

# State of Utah

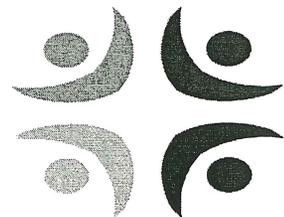
## HIV Medical Case Management Standards of Care

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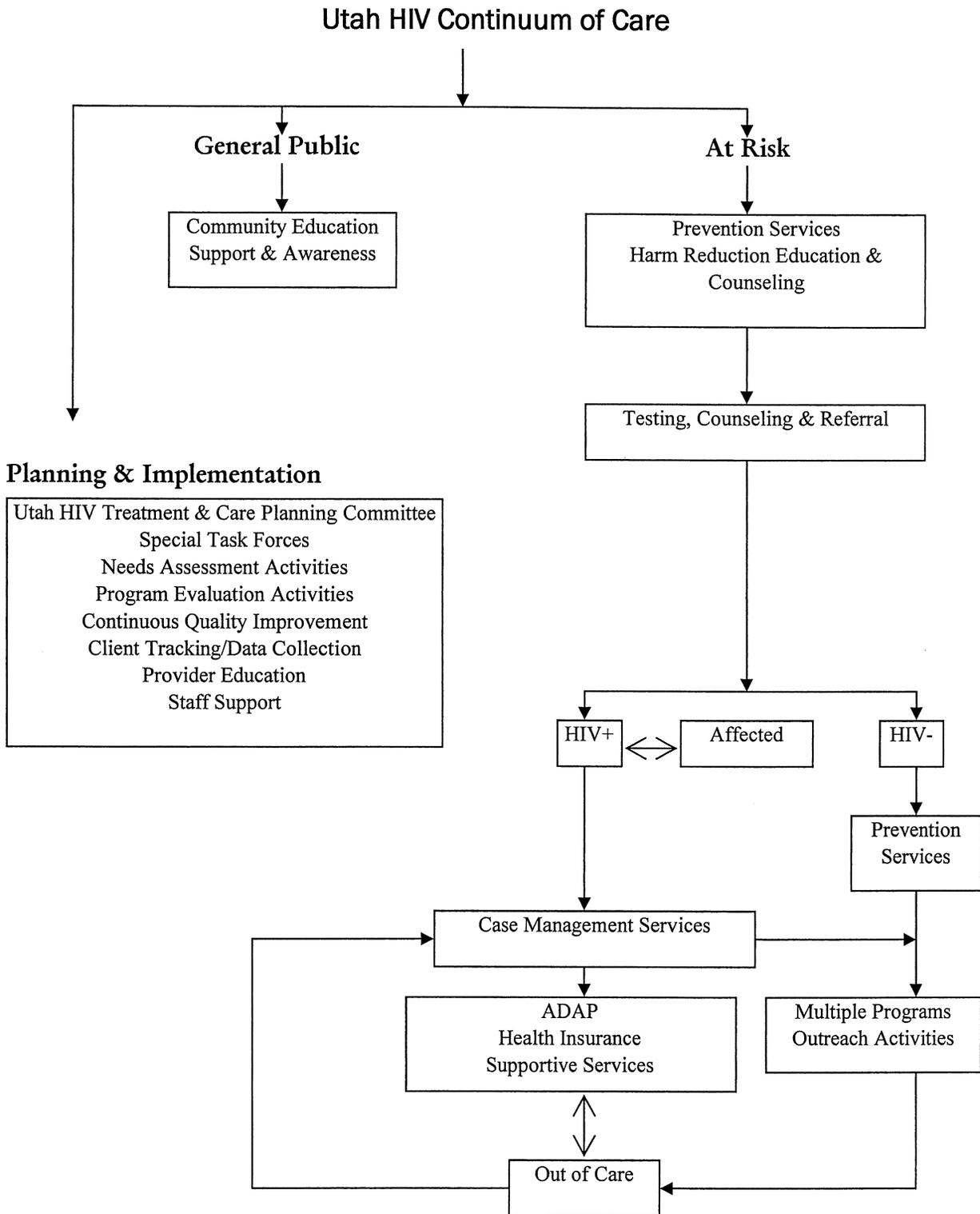
### Utah Overview

Utah has a population of 2,817,222 and covers approximately 82,000 square miles. Utah comprises 29 counties, the population ranging from a low of 941 in Daggett County to a high of roughly a million in Salt Lake County. The majority of the population (76%) lives on a 130-mile long corridor known as the Wasatch Front. This represents a large, urbanized, metropolitan area within the context of a rural/frontier setting. Over 75% of the state's population resides in less than 5% of the state's landmass.

