed during face-to-face meetings and negotiated between client and case manager encourage client active participation and empowerment. A copy of the service plan offered to the client reinforces client ownership and involvement in the case management process.

Measurable goals and activities, taking into consideration the client's cognitive and physical abilities, available resources, support networks and motivation, result in a more realistic, client-specific plan.

Although client signature denotes acceptance of a plan, a client may decline all or any portion of a service plan.

Documenting changes or updates to a service plan as well as actual outcomes provides a simple method of tracking client progress.

Family members and collaterals may assist in ensuring a client receives needed service. They can be included in the service plan to carry out activities.

Additional Resources

Sample Comprehensive Service Plan form is available on the New York State Department of Health web site at <http://www.nyhealth.gov/diseases/aids/index.htm> under the category "Clinical Guidelines, Standards, and Quality of Care."

VI. Service Plan Implementation; Client Contact, Monitoring, and Follow Up

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

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

In general the type and frequency of contact should be based on client needs. However, some individual AIDS Institute initiatives may establish minimum requirements for frequency and type of case management contact by providers.

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

In the **Supportive Case Management Model**, at a minimum, client contact and monitoring is required to follow up on referrals, determine the status of service acquisition, and to assess whether the client has further needs requiring additional case management services.

<i>Standard</i>	<i>Criteria</i>
<p>Provision of case management services outlined in the Brief or Comprehensive Service Plan proceeds immediately after its completion.</p> <p>Clients are contacted based on their level of need. Client status is monitored. Case management staff follows up to determine receipt of service.</p> <p>Comprehensive and Supportive Case Management models</p> <ul style="list-style-type: none"> • Frequency and type of client contact may be established by individual AIDS Institute initiative. 	<ol style="list-style-type: none"> 1. Oversight of service plan implementation is the responsibility of the case manager. 2. Progress notes in the case management record detail the advancement of the case management effort for client and collaterals and record actual outcomes of activities. 3. Evidence is documented in the client’s chart that the case manager and/or team members contact the client and/or providers by a means and frequency appropriate to the client’s needs, or according to AIDS Institute initiative requirements. 4. Documentation indicates contact with client and/or providers occurs after arranging services to determine if services are: <ul style="list-style-type: none"> • delivered as expected • utilized by the client • satisfactory to the client • continue to be appropriate to the client’s need • result in positive outcomes 5. Case management provider follows up on problems with service delivery. 6. Status of the client/collaterals is monitored on a regular basis.

<i>Standard</i>	<i>Criteria</i>
	<p>7. The client's right to privacy and confidentiality in contacts with other providers and individuals is assured:</p> <ul style="list-style-type: none"> • The client's consent to consult with other service providers is obtained. The provider complies with Article 27-F of the Public Health Law regarding confidentiality of HIV-related information. <p>8. Confidential HIV and client level documentation is secured against unauthorized access.</p>

Exceptions

In **Supportive Case Management** programs, home visits are not required. In specified **Comprehensive Case Management** programs, home visits are not required (i.e., ADHCP).

VII. Reassessment

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

<i>Standard</i>	<i>Criteria</i>
<p>A reassessment is performed which re-evaluates client functioning, health and psychosocial status; identifies changes since the initial or most recent assessment; and determines new or ongoing needs.</p> <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p>Time requirement: <i>Comprehensive Case Management</i> Comprehensive Reassessment required 180 days after completion of Initial Comprehensive Assessment. Thereafter, every 180 days at minimum, or sooner if client circumstances change significantly.</p> </div> <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p>Time requirement: <i>Supportive Case Management</i> Brief Reassessment required 180 days following completion of the Brief Intake/ Assessment and every subsequent 180 days for active case management clients, or sooner if client circumstances change significantly.</p> </div> <p><i>Time requirements for ADHCP and HIV Medical Services on next page.</i></p>	<p>In Comprehensive Case Management programs</p> <ol style="list-style-type: none"> 1. Each Comprehensive Reassessment includes: <ol style="list-style-type: none"> a) Updated personal information <ul style="list-style-type: none"> • current contact and identifying information • emergency contact • confidentiality concerns • household members • insurance status • other health and social service providers, including other case management providers. b) Updated client health history, health status, and health-related needs outlined in Initial Comprehensive Assessment, including but not limited to: <ul style="list-style-type: none"> • HIV disease progression • tuberculosis • hepatitis • sexually transmitted diseases • other medical conditions • OB/GYN, including current pregnancy status • medications and adherence • allergies to medications • dental care • vision care • home care • current health care providers, engagement in and barriers to care • clinical trials • complementary therapy. c) Updated client status and needs related to: <ul style="list-style-type: none"> • nutrition • financial resources and entitlements • housing (including home visit to assess living situation) • transportation • support systems • identification of children and separate assessment of children’s needs • identification of collaterals • determination of collaterals needing case management assessment and services <ul style="list-style-type: none"> • parenting needs • partner notification needs • HIV disclosure status/issues • alcohol use/drug use/smoking • mental health • domestic violence • legal needs (e.g. health care proxy, living will, guardianship arrangements, parole/probation status, landlord/tenant disputes)

