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Case Management staff across Florida who work diligently to provide compassionate care to clients.

TABLE OF CONTENTS

ATTACHMENTS

DH1120	ATTACHMENT 1
DH 3204	ATTACHMENT 2
NOTICE OF PRIVACY PRACTICES	ATTACHMENT 3
DH 3203	ATTACHMENT 4
DH 2116	ATTACHMENT 5
BRIEF INTAKE/ENROLLMENT SCREENING	ATTACHMENT 6
COMPREHENSIVE NEEDS ASSESSMENT	ATTACHMENT 7
COMPREHENSIVE SERVICE PLAN	ATTACHMENT 8
CASE CLOSURE FORM	ATTACHMENT 9
CLIENT RIGHTS & RESPONSIBILITY	ATTACHMENT 10
RIGHTS, RESPONSIBILITY/GRIEVANCE	ATTACHMENT 11
GRIEVANCE PROCEDURE	ATTACHMENT 12

Introduction

This manual provides the operating guidelines for case management service providers funded by the Florida Department of Health, Division of Disease Control, Bureau of HIV/AIDS, Patient Care Programs. These guidelines set a minimum service level for providers delivering case management to persons living with HIV/AIDS in the state of Florida.

The anticipated outcomes of HIV/AIDS case management for persons living with HIV/AIDS as set forth in this manual include:

- Early access to health care and social services
- Improved integration of services
- Improved continuity of care
- Education of HIV disease
- Reinforcement of positive outcomes
- Personal empowerment
- Improved quality of life

Program Goals

- To promote and support independence and self-sufficiency.
- To support family members in their care-giving role.
- To promote treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments.

Mission

Promote, protect and improve the health of all people in Florida.

Intent

This document establishes universal core operating guidelines for HIV/AIDS case management services funded by the Florida Department of Health, Bureau of HIV/AIDS. The guidelines set a minimum service level for programs providing HIV case management regardless of setting or size.

Universal core case management operation guidelines 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 the case management operating guidelines 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.

The new operating guidelines describe two models of HIV/AIDS case management: **Supportive Case Management** and **Comprehensive Case Management**. Providers may 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 guidelines set minimum requirements for case management programs under the Bureau of HIV/AIDS, case management providers under Parts A, C, and D are encouraged to utilize these guidelines.

SECTION 1: Confidentiality

Staff must take prudent and reasonable steps to protect applicant/client confidential information. This section provides minimum criteria regarding security records and the management of confidential information.

The U.S. Department of Health and Human Services (HHS) issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Privacy Rule addresses the use and disclosure of individuals' health information - called "protected health information" by organizations subject to the Privacy Rule – called "covered entities." The rule also ensures that individuals' understand and control how their health information is used.

Policy and Procedure

All written and verbal communications with applicants during and after eligibility must be maintained in strict confidence as required by law. These procedures are the same for eligibility and case management agencies.

The Florida Department of Health (DOH) has written security policies, protocols, and procedures to ensure the security of information and protect confidentiality, data integrity, and access to information in accordance with Florida Statute.

- These policies are entitled, Information Security Policy DOHP 50-10-07.
- Contracted and subcontracted providers for DOH HIV/AIDS programs may create their own security policies, protocols and procedures but must be consistent with the DOHP 50-10-07.
- All employees and volunteers with access to client information must receive routine (at least annual) training on confidentiality, the proper exchange of information and required consent. Documentation of training must be maintained in personnel records.

Forms

The following forms have been developed by DOH for the purpose of securing confidential information. Providers are encouraged but <u>not required</u> to use the following DOH forms or must develop similar forms consistent with HIPAA and HIV laws. Staff should check with their agency to determine which forms are utilized.

DH 1120 Computer Use and Confidentiality Agreement

- Must be completed by the employee and their supervisor after review of each section and must be included in the employee's personnel record.
- Should be completed within the first 30 days of employment.
- Should be modified to meet the needs of the agency. (Attachment 1)

If modifying this form, an agency should address, at a minimum, the following subjects:

- An internal and external response to a breach of confidentiality including the understanding by the employee that they can be prosecuted.
- Review of use of DOH software and hardware (Section B of form DH 1120 covers this), if applicable.
- Review and access to the agency policies and procedures.
- Review and access to the agency personnel hand book.
- Review and access to the Florida Statutes and Administrative Rules pertaining to HIV/AIDS services and confidentiality. These can be accessed on the Internet by going to www.MyFlorida.com.
- Procedures to ensure the protection and confidentiality of all confidential matters shall be consistent with the DOHP 50-10-07.