The majority of Utah's residents are white at 86%. Members of the Hispanic community make up the fastest growing ethnic community in Utah, growing from 9% in 2000 to 13% in 2010. Other racial/ethnic groups include African American, 2.9%, Asian and Pacific islander, and 1.2%, Native American or Alaskan Native. As in all states, racial and ethnic groups bear a disproportionate share of the burden of death and disease from preventable communicable and chronic disease.

As of December 31, 2009, there have been 2,551 HIV cases (including AIDS cases) reported in Utah and about fifty percent of these cases have died. Males comprise the majority of cases and male-to-male sexual contact is the most common means of HIV/AIDS exposure reported among men. Among women the most common means of exposure is heterosexual contact followed by injecting drug use.

Approximately 92% of Utah's population living with HIV/AIDS reside along the Wasatch Front and are being treated in Salt Lake City. The majority of individuals from rural areas come to Salt Lake City for their medical treatment.



## Utah Continuum of Care

The proceeding chart represents the HIV Continuum of Care in Utah as discussed by the Utah HIV Treatment and Care Planning Committee (TCP) during its planning process. HIV impacts all Utah residents as community education, HIV support and awareness are issues that impact the general public in Utah. Those who are at risk for HIV infection are target populations of the HIV Prevention Program and are offered prevention services including harm reduction, education and counseling. Persons at risk are also encouraged to utilize the testing, counseling and referral services available through the Prevention Program. Those who test negative for HIV continue to receive HIV prevention services. Those who test positive for HIV are directed into the HIV Treatment and Care Programs available in the state.

There are three Ryan White Programs providing HIV treatment and care services in Utah: Ryan White Program Part B, Ryan White Program Part C, and Ryan White Program Part D. The TCP sets service priorities to facilitate resource allocation of Ryan White Program Part B funds, which are administered by the Utah Department of Health. Ryan White Program Part C and Part D funds treatment services at the University of Utah, Division of Infectious Diseases located in Salt Lake County. These funds are administered within University Health Care, Hospitals and Clinics, Division of Infectious Diseases, Clinic 1A.

These funds are allocated to organizations and/or providers throughout the State of Utah.

The Utah Department of Health allocates funding of Utah Part B HIV Continuum of Care services to organizations and/or providers throughout the State of Utah. All HIV clients utilizing Ryan White Part B services will have access to an HIV case manager in order to access these services. The core services currently funded in the Ryan White Part B program include ambulatory/outpatient medical care, AIDS Drug Assistance Program (ADAP), oral health care (when funding permits), health insurance premium & cost sharing assistance, home health care and medical case management. Supportive services currently funded in the Ryan White Part B program include case management (non-medical), emergency food vouchers, and medical transportation services.

## Chronic Disease Management

Chronic disease management is an approach to health care that involves supporting individuals to maintain independence and to keep as healthy as possible through early detection and effective management of chronic conditions to prevent deterioration, reduce risk of complications, prevent associated illnesses and enable people living with chronic conditions to have the best possible quality of life. A client's ability to follow medical advice, accommodate lifestyle changes and access appropriate support are all factors that influence successful management of an ongoing illness.

People with HIV disease and AIDS need support and information to become effective managers of their own health. Chronic conditions require not just medical interventions, but behavioral intervention as well. Clients with chronic conditions such as HIV/AIDS play a large role in managing their conditions. Each client is at a different place in the process, and appropriate interventions are driven, to a large extent, by each client's desired outcomes. In order to meet these needs, it is essential for clients to have the following:

- ⇒ Basic information about HIV/AIDS and its treatment;
- ⇒ Understanding of and assistance with self-management skill building; and
- ⇒ Ongoing support from members of the health care/case management team, family, friends, and community.

Improving the health of people with chronic illness requires transforming a health care system that is essentially reactive (responding when a person is sick and/or in crisis) to one that is proactive and focused on keeping a person as healthy as possible. This requires not only determining what care is needed, but spelling out roles and tasks in a structured, planned way to ensure that everyone involved as part of the client's care team understands their role. And it requires making coordinated follow-up a part of standard procedure, so clients aren't left on their own once they leave the doctor's or case manager's office. More complex clients need more intensive case management for a period of time to optimize the clinic care, the effectiveness of their treatment regimen and their self-management behavioral skills.

Effective self-management support means more than telling clients what to do. It means acknowledging the clients' central role in their care, one that fosters a sense of responsibility for their health. It includes the use of proven programs that provide basic information, emotional support, and strategies for living with chronic illness. But self-management can't begin and end with a class. Using a collaborative approach, case managers and clients work together to define problems, set priorities, establish goals, create care plans and solve problems along the way.