<i>Standard</i>	<i>Criteria</i>
<div data-bbox="147 212 461 485" style="border: 1px solid black; padding: 5px;"> <p>Time requirement: <i>AIDS Day Health Care Program (ADHCP)</i> Required 90 days after completion of Initial Comprehensive Assessment and every 90 days thereafter.</p> </div> <div data-bbox="147 554 461 1058" style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Time requirement: <i>If client entered care through HIV Medical Services:</i></p> <ul style="list-style-type: none"> • Brief Reassessment yearly, for those not actively engaged in case management. • Brief Reassessment every 180 days for active case management clients, or sooner if client circumstances change significantly. </div>	<ul style="list-style-type: none"> • activities of daily living • knowledge, attitudes, and beliefs about HIV disease; current risk behaviors; and prevention of transmission • employment/education. <p>d) Additional information:</p> <ul style="list-style-type: none"> • other agencies serving client and collaterals • brief narrative summary • name of person completing assessment and date of completion • supervisor signature and date, indicating review and approval. <ol style="list-style-type: none"> 2. The case manager has primary responsibility for the Comprehensive Reassessment and meets face-to-face with the client at least once during the reassessment process. 3. Unless exempt, programs providing Comprehensive Case Management conduct a home visit during the Comprehensive Reassessment process. 4. The Comprehensive Reassessment is documented in the case record on forms developed or approved by the AIDS Institute. 5. Documentation includes appropriate releases, including Authorization for the Release of HIV Confidential Information in accordance with Article 27F, and other releases for information as required by applicable law. 6. Case Management Policies and Procedures include guidelines for conducting the Comprehensive Reassessment, staff responsible for performing it, and supervisory oversight of the reassessment process. <p>In Supportive Case Management programs</p> <ol style="list-style-type: none"> 1. Each Brief Reassessment includes: <ol style="list-style-type: none"> a) Client's presenting needs. b) Updated client information in the following areas: <ul style="list-style-type: none"> • contact and identifying information • emergency contact • confidentiality concerns • household members • insurance status • other health and social service providers, including other case managers. c) A re-evaluation of the client's status and needs regarding: <ul style="list-style-type: none"> • food/clothing • financial/benefits • housing • transportation • legal • substance use • mental health • domestic violence • HIV disease and other medical concerns • prevention of transmission and secondary prevention • support system.

<i>Standard</i>	<i>Criteria</i>
	<ol style="list-style-type: none"> <li data-bbox="492 195 1341 289">2. The case manager has primary responsibility for the Brief Reassessment. The Brief Reassessment is performed in person or by phone. <li data-bbox="492 327 1305 527">3. In Supportive Case Management, the Brief Reassessment is documented in the chart. A new or clearly updated Brief Intake/Assessment form, a form developed for the purpose, or a detailed progress note covering the areas of information listed in numbers 1a through 1c above (bottom page 4-15) may be used as documentation of a Brief Reassessment. <li data-bbox="492 564 1360 695">4. Documentation includes appropriate releases, including Authorization for the Release of HIV Confidential Information in accordance with Article 27F, and other releases for information as required by applicable law. <li data-bbox="492 732 1382 829">5. Case Management Policies and Procedures include guidelines for conducting the Brief Reassessment, staff responsible for performing it, and supervisory oversight.

Exceptions

AIDS Day Health Care Programs are not required to use forms developed or approved by the AIDS Institute.

Best Practices

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

See also Best Practices under Comprehensive Assessment.

Additional Resources

Sample Comprehensive Reassessment form is available on the New York State Department of Health web site at <http://www.nyhealth.gov/diseases/aids/index.htm> under “Clinical Guidelines, Standards, and Quality of Care.”

VIII. Service Plan Update

A Reassessment is always accompanied by a revision of the Service Plan. However a Service Plan may be updated between reassessments to reflect changes in direction of client goals and case management activities.

<i>Standard</i>	<i>Criteria</i>
A new or updated Service Plan is required at completion of each Reassessment, or sooner if client circumstances necessitate a change in goals, objectives, or case management activities.	<ol style="list-style-type: none"><li data-bbox="500 457 1446 520">1. In Comprehensive Case Management programs, a Comprehensive Service Plan accompanies each Comprehensive Reassessment.<li data-bbox="500 556 1328 619">2. In Supportive Case Management programs, a Brief Service Plan accompanies each Brief Reassessment.

Best Practices

See Best Practices previously listed under Brief or Comprehensive Service Plan.