DH 3204 Initiation of Services

- Completed by the applicant/client.
- Allows the agency to obtain or provide necessary information on the applicant/client related to treatment, payment and health care operations.
- Allows for alternative methods of communication which applicant/client must initial next to all applicable.
- Is in effect indefinitely unless the applicant revokes the form. (Attachment 2)

Notice of Privacy Practices

- Given to the client when they sign DH 3204 upon initial enrollment and as necessary or requested by the applicant/client.
- Describes how medical information about the applicant may be used and/or disclosed, and how the applicant/client can get access to this information. (Attachment 3)

DH 3203 Authorization to Disclose Confidential Information

- Establishes written documentation that the applicant/client has given permission to disclose protected health information for purposes other than treatment, payment or health care operations.
- Examples include attorneys, caregivers, spouses and partners. Information provided to the person on the release should be on a “need to know” basis and be pertinent to the applicants/clients care. (**Need to know** is defined as **1.** The legitimate requirement of a person or organization to know, access, or possess sensitive or classified information that is critical to the performance of an authorized, assigned mission. **2.** The necessity for access to, or knowledge or possession of, specific information required to carry out official duties.)
- Must be renewed annually unless a specific date is inserted. (Attachment 4)

DH 2116 Client Consent for Fax - OPTIONAL

- DH 3204 now has faxing as part of the consent form.
- May be used when the applicant/client is requesting their information be faxed to another provider or to receive information from another provider.
- A different form must be completed for each provider.
- This form is in effect indefinitely until or unless the applicant/client revokes the form. (Attachment 5)

Phone Calls

All telephone calls in which confidential information is discussed must be made from an area that ensures confidentiality is maintained:

- Cell phones and Blackberry's are not considered secure and should not be used for confidential phone calls, unless the client consents.
- Cell phone calls regarding confidential information must be limited to the minimum information.
- The call recipient must be informed the call is taking place on a cell phone.
- Employee must determine the ID of the caller and what information may be disclosed.

Mailing

A secured mail intake site must be used to receive incoming confidential information.

- Mailrooms and mailboxes must be secured to prevent unauthorized access to incoming and outgoing mail.
- Double-enveloping is required for mailing confidential information. The outside envelope is addressed to the recipient. The inside envelope specifies confidential and the recipient name.

Faxes

Confidential information may be faxed in a medical emergency or with written consent of the client.

- Fax machine must be in a secured area.
- Fax Cover Sheets must have the appropriate language and state "Confidential." This language should state ***"this transmission may contain material that is confidential under Federal law and Florida Statutes and is intended to be delivered to only the named addressee. Unauthorized use of this information may be a violation of criminal statutes. If this information is received by anyone other than the named addressee, the recipient shall immediately notify the sender at the address or telephone number above and obtain instructions as to the disposal thereof. Under no circumstances shall the material be shared, retained or copied by anyone other than the named addressee."***
- Medical information that is faxed must have a permanent copy in the record and documentation in the progress notes.

Email

- Applicants/clients wishing to use email must sign DH 3204 (or similar form) and specify the email address.
- The applicant/client should be informed that email is not secure.
- Information given in an email should be generic in nature and limited, even with consent from the applicant/client. Example: "This is an appointment reminder for May 27th at 8:00 a.m." Information specific to HIV/AIDS or other medical information should be given by alternate methods.
- Email as a method of communication is at the discretion of each agency regardless of a consent form. The agency's policies and procedures manual should provide guidance to local limitations regarding email.

Field Security

Job descriptions must document the authority to transport confidential information into the field. In addition:

- All confidential information taken into the field must be tracked, including who, what, when, why, and expected date of return.
- Information taken into the field is limited to what is needed to perform responsibilities.
- Prior permission must be obtained, if information is not to be returned by close of business.
- Information must be safeguarded from unauthorized access.

Work Space

- Eligibility staff must be provided with office space, which allows business to be conducted in a timely and confidential manner.
- If private office space with a door is not available, the provider must ensure all communications remain confidential.

Storage

- Offices and staff must maintain confidentiality of all data, files, and records including client records related to the services and shall comply with state and federal laws, including, but not limited to, sections 384.29, 392.65 and 455.667, Florida Statutes.
- Appropriate storage systems for hard copy client records are required.
- Storage systems include, at a minimum, file folders and maintained in locked file cabinets.

Client File Retention

- File retention must follow the Department of State, Bureau of Archives and Records Management storage and disposition procedures as mandated in Florida Statute Chapters 119 and 257.
- File retention schedule for agencies contracted with the DOH is five years from the date of termination of a provider (contract) with the DOH, or closure of the file.

- Upon completion or termination of the contract and at the request of the DOH, the provider will cooperate with the department to facilitate the duplication and transfer of any said records or documents during the required retention period.
- In the event that a client file is closed, the file is retained at the agency for the minimum five years before disposing of said record.
- Shredding of documents is the preferable method of disposal.

Electronic Files and Computers

The use of electronic files to gather and collect client information requires specific precautions to avoid a breach of confidentiality and protect the client's right to privacy. DOHP 50-10-07 includes but is not limited to the following guidance concerning electronic files and information:

- Computer monitors must be positioned to prevent unauthorized viewing.
- All computers including laptops that access and store confidential information must be password protected and the data must be encrypted in accordance with Department of Health Information Security policies, protocols and procedures.
- Laptops may be used for storing and accessing HIV/AIDS information with client identifiers if they adhere to the specific requirements in DOHP 50-10-07.
- Laptops containing confidential information must be returned to the secured area at the end of the working day and never stored in an unsecured, unauthorized area. This directive includes storing laptops in the employee's car, car trunk or home unless there is prior supervisory approval.
- Deleting files from a computer hard drive is not necessarily sufficient if the computer is to be stored. Hard drives must be wiped. If you are unsure how to do this or what it means, consult with your IT staff.