Key principles of chronic disease management & client self-management:

- ⇒ Emphasis on the client's role
- ⇒ Standardized assessment
- ⇒ Effective, evidence based interventions
- ⇒ Care planning (goal-setting) and problem solving
- ⇒ Active, sustained follow-up

## Chronic Care Self-Management Guidelines for HIV Case Managers

### **STEP #1: Define the problem** (*the case management assessment process*)

- ⇒ Impact of the illness
- ⇒ Symptoms of the illness
- ⇒ Medication side-effects
- ⇒ Lifestyle factors
- ⇒ Strengths and barriers
- ⇒ With the client determine factors that will affect his or her capacity for self-management

### **STEP #2: Planning** (*care planning*)

Together with the client:

- ⇒ Determine stage of change (*see "Determine Stage of Change" which follows*)
- ⇒ Determine specific goals
- ⇒ Prioritize goals
- ⇒ Identify outcomes
- ⇒ Determine realistic timeframes
- ⇒ Select interventions
- ⇒ Document the care plan

### **STEP #3: Management** (*case management*)

Select the appropriate mix of strategies depending on:

- ⇒ Context
- ⇒ Goals
- ⇒ Availability of resources
- ⇒ Quality of resources
- ⇒ Personal capacity

#### **Important factors to address in management**

- ⇒ Adherence to medication
- ⇒ Behavioral change related to lifestyle and activities
- ⇒ Adjustment to change
- ⇒ Coping skills
- ⇒ Effective use of community resources

#### **Approaches to self-management**

- ⇒ Education and training
- ⇒ Interventions (i.e. interventions such as nutritional counseling and psychosocial interventions such as risk reduction counseling)
- ⇒ Structured self-management programs offered through hospitals, health plans, clinics, physician locations, community based organizations, etc.
- ⇒ Client diary
- ⇒ Motivational interviewing (requires training)
- ⇒ Peer support

## Determine Stage of Change

### Stage 1: Not thinking of change

Appropriate case management actions:

- ⇒ Reflective listening (empathic approach)
- ⇒ Effective questioning
- ⇒ Provide objective information in a non-judgmental manner
- ⇒ Explore barriers

*Note: Action-oriented message may not be appropriate at this stage.*

### Stage 2: Thinking of change

Appropriate case management actions:

- ⇒ Reflective listening
- ⇒ Empathy
- ⇒ Effective questioning
- ⇒ Provide objective information in a non-judgmental manner
- ⇒ Encourage ownership of the problem
- ⇒ Increase awareness of negative consequences
- ⇒ Recognize how situations affect illness

### Stage 3: Ready for change

Appropriate case management action:

- ⇒ Encouragement
- ⇒ Empathy
- ⇒ Goal setting
- ⇒ Support for behaviors that show an ability to produce a change

### Stage 4: Changing behavior

Appropriate case management action:

- ⇒ Encourage client to make changes in their environment to support positive behavior change
- ⇒ Skills training interventions
- ⇒ Encourage support from others

### Stage 5: Maintaining change and relapse

Appropriate case management action:

- ⇒ Reinforce/praise change by helping client focus on the achieved outcomes/goal attainment
- ⇒ Support incremental goal development that builds on changes
- ⇒ Do not view relapse as a failure but as a way to gain knowledge of triggers
- ⇒ Increase awareness of environmental and internal stimuli that trigger problem behaviors

## HIV Case Management Program Policies

### 1. Procedure for Accessing Services:

The client may contact the provider directly. The client may also be referred by providers, family members, the State and/or Local Health Departments and any other person or entity approved by the client to make the referral.

### 2. Other Conditions:

The Case Management providers must work in conjunction with:

- ⇒ The client's primary care physician;
- ⇒ Other Ryan White Part B providers as necessary to assist with the application of benefits.
- ⇒ The client and their family and/or caregivers;
- ⇒ All other persons or entities included at the client's request in their care as pertinent to the case management care plan;
- ⇒ Follow the adopted State of Utah HIV Medical Case Management Standards of Care.

### 3. Utah Ryan White Program, Part B funded HIV case managers may provide case management services to facilitate an HIV positive inmate's transition from a prison to the community under the following circumstances:

1. The incarcerated person must volunteer information to the nurse or medical providers that they are being released;
2. A case manager is notified and goes to the correctional facility within one month before the release date;
3. The case manager determines where the client is going to go after their release, if they are on medications, when they need to see the doctor next, and if they need housing;
4. There are no other transitional case management or discharge planning services provided by the correctional facility.

Under no circumstances, can Ryan White Program, Part B funds be used to pay for any other support service (besides case management), primary medical care or prescription drugs for any incarcerated person in a local, State or Federal correctional facility (including city or county jail.)