IX. Case Coordination and Case Conferencing

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

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

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

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

<i>Standard</i>	<i>Criteria</i>
<p>Supportive and/or Comprehensive Case Management providers routinely coordinate all necessary services along the continuum of care, including institutional and community-based, medical and non-medical, social and support services.</p> <p>Case conferencing is utilized as a specific mechanism to enhance case coordination.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Time requirement for Case Conferencing: Comprehensive Case Management</p> <ul style="list-style-type: none"> • Required every 180 days at minimum. • Recommended as needed. </div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Time requirement for Case Conferencing: Supportive Case Management</p> <p>Not required but recommended as needed.</p> </div>	<ol style="list-style-type: none"> 1. Coordination activities include frequent contacts with other service providers and case managers and are documented in the progress notes. 2. Evidence of timely case conferencing with key providers is found in the client's records. 3. The client's right to privacy and confidentiality in contacts with other providers is maintained. <ul style="list-style-type: none"> • The client's consent to consult with other service providers is obtained. The provider complies with Article 27-F of the Public Health Law regarding confidentiality of HIV-related information.

Best Practices

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

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

Additional Resources

Sample case conference form is available on the New York State Department of Health web site at <http://www.nyhealth.gov/diseases/aids/index.htm> under the category "Clinical Guidelines, Standards, and Quality of Care."

X. Crisis Intervention

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

<i>Standard</i>	<i>Criteria</i>
<p>Agency has a policy for client crisis intervention services that ensures all onsite emergencies are addressed immediately and effectively.</p> <p>Clients are provided resources to address a crisis after hours.</p>	<ol style="list-style-type: none"> 1. All clients are provided with emergency contact information that includes resources and guidance to secure assistance outside of agency business hours. 2. The need for a crisis plan is determined for each client. Individual crisis plans must include at minimum information on service providers who are accessible 24 hours a day and able to handle emergency situations. 3. Program staff is trained on agency crisis policy and how to respond to crisis situations. 4. Administrative Policy and Procedure manual addresses crisis intervention protocol for incidents that occur on site.

Best Practices

A crisis plan is specific to an individual client's needs. Plans should be developed to ensure a client is able to navigate services during crisis and has specific instructions and provider contact information. Co-occurring disabilities or life circumstances affect the nature and extent of the plan, i.e. people with mental illness or at risk of domestic violence need to have their special needs addressed in advance to minimize the impact of emergencies.

Case managers discuss with clients what constitutes a crisis.

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

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

XI. Case Closure

Clients who are no longer engaged in active case management services should have their cases closed based on the criteria and protocol outlined in a program’s Policies and Procedures. A closure summary usually outlines the progress toward meeting identified goals and case disposition.

Common reasons for case closure include:

- Client lost to care or does not engage in service.
- Client chooses to terminate service.
- Client relocates outside of service area.
- Agency terminates as described in Policies and Procedures.
- Mutual agreement.
- Client is no longer in need of service.
- Client completed case management goals.
- Client no longer eligible.
- Client is referred to a program that provides comparable case management services.

<i>Standard</i>	<i>Criteria</i>
<p>Upon termination of active case management services, a client case is closed and contains a closure summary documenting the case disposition.</p>	<ol style="list-style-type: none"> 1. Closed cases include documentation stating the reason for closure and a closure summary. 2. Supervisor signs off on closure summary indicating approval. 3. Policies and Procedures outline the criteria and protocol for case closures (see Section 5 - <i>Requirements for All CM Programs</i>).

Best Practices

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

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

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

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

Additional Resources

Sample Case Closure form is available on the New York State Department of Health web site <http://www.nyhealth.gov/diseases/aids/index.htm> under the category “Clinical Guidelines, Standards, and Quality of Care.”

5. REQUIREMENTS FOR ALL CASE MANAGEMENT PROGRAMS

5. Requirements for All Case Management Programs

Policies and Procedures

Each agency providing case management must establish written policies and procedures specific to the case management services they provide. Policies and Procedures should be submitted to the AIDS Institute and be available on site to program employees. Using the AIDS Institute Case Management Standards (Section 4) as a guide, the policy and procedure manual for both Supportive and Comprehensive case management must include, unless specified, the following topics at minimum:

Program Design

Case Management Model(s) – the model(s) of case management to be provided by the program as approved by the AIDS Institute. If both Supportive and Comprehensive case management are to be provided, describe procedure for determining how clients will be assigned to a specific model, and how clients will be transferred from one model to another as their level of service need changes. If program provides only one model of case management, describe process for referring client to another program if their needs don't meet or exceed service level of model provided.

Eligibility and Enrollment Procedures – requirements for eligibility for case management services, and process used by the case management program to determine client eligibility. Considering the eligibility requirements of the funding source, list documentation and process required to verify client eligibility.

Consent for Case Management Services – policy assuring that case management services are voluntary, and that each client consents to receive case management. Describe process for obtaining written client consent for case management services at intake/brief assessment. Include consent form to be used. Consent must include description of case management services offered, and right to decline any or all of case management services.