Additional Information

- Agencies need to document which positions have "need to know" access in their written job descriptions. (**Need to know** is defined as **1.** The legitimate requirement of a person or organization to know, access, or possess sensitive or classified information that is critical to the performance of an authorized, assigned mission. **2.** The necessity for access to, or knowledge or possession of, specific information required to carry out official duties.)
- Unauthorized persons shall not be left unattended in areas where confidential or sensitive information is maintained.
- All visitors must sign in on a security log.

Section 2 - Staff Qualifications

This section describes staff qualification requirements for both case management models as well as their supervisors.

Guidelines	*Criteria*
Documentation in personnel files of sufficient education, knowledge, and skills to provide effective services to clients. **Time Frame** **Upon hiring.**	Comprehensive Case Managers: 1. Case managers must meet one of the minimum qualifications: a. A bachelor's or master's degree in social science or be a registered nurse. b. A bachelor's degree not in social science with at least 6 months of case management experience. c. An individual may substitute applicable experience on a year-to-year basis for the required education. 2. Receives direct supervision. 3. Become familiar with local community resources. Supportive Case Managers: 1. Providers are not required to use the criteria listed above for supportive case managers. For example, an eligibility worker whose position does not require the same educational requirements as referenced above can provide supportive case management. Supervisors: 1. Must meet the comprehensive case manager qualifications and the following: a. Must have related experience in providing case management services. b. Have time to routinely review and approve case management records to facilitate case management duties. c. Provide routine support and supervision to the case manager. d. Provide interim staff for vacancies and staff on leave. e. Supervisory experience is preferred but not required.

Exception:
If there are barriers to the qualification criteria above, written justification is required and approval received from the local HIV/AIDS Program Coordinator.

Section 3 – Staff Training

This section describes staff training topics, the process for accessing training needs, monitoring, and documenting all training.

Guidelines	*Criteria*
Documentation of all trainings in staff personnel file. **Time Frame** **Required: Within 6 months of hire.** **Recommended: Upon completion of trainings.**	Required trainings include: 1. Annual confidentiality with attestation signed by staff person. 2. Initial agency orientation including job duties and responsibilities, agency policies and procedures. 3. Introduction to applicable local, state, and federal resources (includes ADAP, AICP, and HOPWA programs). 4. Basic and advanced information on HIV/AIDS (104 or higher). 5. DOH sponsored case management training. 6. Code of ethics including cultural diversity and professional boundaries. Recommended trainings to be determined by the supervisor and case manager, examples include: 1. Mental health 2. Substance abuse 3. Medicaid 4. Medicare (includes Part D) 5. HIV treatment and trends 6. Medical terminology 7. Lab interpretation 8. Documentation 9. AETC Training 10. Local resources **NOTE:** All required trainings must be made available to staff, either internally or through statewide training mechanisms. All trainings must be documented in staff personnel files. Staff personnel files are included in agency monitoring activities and therefore should include the above referenced trainings.

SECTION 4 - Case Management Defined

This section provides information about the Florida Department of Health, Division of Disease Control, Bureau of HIV/AIDS, Patient Care Program's case management models and services, definitions, significant terms, and descriptions of the more commonly known programs that provide case management services to persons living with HIV/AIDS.

Introduction

In 2007, the Health Resources and Services Administration (HRSA) provided the Bureau of HIV/AIDS the new Part B fundable program service list, including HRSA's revised definition of case management, which includes treatment adherence. Case management is an authorized and client-centered service performed by trained and experienced staff in a caring and compassionate manner. Case managers assist clients and their families in making informed decisions based on their needs, abilities, resources, and personal preferences. Case management is the link clients need to access appropriate HIV/AIDS medical and support services that range from medical, dental, lab, transportation, housing, financial assistance and other support services.

Authority

The case management services presented in this document are provided under the authority and oversight of the Patient Care Programs administered by the Department of Health, Division of Disease Control, Bureau of HIV/AIDS. Patient Care Programs include the following:

- Ryan White Part B Program
- AIDS Drug Assistance Program (ADAP)
- AIDS Insurance Continuation Program (AICP)
- State Housing Opportunities for Persons with AIDS Program (HOPWA)
- HIV/AIDS Patient Care Programs provided by the General Revenue Patient Care Networks
- County Health Departments HIV/AIDS Programs as administered by the Department of Health, Bureau of HIV/AIDS.

Allowable Services

Allowable services are the authorized services provided to clients receiving case management. Services vary depending on the area and funding, therefore agency supervisors will know funded service availability. Case managers may not directly provide services, but are responsible for locating service providers and referring clients. Examples include dental, mental health, substance abuse and transportation.