Crisis Intervention – protocol for addressing client crises during business hours and during non-working hours. Include specific crisis intervention services available to clients during off hours, and process for informing them of these services. Describe process for assessing clients to determine who needs individual crisis plans, and for providing them with appropriate information. Describe staff training to be provided.

Documentation – procedures for establishing a client's case record and recording: 1) written progress notes for all client contacts or case management activities made on the client's behalf, 2) all required forms, and 3) staff signatures and dates of service. Describe which documentation will require supervisory review and signature signifying approval (i.e. assessment forms, reassessments, case closure forms, etc.). Describe policy for protecting privacy and securing client records against breach of confidentiality.

Consumer Confidentiality – policy regarding compliance with New York State HIV Confidentiality Law protecting of the confidentiality of all HIV-related information shared or received in the course of providing client services. Include requirement for written client consent to release HIV information and the prohibition against further disclosure without specific written consent of the client (see web link for DOH form 2257, *HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV-related Information* at <http://www.nyhealth.gov/diseases/aids/forms>). Policies and procedures should include a general description of other safeguards to insure confidentiality (i.e. securing case records, meeting privacy, waiting areas, return addresses on agency correspondence, etc).

Client Rights and Responsibilities – (recommended, not required) an outline reviewed with clients upon initiation of services establishing the mutual expectations of program and client conduct while engaged in case management services.

Consumer Grievance – the steps a client may take to file a grievance and the process program staff must take to respond to a grievance. Include staff responsible, required documentation, review process, appeal process, time frames, policy regarding maintenance of confidentiality, and process for advising consumer and staff of outcome.

Consumer Input – process for soliciting client views and feedback on current and planned program services including activities such as a Consumer Advisory Board, focus groups, and consumer satisfaction surveys. Include timeframe and frequency of activities.

Data/Reporting – procedure for entering data into URS, the AIDS Institute’s Uniform Reporting System. Include person(s) responsible, frequency and timeframe for data entry, the process for internal review of data, and for reporting data to the AIDS Institute.

Quality Improvement/Quality Assurance – process agency will use for measuring quality of case management services and making improvements. Describe Quality Assurance plan including processes for regular, random or peer review of case records, and for administrative review of the case management program. Outline Quality Improvement program including responsible individual(s), staff and consumer involvement in quality activities, development and measurement of key indicators, review of results, and execution of Quality Improvement projects. Policy and procedures must be consistent with AIDS Institute standards on Quality Improvement. (See http://www.hivguidelines.org/public_html/qoc-program/qoc_improvement_standard.htm).

Program Processes

Case Conferencing – process, documentation, and frequency of required case conferencing with a client’s other providers. Include circumstances when case conferencing is recommended (see glossary for definition of case conference and see standards under “case conferencing” for specific requirements).

Client Contacts – where required by AIDS Institute initiative, or by agency policy, the minimum expected type and frequency of case management contacts with clients. (see general

requirements for client contacts for each model under *Service Plan Implementation, Client Contacts, Monitoring, and Follow up* in Section 4 Part VI , on pages 4-12 and 4-13).

Referrals – process for making, monitoring, and following up on client referrals to other providers and services, including required documentation. Recommended: list any preferred or standard referral agencies and contact information.

HIV Prevention – means for integrating HIV prevention (prevention of HIV transmission as well as primary and secondary disease prevention) with case management services. Describe process to assess client risk of HIV transmission to sexual and/or drug-use partners, both current and former, and assessment of behaviors that put the client at risk for other infections/re-infection, and/or disease progression. Explain procedures for providing appropriate referrals, follow-up on referrals, support, and/or information to address a client’s prevention needs. Clients should be provided information on the process of partner notification and where to find referrals for a variety of prevention interventions.

Case Closure – protocol for closing case management cases, including criteria for determining closure, closure process, and required documentation. Clarify expectation regarding staff efforts to locate and communicate with clients who have not appeared for or engaged in case management services. Describe timeframe and process for closing cases for clients who are lost to follow-up. Identify supervisory position(s) that will approve case closures with their sign-off.

Staffing

Staff Qualifications – description of qualifications required for all case management staff positions, utilizing AI standard as a minimum (see Staff Qualifications pages 5-4 & 5-5).

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

Staff Supervision – description of ongoing supervision of case management staff and their activities. Include staff responsible for supervision, type and frequency of supervisory activities (including evaluations of staff job performance), and required documentation.

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

Caseloads

Each case management program must be able to identify clients actively engaged in case management services and their caseload per case manager or team. In order to prevent case

manager burnout and maintain quality of case management services, the AIDS Institute requires that programs either set caseload limits in their Policies and Procedure manual or establish them yearly in their program workplan. Individual AIDS Institute program initiatives may set limits or demand other requirements for program caseloads.

For programs providing **Comprehensive Case Management**, the AIDS Institute recommends that programs maintain caseloads of no more than 15-20 clients per individual case manager. In comprehensive programs using a team model, caseload may increase by approximately 10 clients for each additional team member. The recommended maximum per case management team of 3 people is 30-35 clients.

For programs providing **Supportive Case Management** caseload limits should be specified in a Policies and Procedures Manual, or in the program's yearly workplan, depending on individual AIDS Institute initiative requirements.

For programs providing both **Comprehensive and Supportive Case Management** in a mixed caseload served by the same staff (blended model), the program's Policies and Procedures must specify caseload limits and recommendations for caseload mix.

Staff Qualifications

Case Manager Qualifications:

Preferred qualifications for a Case Manager include a Bachelor's or Master's degree in health, human or education services and one year of case management experience with HIV+ persons, and/or persons with a history of mental illness, homelessness, or chemical dependence. For Comprehensive Case Manager, and for certain Supportive Case Manager programs, experience with families is preferred.

Alternately, a Case Manager may possess an Associate's degree in health or human services, licensure as an RN or LPN, or certification as CASAC, and two years of case management experience with HIV+ persons, and/or persons with a history of mental illness, homelessness, or chemical dependence. For a Case Manager in a Comprehensive model, and for certain Supportive Case Management initiatives, experience with families is preferred.

Waiver for Meeting Case Manager Qualifications

The qualification requirements listed above may be waived on a case-by-case basis with approval of the AIDS Institute contract/program manager. Experience or education which would be considered for waiving Case Manager Qualifications include:

- Two years experience providing case management services or HIV-related services, or
- One year of case management experience and an associate's degree in health or human services, or
- One year case management experience and an additional year of experience in other activities with HIV+ persons, or
- A bachelor's or master's degree in health or human services.

Case management experience should encompass the functions of intake, assessment, reassessment, service planning, case coordination, case conferencing, service plan implementation, crisis intervention, monitoring and follow-up of services provided, and case closure.

Case Management Supervisor Qualifications

Preferred qualifications for a Case Management Supervisor include a Masters degree in Health or Human Services, one year of supervisory experience, and one year of case management experience with HIV+ persons, and/or persons with a history of mental illness, homelessness, or chemical dependence. For Comprehensive Case Management Supervisor, experience with families is preferred.

Alternately, a Case Management Supervisor may hold a Bachelor's degree in Health or Human Services, and have two years of supervisory experience and two years of case management experience with HIV+ persons, and/or persons with a history of mental illness, homelessness, or chemical dependence. For Comprehensive Case Management Supervisor experience with families is preferred.

Waiver for Meeting Case Management Supervisor Qualifications

The qualification requirements listed above for Case Management Supervisor may be waived on a case-by-case basis with approval of the AIDS Institute contract/program manager.

6. STANDARDS AT A GLANCE

6. AIDS Institute Case Management Standards At A Glance

	CORE ELEMENTS	COMPREHENSIVE	SUPPORTIVE
1	Brief Intake/Assessment	<p>Within 15 days from referral.</p> <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 10px auto;"> <p>If entry to case management is through HIV medical services, due by completion of initial comprehensive visit(s)</p> </div> <p>N/A AIDS Day Health Care Programs (ADHCP)</p>	<p>Within 15 days from referral.</p>
2	Selecting Appropriate Case Management Model and Placement	Required	Required
3	Brief Service Plan	Required (if case management services needed) at completion of Brief Intake/Assessment	Required (if case management services needed) at completion of Brief Intake/Assessment
4	Supervisory Signoff on Brief Service Plan	As established in Program's Policies and Procedures	As established in Program's Policies and Procedures
5	Initial Comprehensive Assessment	<p>60 days from Brief Intake/Assessment</p> <p>In ADHC Comprehensive Assessment required 30 days from enrollment</p>	N/A
6	Initial Comprehensive Service Plan	<p>60 days from Brief Intake/Assessment</p> <p>In ADHC 30 days from enrollment</p>	N/A
7	Supervisor signoff on Initial Comprehensive Assessment and Service Plan	Required	N/A
8	Documented follow-up on Service Receipt	Required	Required
9	Reassessment	<p>Comprehensive Reassessment required at minimum every 180 days, or sooner if warranted.</p> <p>In ADHC, Comprehensive Reassessment required every 90 days</p>	<p>Brief Reassessment for those engaged in ongoing case management required at minimum every 180 days, or sooner if warranted. May be face-to face or by phone.</p> <p>In settings where patients are receiving HIV medical services, updated Brief Intake/ Assessment required yearly for those not engaged in ongoing case management</p>
10	Service Plan Update	<p>In response to changes in client life circumstances requiring new activity. Required at every comprehensive reassessment, if services needed.</p> <p>In ADHCP every 90 days</p>	<p>In response to changes in client life circumstances requiring new activity. Required at every Brief Reassessment or yearly at updated Brief Intake/ Assessment if services needed</p>