See Appendix 2 for a full list of HRSA approved services.

64D-4 F.A.C

Eligibility Rule (Chapter 64D-4 F.A.C. Florida Administrative Code)
Eligibility Requirements for HIV/AIDS Patient Care Programs

The Eligibility Rule establishes the statutory authority for standardized eligibility requirements of all of the HIV/AIDS Patient Care Programs to ensure services are provided to low-income individuals as intended. The Florida Department of Health, Division of Disease Control, Bureau of HIV/AIDS, Patient Care Program's eligibility procedures provide standardized and systematic procedures for eligibility staff (including case managers) when determining eligibility for the HIV/AIDS Patient Care Programs.
Refer to Florida HIV/AIDS Eligibilities Procedures Manual and the Florida Department of Health website at http://www.doh.state.fl.us/disease_ctrl/aids/care/EligibilityAdRule.html

Exempt Programs

Not included under this authority are the HIV/AIDS services provided by other local, state or federal HIV/AIDS programs such as the Ryan White Treatment Modernization Act of 2006 (Parts A, C, D, and F), City Housing Opportunities for Person with AIDS, the Agency for Health Care Administration (Project AIDS Care, Medicaid), Medicare and other non-Department of Health programs. There is, however, nothing to preclude any agency or program from adopting the case management operating guidelines established in this document.

See Appendix 1 for a description of exempt programs.

Definitions

The HIV/AIDS Patient Care Programs case management services are defined by the Ryan White Treatment Modernization Act of 2006, and are implemented according to the Florida HIV/AIDS Case Management Operating Guidelines. The Bureau of HIV/AIDS has established the two definitions for case management.

Note: Throughout this manual, Medical Case Management as defined by HRSA is referred to as Comprehensive Case Management.

Comprehensive Case Management (including treatment adherence) includes a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These activities ensure timely service delivery and continuity of care, through ongoing assessment of the client's and other key family member's needs and personal support systems.

Note: Throughout this manual, Non-Medical Case Management as defined by HRSA is referred to as <u>Supportive Case Management.</u>

Supportive Case Management includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-Medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.

Supportive Case Management:

- Provides an option from comprehensive case management.
- Requires the client to be eligible for HIV/AIDS Patient Care Services (Notice of Eligibility) before receiving services.
- Does not involve coordination and follow-up of medical treatments, as medical case management does.
- Does not require a comprehensive client needs assessment, plan of care or other five key activities required by comprehensive case management.

Comprehensive Case Management

Comprehensive Case Management is a proactive and inclusive case management model intended to serve individuals with multiple complex psychosocial and health-related needs and their families. This model is designed to serve those who may require a longer, more intensive level of case management.

Comprehensive Case Management includes the following service activities:

- Assessment and Reassessment of:
    - Health care
    - Bio-psychosocial
    - Needs of client and family support
- Develop individual service plan
- Requires frequent contact
- Linkage and follow up with community referrals
- Home visits as needed

The goal of comprehensive case management includes but is not limited to addressing the client's needs for services related to:

- Health care concerns
- Entitlements (i.e. Medicaid)
- Housing
- Nutrition
- Substance abuse
- Mental health
- Domestic violence

Key Activities: Comprehensive Case Management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments.

Five Key Activities of comprehensive case management include:
1. Initial assessment of the client's needs;
2. Development of a comprehensive, individualized plan of care;
3. Coordination of services required to implement the plan;
4. Client monitoring to assess the efficacy of the plan, and
5. Periodic re-evaluation and revision of the plan as necessary over the life of the client.

Comprehensive case management:
- Requires the client to be determined eligible for HIV/AIDS Patient Care Services (Notice of Eligibility) before any service is provided.
- Includes and requires the five (5) key activities (listed above).
- Emphasizes adherence treatment programs.
- Is not the same service as supportive case management.

Supportive Case Management

Supportive Case Management is responsive to the immediate needs of persons living with HIV/AIDS. Supportive case management is for persons with needs that can be addressed in the short term, is suitable for clients who may have completed comprehensive case management, but still require a maintenance level of periodic support, or who have become self-sufficient and need minimal management.

Supportive case management is provided to clients with multiple needs who may best be served by comprehensive case management, but are not ready or willing to engage in the level of participation required by the comprehensive model.

Clients enrolled in this model experiencing a repeat cycle of the same crisis should be encouraged by the case manager to transition to comprehensive case management services to reap the benefits of activities provided by the comprehensive model.

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.

Note: Eligibility staff can provide supportive case management if funded to do so.

Section 5 - Enrollment Procedure

This section provides client enrollment procedures to access case management services, once client eligibility is determined.

- Brief Intake/Enrollment Screening
- Selection of appropriate case management model
  - Comprehensive
  - Supportive
- Clients Rights and Responsibilites
- Client Grievance Policy

Eligibility

Eligibility is a pre-requisite to enrollment for all HIV/AIDS Patient Care Programs, including case management.

- See Eligibility Rule 64D-4 for specific requirements.

Enrollment Requirements

Enrollment is an administrative process of gathering initial client specific information (name, address, service needs, etc.) to create a client file for assignment to a case manager for services.

Enrollment Procedures

The enrollment procedure is presented in the following three steps:

- Confirmation of Notice of Eligibility (NOE)
- Client file and enrollment information
- Assignment to a case manager

Step One: Confirmation of the Notice of Eligibility

- A copy of the NOE is obtained from the client or requested from the originating eligibility provider.
- If a client has not been determined eligible, the client is referred to a provider for an eligibility determination before enrollment can continue.
- If the validity of the NOE is questionable, the client's eligibility status will remain "*eligible"* until the issue is resolved with the eligibility provider. Supervisory oversight is required for resolution.

Step Two: Client file and enrollment information

- During the initial enrollment process, a client file is created that will include the following documentation:
  - Notice of Eligibility
  - Confidentiality forms
  - Brief Intake/Enrollment Screening form (Attachment 5)

- Client Rights & Responsibilities (Separate from Eligibility Application, specific to provider) {See Attachment 10}.

Step Three: Assignment to a case manager

- The final step in the enrollment process is the assignment and transfer of the completed enrollment file to a case manager. Case management providers have varied procedures for staff assignment but generally take into account the following factors:
  - Current caseload count, i.e., number of clients that are comprehensive, supportive, or combined.
  - The service needs of the clients.
  - Current caseload status:
    - New – newly enrolled clients
    - Active – ongoing contact within 180 days

Providers must be able to identify clients actively engaged in case management services and the caseload per case manager or team. In order to prevent case manager burnout and maintain quality of case management services for clients, it is recommended that providers set caseload limits in their local policies and procedures manual.

Brief Intake/Enrollment Screening Process

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

The Brief Intake is also be used to screen clients to determine if they need case management services, the model of case management most appropriate, and to assess the client's willingness to engage in case management services.

In the **Supportive Case Management model**, the Brief Intake/Enrollment Screening is the sole mechanism for assessing client needs. In this model, a comprehensive assessment is not required.

In the **Comprehensive Case Management model,** the Brief Intake/Enrollment Screening allows initiation of case management activities until a comprehensive needs assessment can be completed.

Guidelines	***Criteria***
Key information concerning the client, family, caregivers, and informal support is collected, as well as eligibility documentation, the need for ongoing case management services, and appropriate level of case management service. Time Frame **Due within 2 weeks upon referral from Eligibility provider.**	1. Brief Intake/Enrollment documentation include: • Basic information o Notice of Eligibility o Confidentiality o Other current health care and social service providers, including other case management providers o Presenting problem o Contact and demographic information o Language choice • Overview of status of needs regarding o HIV/AIDS disease, other medical concerns, access, and adherence to other health care services o Substance abuse o Mental health o Housing o Food/clothing o Finances/benefits o Transportation o Legal services o Substance abuse o Domestic violence

	2. Document in the client's chart Client's Rights and Responsibility form. (Attachment 10) 3. Obtain appropriate confidentiality releases. 4. Client meets program eligibility per Notice of Eligibility.
Exception: Time limits may exceed the two weeks on a case-by-case basis with supervisory approval.	

Selection of Case Management Model and Placement

The **Comprehensive** and **Supportive** models of case management provide different levels of service geared to the needs and readiness of the client. A provider can make available 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 change.

Comprehensive Case Management is intended for clients with multiple, complex needs who require intensive, longer-term service. In this model**,** the brief intake allows initiation of case management activities until the comprehensive assessment can be completed. A client is suitable for enrollment if they present with one or more of the following characteristics:

- New to or unfamiliar with the HIV/AIDS service delivery system.
- Clients who require assistance in accessing or interpreting the health care delivery system or who have trouble making informed decisions based on their own needs, abilities, resources, and personal preferences.
- Clients with health and social issues.
- Clients with adherence issues regarding medications and appointments.
- Clients with barriers relating to:
  - Housing
  - Substance abuse
  - Mental health
  - Transportation

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 the comprehensive case management model. In supportive case management, a comprehensive needs assessment is not required; the brief intake/enrollment form is the sole mechanism for assessing client needs.

Guidelines	*Criteria*
Clients are enrolled in a Comprehensive or Supportive case management program that provides a level of service that meets the needs identified in the Brief Intake/Enrollment Screening and in which the client is ready and willing to participate. Time Frame **Upon completion of Brief Intake/Enrollment Screening.**	1. Appropriate case management model for client is determined. • Client's level of need is ascertained. • Services are explained. • Readiness and interest in case management are assessed. • Client is enrolled in model most suited to his/her needs. 2. Program capacity is evaluated. • Program has caseload capacity. • Program has capacity to meet clients' cultural and linguistic needs. • Program service level and staff qualifications and/or expertise meets the client's needs. 3. Clients are enrolled in Comprehensive or Supportive Case Management within the agency or referred appropriately. • Consent for case management services is obtained. • Client signs all required forms and releases, if necessary. 4. For providers who are not able to provide level or type of case management services necessary for client (where applicable): • Agency refers the client to another case management program. • Referral to another case management program occurs within 5 business days after determination of appropriate level of care. • Referring agency follows up and verifies with client that placement was appropriate and client is receiving service. 5. Agency has referral arrangements with local case management providers to ensure diverse needs of clients are met. 6. Agencies providing both models of case management: • Are able to identify which clients receive comprehensive or supportive case management. • Are able to report total number of clients served in either model. • Have a process to move clients between models.