	CORE ELEMENTS	COMPREHENSIVE	SUPPORTIVE
11	Supervisor signoff on Reassessment and Service Plan Update	Required	As established in Program's Policies and Procedures
12	External and Internal Coordination with Other Case Managers and Service Providers a) Case Conference b) Case Conference Frequency	Coordination and communication required a) Case conference required b) As needed, minimum every 180 days	Coordination and communication required a) Case conference recommended, especially for high need clients b) As needed
13	Caseload Limit	Recommended 15 - 20 per individual Case Manager, 30-35 per full CM Team of 3 persons.	For individual Case Manager or for CM Team, as established in program workplan or Policies and Procedures.
14	Case Manager contacts with Client	Multiple frequent contacts	Multiple contacts as needed by client
15	Crisis Intervention	Required	Required
16	Family assessment and services	Required	Not required, except for specific program initiatives
17	Home Visits	Required, except for specific program initiatives	Not required, except for specific program initiatives
18	When to do Home Visit	As needed. Minimum at Initial Comprehensive Assessment and Reassessment. Specific program initiatives are exempt.	N/A
19	Case Closure Summary	Required	Required
20	Supervisory signoff on closure	Required	Required
21	Case Manager Qualifications	See Case Manager Qualifications* below	See Case Manager Qualifications* below
22	Supervisor Qualifications	See Supervisor Qualifications** below	See Supervisor Qualifications** below
23	Client Eligibility	HIV+ and affected family	HIV+
24	Written Policies and Procedures ***	Required	Required

***Case Manager Qualifications:**

Bachelor's or Master's degree in health, human or education services and one year of case management experience with HIV+ persons, and/or persons with a history of mental illness, homelessness, or chemical dependence. For Comprehensive Case Manager, and certain Supportive Case Management initiatives, experience with families preferred.

OR

Associate's degree in health or human services, or licensure as an RN or LPN, or certification as CASAC, and two years of case management experience with HIV+ persons, and/or persons with a history of mental illness, homelessness, or chemical dependence. For Comprehensive Case Manager, and certain Supportive Case Management initiatives, experience with families preferred.

Note: These qualification requirements may be waived on a case-by-case basis with approval of the AIDS Institute program/contract manager.

Examples of experience/education which would be considered for waiving Case Manager Qualifications:

Two years experience providing case management services or HIV-related services

OR

One year of case management experience and an associate's degree in health or human services

OR

One year case management experience and an additional year of experience in other activities with HIV+ persons

OR

A bachelor's or master's degree in health or human services.

Case management experience should encompass the functions of intake, assessment, reassessment, service planning, case coordination, case conferencing, service plan implementation, crisis intervention, monitoring and follow-up of services provided, and case closure.

****Case Management Supervisor Qualifications**

Masters degree in Health or Human Services, one year of supervisory experience, and one year of case management experience with HIV+ persons, and/or persons with a history of mental illness, homelessness, or chemical dependence. For Comprehensive Case Management Supervisor, experience with families preferred.

OR

Bachelor's degree in Health or Human Services, two years of supervisory experience and two years of case management experience with HIV+ persons, and/or persons with a history of mental illness, homelessness, or chemical dependence. For Comprehensive Case Management Supervisor experience with families preferred.

Note: These qualification requirements may be waived on a case-by-case basis with approval of the program/contract manager.

***** Policies and Procedures and Other Requirements of All Case Management Programs**

Each case management program will be required to write policies and procedures that describe specific elements of their program design, program processes, and staffing. Topics include case management model provided, eligibility and enrollment procedures, consent for case management services, crisis intervention, documentation, consumer confidentiality, client rights and responsibilities, consumer grievances, consumer input, data and reporting, quality improvement/quality assurance, case conferencing, client contacts, referrals, HIV prevention, case closure, staff qualifications, staffing structure, staff supervision, staff training, and caseloads. See Section 3 of the Case Management Standards for more information.

Note: Although the AI Case Management Standards set minimum requirements across AIDS Institute case management programs, specific bureaus within the Institute may establish additional requirements for case management programs they oversee.

7. GLOSSARY

7. Glossary

The definitions listed in this glossary should be considered in the context of case management as defined and described in the AIDS Institute Case Management Standards.

ACTIVITIES (service plan): A set of tasks or steps that a client and case manager have agreed upon that will result in the implementation and/or completion of goals and objectives of a Brief or Comprehensive Service Plan. These tasks may be completed by the case manager/team, the client, another assigned person or, in some cases, jointly.

ACUITY: Severity of identified client needs.

ADULT DAY HEALTH CARE PROGRAM (ADHCP): Department of Health (DOH) licensed program that provides comprehensive medical and psychosocial services at one site to persons living with HIV/AIDS.