Exception:
In some cases, 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 such cases, supportive case management is provided to meet the immediate need of the client, but every effort should be made to encourage the client to engage in the comprehensive model.

Client Rights and Responsibilties

Each agency will have a policy that protects the rights and outlines the responsibilities of the clients and the agency.

Guidelines	*Criteria*
Policy on client rights and responsibilities and documentation that client received this information. **Time Frame** **Upon completion of Brief Intake/Enrollment Screening.**	1. All clients have the right to be treated respectfully by staff, and the client's decisions and needs should drive services. 2. Agencies must develop a written Client Rights and Responsibilities Statement that is reviewed with each client, signed by the client, and a copy provided to the client during the intake or assessment process. 3. Agencies can reserve the right to refuse services to clients who are verbally or physically abusive to staff, or who possess illegal substances or weapons on agency property. 4. The Client Rights and Responsibilities should be posted in an area accessible to the public.

NOTE: See Attachments 10 and 11 for samples.

Client Grievance Policy

Providers must have a formal written grievance policy.

Guidelines	*Criteria*
Written client grievance procedure outlining criteria. **Time Frame** **Upon initial Brief Intake/Enrollment Screening.**	1. The grievance procedure must include: • Staff responsible • Required documentation • Review process • Time frames • Maintenance of confidentiality • Process for advising consumer and staff of outcome • Appeals process 2. New clients are to be informed of the grievance policy and procedures during the initial intake and as necessary. 3. Provider grievance policy must be posted in area accessible to the public. 4. Written documentation client received grievance policy must be in client file.

NOTE: See Attachments 11 and 12 for samples.

SECTION 6 – Supportive Case Management

This section provides information about supportive case management and necessary documentation.

Supportive Case Management

Supportive Case Management is responsive to the immediate needs of persons living with HIV/AIDS. Supportive case management is for persons with needs that can be addressed in the short term, is suitable for clients who may have completed comprehensive case management, but still require a maintenance level of periodic support, or who have become self-sufficient and need minimal management.

Supportive case management is provided to clients who have multiple needs who may best be served by comprehensive case management, but who are not ready or willing to engage in the level of participation required by the comprehensive model.

Clients enrolled in this model experiencing a repeat cycle of the same crisis should be encouraged by the case manager to transition to comprehensive case management in order to access services provided by the comprehensive model.

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.

Note: Eligibility staff can provide supportive case management if funded to do so.

Who can receive supportive case management?

Clients who may benefit from this model may include but are not limited to:

- Individuals covered by private insurance in need of co-pay assistance only.
- Individuals on Medicaid, medically stable, and in need of support services such as transportation or food vouchers.
- Clients who may present with intense needs but are not ready to engage in comprehensive case management.
- Clients enrolled in Project AIDS Care (PAC) who only need a support service.
- Long term clients who want to remain on active status but have no real needs.

Can a client move from one model to the other?

Yes, clients can move from supportive to comprehensive or vice versa as their needs change. Local infrastructure will determine how the transition can occur and may include:

- Remaining with the same case manager who may cover both models.
- Transitioning from one case manager to another within the same agency.
- Transitioning from one agency to another.

How is this model beneficial?

Client

- Does not force services a client may not be ready to access.
- Reduces amount of paperwork in order to access services.
- Can remain a client with an agency without "loosing their slot".

Case Manager

- Reduce unnecessary paperwork.
- Allows attention to be directed towards clients most in need of comprehensive services.
- Allows for more accurate case load accountability.
- Case manager can maintain the relationship.

Required Documentation

The intent of this model is to provide limited services to clients who are stable, system savvy, or not ready to engage in intense case management.

As such, required documentation includes:

- Brief Intake/Enrollment form completed at intake and updated annually.
- Current Notice of Eligibility.
- Case note documentation that must include date, detailed description of activities and case manager name. (See Appendix 3)

NOTE: In the supportive case management model, the initial comprehensive assessment is not required. Case management services are provided based on information gathered from the Brief Intake/Enrollment Screening and are updated throughout service provisions and reassessed as needs change or annually.

Section 7 – Comprehensive Case Management

Comprehensive Case Management is a proactive and inclusive case management model intended to serve individuals with multiple complex psychosocial and health-related needs and their families. This model is designed to serve those who may require and agree to a longer, more intensive level of case management. This section provides the required documentation for comprehensive case management including:

- Comprehensive assessment.
- Service plan development.
- Service plan implementation, client contact, monitoring and follow-up.
- Reassessment.
- Service plan update.