AGENCY: The entity ultimately accountable for case management services, or one to which a client has been referred. The agency is usually the organization sponsoring a case management program, which in turn provides direct case management services.

AIDS INSTITUTE INITIATIVE: Within an AIDS Institute bureau, an organized effort with specific funding and programmatic requirements established to address a significant issue or service in the continuum of HIV care. AIDS Institute initiatives range from education, health promotion, and community planning programs to prevention services, medical care, chronic care, and supportive client services. AIDS Institute initiatives which include case management services covered by the AIDS Institute Case Management Standards are: the AIDS Day Health Care Program (ADHCP), Centers of Excellence in Pediatric HIV Care, COBRA Community Follow-Up Program, Community-Based HIV Primary Care and Prevention Services, Community Service Programs (CSP), Designated AIDS Centers (DACs), Family-Centered Health Care Services, HIV Primary Care and Prevention Services for Substance Users, HIV Services for HV-Infected Women and Their Families, Multiple Service Agencies (MSA), Ryan White Title II-funded Case Management Programs, Supported Housing Programs, and Youth-Oriented Health Care Programs (Special Care Centers).

BEST PRACTICE: A technique, methodology or action that, through experience and/or research, has proven to lead to a desired result. Best practices may include performance recommendations that assist agencies in meeting or exceeding the set standard.

CASE CONFERENCE: A formal, planned, structured activity, separate from routine contact, that brings together individuals providing specific services to a client for the purpose of assuring unduplicated, integrated and well-coordinated services. A case conference is usually interdisciplinary and includes, preferably, a client and members of his/her support network. A case conference may be used to clarify a client's current status, review progress and barriers towards goals, map roles and responsibilities of the participants, create an integrated service plan, or adjust current plans to respond to a client's situation. Case conferences may be required at routine intervals and are also recommended during times of significant change, crisis, or lack of progress. A case conference is documented in progress notes or on a case conference form.

CASE MANAGER: An individual responsible for carrying out case management activities, including assessment of needs, service planning, service plan implementation, service coordination, monitoring and follow-up, reassessment, case conferencing, crisis intervention and case closure. Note: in some settings this individual may not have the title of case manager, but should have the minimum qualifications detailed in Section 5 Staff Qualifications.

CASE MANAGEMENT MODEL SELECTION: The process through which a case manager and client determine the model of case management the client needs and is willing to accept. This process is completed after the Intake/Brief Assessment.

CHILDREN: Youths under the age of 21 residing in or outside the home who are related to a client or their collaterals (socially or biologically), or who are the responsibility of the client or their collaterals.

CLIENT CONSENT FOR CASE MANAGEMENT: A designated form presented to a client and discussed following the Brief Intake/Assessment and model selection that describes the case management services, the voluntary nature of the program, and the right to decline all or part of services. The client's signature confirms agreement to participate in the case management program and processes.

COLLATERAL: Any person identified by a client as playing a significant role in his/her life or who is dependent upon the client (i.e., children, domestic partner, spouse, parent, etc.).

COMMUNITY BASED ORGANIZATION (CBO): Not-for-profit agency governed by a Board of Directors and staffed by individuals who often reflect the community served by the organization. These organizations may be funded to provide specific health and social services to assist individuals living with HIV/AIDS. Service may include case management, crisis intervention, housing, meals, HIV prevention services, and others.

COMPREHENSIVE MEDICAL VISIT: The provision of a full medical evaluation to assess health, determine appropriate level of medical care, or need for specific interventions to achieve optimal well being and quality of life. The comprehensive medical visit may involve more than one visit to a single provider or to multiple providers to complete the full medical evaluation.

COORDINATION: Contact and communication between a case manager and other service providers including medical, mental health, substance use, social service, and staff of other agencies to assure that each entity is informed of client's status related to service acquisition and meeting set goals or objectives. Coordination is a routine activity of case management, which updates providers on client progress and barriers as well as helps define provider roles and responsibilities, and avoid service duplication.

CRISIS INTERVENTION: An immediate response by a service provider to address a client's emergency need, i.e. emergency medical situation, domestic violence, mental health crisis, etc.

CRITERIA: Requirements for meeting a standard or the information used to determine if a standard has been met.

CULTURAL COMPETENCY: Staff ability to make services respectful of a client's cultural beliefs and behaviors, whether influenced by gender, ethnicity, poverty, language, disability, sexuality, age or other cultural influences, so that services are sensitive, comfortable, and acceptable to clients. Cultural competency implies that service delivery is designed and implemented with the understanding that

culture and language have considerable impact on how clients access and respond to health and human services.

FAMILY: The chosen close support system of a client as defined by the client. This expanded family definition may include blood relatives, domestic partners, spouse, children, and/or friends.

GOALS (service plan): A statement of broad outcomes that a client and case manager have agreed upon. These should be simple and achievable and are the basis for the tasks and activities that client and case manager will undertake.

HARM REDUCTION: An approach to behavior change that incorporates immediate and practical strategies for reducing harm associated with drug-related and sexual risk behaviors. An individualized, client-centered approach requiring a non-judgmental assessment of the client's current behavioral practices, and work toward small gradations in risk reduction to achieve behavioral changes in a manner consistent with the client's abilities and desires.

IMMEDIATE NEEDS: Client-identified issues that must be addressed at once to stabilize the client's situation and facilitate further engagement.

MEDICAL CASE MANAGEMENT/CARE COORDINATION: Medical care coordination is a service provided on-site at a health care facility by a member of the multidisciplinary team treating a patient (usually nurse, PA, NP, physician or assigned social worker). A medical care coordinator is responsible for a psychosocial assessment and ensuring that a patient receives the core services associated with HIV primary care such as: nutritional assessments; substance use and mental health assessments and interventions; treatment adherence counseling; prevention education; and partner notification assistance as needed. A medical case manager/care coordinator ensures coordination between inpatient and outpatient care and between the clinical staff coordinating the patient's medical care and community-based case managers. She/he also ensures timely referral to other specialists both within and outside the facility, and follow-up on referrals and missed appointments.

MEDICAL SETTING: Article 28 DOH-licensed HIV acute and primary care programs such as hospitals and Diagnostic and Treatment Centers. These include: hospital-based Designated AIDS Centers (DAC); non-DAC Hospital HIV clinics; free-standing Community Health Care Centers; Substance Abuse Treatment Programs co-located with HIV primary care; county health departments; and Federally Qualified Health Centers (FQHCs).

NARRATIVE SUMMARY: Documentation that provides an overview of issues presented by the client during an assessment. The narrative summary may prioritize needs and include a plan for following up on them.

OBJECTIVE (service plan): A short term (about six months or less) desired outcome, agreed upon between a case manager and a client, that contributes to the achievement of a broader goal in a client's service plan. Objectives are concrete and may require one or more activities to reach the desired result.

PARTNER NOTIFICATION ASSISTANCE: Service to determine if a client has informed past and present sexual and needle-sharing partners of their exposure to HIV and offer assistance with disclosure. Partner notification activities may include individual interventions such as role-playing with a client who wishes to self-inform partners, referral to self-help group discussions on partner notification, or referral to the Partner Notification Assistance Program (PNAP) or Contact Notification Assistance

Program (CNAP). Client needs regarding partner notification should be reviewed regularly and included in assessments/reassessments.

PROGRAM CAPACITY: The ability of a program and its staff to meet the case management needs of presenting clients, based on current resources, program design, and current caseload.

PROOF OF HIV STATUS: Documentation that provides verification of positive HIV status, such as a letter from physician, copies of laboratory results of HIV tests, T-cell and viral load results, M-11Q or medical chart documentation. Acquiring this documentation directly from a provider requires a release of information signed by the client, as per Article 27-F of the NYS Public Health Law.

REFERRAL ARRANGEMENTS/AGREEMENTS: Pre-established agreements with other agencies to send or accept clients for specified program services. An ongoing active partnership with agencies offering needed services is essential in providing quality case management.

STANDARDS: A set of requirements that the agency/program must follow when providing AIDS Institute-supported Comprehensive or Supportive Case Management Services.

SUPPORTIVE SERVICES: Discrete non-medical concrete services that assist a client with day-to-day living (i.e., food, transportation and support groups). AI sponsored support services are funded separately from case management.

TRANSITIONAL CASE MANAGEMENT (Youth Access Programs): Low threshold service to connect at-risk youth to clinical and social services to meet their immediate health care and social service needs. Transitional case management is often done in conjunction with outreach.

TRANSITIONAL PLANNING: Time limited case management that insures a continuum of services to HIV infected inmates who have disclosed their HIV status within a correctional facility. Arrangements for health care, prevention and support service are made pre-release to insure a coordinated transition from incarceration to community. Post-release follow up is provided to determine outcomes and reconnect individuals to care and services.

8. SAMPLE FORMS

8. Sample Forms

Sample forms for performing key case management processes and completing documentation are available at the New York State Department of Health website. These samples may be used as is or adapted. Go to the AIDS Institute pages at <http://www.nyhealth.gov/diseases/aids/index.htm> and click on the category “Clinical Guidelines, Standards, and Quality of Care.”

Forms included are:

- Brief Intake/Assessment
- Sample Screening Questions to Determine Case Management Need and Level of Case Management Services
- Brief Service Plan
- Initial Comprehensive Assessment
- Comprehensive Service Plan
- Comprehensive Reassessment
- Case Conference Form
- Case Closure Form

Changes in the HIV epidemic are frequent and impact case management services and documentation. Please visit the NYS DOH website periodically for updated versions of forms and other case management resources.

An electronic copy of the *AIDS Institute Standards for HIV/AIDS Case Management* is also available for download at this site.