Comprehensive Needs Assessment

The Comprehensive Needs Assessment is required for the comprehensive case management model. It expands the information gathered in the brief intake to provide the broader base of knowledge to address complex health care needs. A good rapport with the client enhances the ability for the case manager to gather sensitive information.

The Comprehensive Needs Assessment is completed within 30 business days to permit the initiation of case management activities, as well as to meet immediate needs and allow for a thorough collection of pertinent information.

The Comprehensive Needs Assessment may be a face-to-face interaction that takes place at a mutually acceptable location. This action is accomplished through a series of contacts that often occur in a variety of settings, including the case management providers' office, telephone, inpatient settings, clinics, and home-visits. There is no requirement that assessments be conducted at the client's home. Home-visits are only required if home-based services are being considered. Always exercise caution and good judgment when conducting home-visits.

Guidelines	***Criteria***
An Initial Comprehensive Needs Assessment describes in detail the client's medical, physical, and psychosocial condition and needs. It identifies service needs that are addressed and by whom; service needs not provided; barriers to care, and services not adequately coordinated; evaluates the client's resources and strengths, including family support, which can be utilized during service planning.	1. Initial Comprehensive Needs Assessment includes at a minimum: a. Assess history and current needs in these primary areas: • Outpatient/Ambulatory health services • AIDS Drug Assistance Program (ADAP) treatments • AIDS Pharmaceutical Assistance (local) • Oral Health Care • Early Intervention Services • Health Insurance Premium & Cost Sharing Assistance • Home Health Care • Home and Community-based Health Services • Hospice Services • Mental Health Services • Medical Nutrition Therapy • Substance Abuse Services-Outpatient

Time Frame **Due within 30 business days of completion of the Brief Intake/Enrollment Screening.**	b. Assess history and current needs in these secondary areas: • Child Care Services • Emergency Financial Assistance • Food Bank/Home-Delivered Meals • Health Education/Risk Reduction • Housing Services • Legal Services • Linguistic Services • Medical Transportation Services • Outreach Services • Psychosocial Support Services • Referral for Health Care/Supportive Services • Rehabilitation Services • Respite Care • Treatment Adherence Counseling c. Additional information • Client strength and resources • Collaboration with other agencies serving client • Brief narrative summary 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.

Comprehensive Service Plan Development

The Comprehensive Service Plan is a critical component of the comprehensive case management model. It guides the client and case manager with a systematic approach to addressing the client's needs.

The service plan includes clearly defined priority areas for needed services and specific actions that must be taken to meet these goals; the agencies and service providers to which clients contracted; realistic periods for completing activities and the identification of potential barriers to service utilization and delivery with proposed solutions to these problems. Unforeseen situations e.g., illnesses, incarcerations, may alter the normal periods on delivery of services. In addition, it serves as a review tool at reassessment to evaluate accomplishments and barriers. The service plan is a working document reflecting changes as goals are reached and/or new ones added.

Guidelines	*Criteria*

Identified needs are prioritized and translated into the service plan defining specific goals, objectives, and activities to meet those needs.
 	
Time Frame
 	
Due at completion of Comprehensive Needs Assessment, and every six months, or as needed when changes occur.
	1. The Comprehensive Service Plan includes at a minimum:
	• Goal (s) – address client needs/gaps in services
	• Activities:
	  • Individuals responsible for action or activity
	  • Time-frame for completion of action or activity
	  • Barriers and denials to service
	  • Expected outcome of goals
	• Client signature and date
	• Case Manager signature and date
	
	2. The case manager and the client have primary responsibility for developing the service plan.
	
	3. The plan is included in the case record as well as updated with outcomes and revised or amended in response to any changes in client life circumstances or goals.

Exception:
The Comprehensive Service Plan is not required in the supportive case management model. Accurate and concise case notes mirroring the needs identified in the Brief Intake/Enrollment Screening form act as service plan for this model.

Service Plan Implementation, Client Contact, Monitoring and Follow Up

The majority of case management work occurs in the implementation of the service plan. It involves carrying out the tasks listed in the plan, including the following activities:

- Contacting client in person, by phone, or in writing.
- Assisting the client in applications for services or entitlements.
- Assisting the client in arranging services, making appointments, confirming service delivery dates.
- Encouraging the client to carry out tasks.
- Providing education to the client.
- Supporting the client in overcoming barriers and accessing services
- Negotiating and advocating as needed.
- Performing other case management activities as needed by client, and as expected and permissible by program initiative.

The type and frequency of contact should be based on client needs.

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, avert crises, and support the client in achieving service goals. Types of contact may include telephone, face-to-face, home visits, and accompanying the client to providers where necessary to ensure service delivery.

In the **Supportive Case Management model**, client contact and monitoring are required to follow up on referrals, determine the status of service delivery, and to assess whether the client has further needs and if he requires additional case management services.

In both case management models, referral to some service will occur. **Linkage** is sometimes confused with referral. Linkage constitutes identifying a need, researching how to best address the need, providing client with means to meet the need and most importantly, following up with the client on the outcome.

Guidelines	*Criteria*
Clients are contacted based on their level of need and monitored accordingly. Case managers follow up to determine delivery of service. **Time Frame** **Ongoing**	1. Case manager is responsible for the oversight of service implementation plan. 2. Case manager is responsible for keeping progress notes recording the results of client's goals and outcomes. 3. Documentation in client's chart of type and frequency of contact made on the client's behalf or to and from client. 4. Documentation indicates contact with client and providers after arranging services to determine if services are: • Delivered and utilized by the client • Continue to be appropriate to the client's needs 5. Case manager follows up on any problems with service delivery. 6. The client's right to privacy and confidentiality in contacts with other providers and others is ensured. Documentation of client's consent to consult with other service providers is obtained.
Exception: Home visits are not a requirement unless patient care programs fund a home-based service.	

Reassessment

Reassessments apply to the comprehensive model of case management and provide an opportunity to review the client's progress, consider successes and barriers, and to evaluate the previous time frame of activities. It also serves as an opportunity to update the service plan, determine if the current model of case management is appropriate, or if the client needs to transition to another model that is better suited for their needs.

Guidelines	*Criteria*
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. **Time Frame** **As needed for Comprehensive Case Management, when changes occur, or at least annually.**	1. Each reassessment includes: a. Updated personal contact information • Demographic information • Insurance status • Other health and social service providers b. Updated health history, health status, and health-related needs outlined in the Initial Comprehensive Assessment (see Initial Comprehensive Assessment, criteria 1: a, b). c. Any additional information • Client strength and resources • Collaboration with other agencies serving client • Brief narrative summary • Case manager signature and date 2. The case manager has primary responsibility for the reassessment of the client and meets face-to-face with the client at least once during the reassessment process. 3. The reassessment is documented in client's chart. 4. The client's right to privacy and confidentiality is ensured.

Service Plan Update

A reassessment is accompanied by any revisions to the service plan. However, the service plan must be updated between reassessments to reflect changes in direction or completion of client's goals and case management activities.

Guidelines	*Criteria*
A new Service Plan is required if the client's circumstances necessitate a change in goals, objectives, or case management activities. **Time Frame** **When changes occur or every six months minimum.**	1. In Comprehensive Case Management, a service plan accompanies each reassessment. 2. The service plan is updated at least every 6 months or as client's circumstances change.

Section 8 – Client File Organization

Providers of case management must organize their files in a consistent manner. Files must contain the minimum information outlined below.

Guidelines	*Criteria*
All client records/files will be neatly maintained and organized. **Time Frame** **Ongoing**	1. All client records will contain at a minimum the following documentation: a. Brief intake b. Initial comprehensive assessment (if applicable) c. Initial service plan (if applicable) d. Revised service plan (every six months if applicable) e. Case conferences (if applicable) f. Case closure (if applicable) 2. Detailed case notes documenting activities. Memory recall is not an option. All activities must be documented in client file. 3. Confidentiality forms (if applicable). 4. Other documentation an agency deems appropriate.

Section 9 – Case Coordination and 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 is to provide holistic, coordinated, and integrated services across providers, and 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 or designated care giver(s).

Case conferences can be used to identify or clarify issues regarding a client status, needs, and goals; to review activities including progress and barriers towards goals; or to resolve conflicts or strategize solutions. Case conferences may be face-to-face or by phone, held at routine intervals or during significant changes.

Guidelines	*Criteria*
Case Managers routinely coordinate all necessary services along the continuum of care, including institutional and community-based, medical and non-medical, social and support services. **Time Frame** **As needed and appropriate.**	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 through case note documentation. 3. The client's right to privacy and confidentiality in contacts with other providers is maintained.

Section 10 – Case Closure

Closed cases are not counted in the caseload. A case is closed with supervisor approval and with a final discharge/termination narrative in the file. (Attachment 9)

The following are some reasons for case closure:

- Death of client
- Notice of Ineligibility that client is no longer eligible for services
- No contact for six months
- Closure at client's request
- Client declines case management services
- Client has transferred to another case management provider
- Client moves from service area
- Client is incarcerated in a state or federal facility
- Client is enrolled in Medicaid (PAC, MediPass, Medicaid, HMO) and is not accessing HIV/AIDS Patient Care services
- Termination with cause, examples include:
    - Repeated failure to make/keep appointments which result in negative consequences
    - Refusal to follow treatment plans
    - Violent, abusive, threatening behavior

Guidelines	***Criteria***
Upon termination of active case management services, a client's case is closed and contains a closure summary documenting the case disposition. **Time Frame** **At the time the file is closed.**	1. Closed cases include documentation stating the reason for closure and a closure summary. 2. Supervisor signs off on closure summary indicating approval. 3. Supervisor review is completed in situations where provider intends to terminate services related to a client who threatens, harasses, or harms staff.