## Definition of HIV Medical Case Management

Medical case management is a formal and professional service which links clients with chronic conditions and multiple service needs to a continuum of health and social service systems. Medical case management strives to ensure that clients with complex needs receive timely coordinated services which assist a client's ability to function independently for as long as is practical. Medical case management assesses the needs of the client, the client's family, and the client's support system, and arranges, coordinates, monitors, evaluates and advocates for a package of multiple services to meet the specific client's complex needs.

Effective May 2007, the Health Resources Services Administration (HRSA) defines medical case management as:

*“Medical case management services (including treatment adherence) are 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 services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client’s and other key family members’ needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments.*

Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (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 adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.”

The first and highest priority of all HIV Medical Case Management systems must be to ensure that persons living with HIV/AIDS are enrolled and sustained in coordinated health care for HIV disease that optimizes their health and well-being.

## Utah Case Management Criteria and Values

### Case Management Criteria:

- ⇒ Outcomes, quality and cost-effectiveness of case management activities should be measurable.
- ⇒ Duplication of services should be minimized.
- ⇒ Case management services should be based on documented and emerging needs.
- ⇒ Case management should follow established standards, benchmarks, training criteria, and protocols.
- ⇒ Case management should reduce barriers to care.
- ⇒ Reporting, invoicing and documentation should be kept as simple as possible.

### Case Management Supporting Values:

- ⇒ Case management will offer referral and supportive services in an effort to link clients to medical care.
- ⇒ Case management should be caring, empowering, efficient and effective.
- ⇒ Case management is available to everyone, but recognizes not everyone needs the same level of case management services.
- ⇒ The goal of successful case management is to obtain, maintain or increase self-sufficiency.
- ⇒ Case management will incorporate an education component.
- ⇒ Case management will be flexible with a continuum of services for different acuity (e.g. levels of need).
- ⇒ The case management system will be culturally responsive.
- ⇒ Case management should be accessible to everyone statewide.
- ⇒ Case management should meet established standards of care and be of demonstrated quality and effectiveness.

## Client-Centered Approach to Case Management

The client-centered model was originally developed by Carl Rogers and contains the key ingredients of a helping relationship: empathy, respect and genuineness. The fundamental tenet of the approach is that all people have an inherent tendency to strive toward growth, self-actualization, and self-direction. A client-centered approach places the needs, values and priorities of the client as the central core around which all interaction and activity revolve. Understanding how the client perceives their needs, their resources, and their priorities for utilizing services to meet their needs is essential if the case management relationship is truly going to be client-centered.

Each client has the right to personal choice though these choices may conflict with reason, practicality or the case manager's professional judgment. The issue of valuing a client's right to personal choice is a relatively simple matter when the case manager's and client's priorities are compatible. It is when there is a difference between the priorities of the case manager and their client that the case manager must make a diligent effort to distinguish between their own values and judgments and those of their client. One of the most difficult challenges for a case manager is to see their client making a choice that will probably result in negative outcomes, and which opposes the case manager's best counsel. In these situations, case managers must be willing to let the client experience the consequences of their choices, and hope that the relationship with the case manager will be a place to which the client can return to for support without being judged. The exception is if

## HIV Medical Case Management Program Requirements

### Utah Ryan White Program, Part B Model of HIV Medical Case Management

In Utah, the majority of HIV case managers are social workers. Some may use paraprofessionals to assist them with the intake process, psychosocial assessments, care planning and the referral and follow-up activities. The Utah Part B Program model of HIV Medical case management recognizes the important link between the client's physical health and their overall quality of life. The Ryan White Program addresses the needs of persons with HIV disease by funding primary health care and supportive services that enhance access to and retention in HIV medical care and treatment. The goal of medical case management is to help individuals living with HIV to access primary medical care and medications, identify and remove barriers to medical care, and ensure adherence to a prescribed treatment plan.

Clients who see a physician at the University of Utah Medical Center, Clinic 1A, must use a clinic-based case manager. Clients who see a physician outside of Clinic 1A must use a case manager from the Utah AIDS Foundation. VA Medical Center clients must use the VA case manager.

HIV Medical case management is a range of client-centered services that ensure timely and coordinated access to primary medical care, medications, and other support services, including treatment adherence, for HIV-positive individuals. Primary activities link a person to primary medical care or services. Secondary services may be needed for HIV-positive individuals to achieve their medical outcomes and must have a direct relationship to an individual's HIV clinical outcomes.

**Primary** activities of Medical HIV Case Management include assistance and support applying, accessing, and adhering to HIV medical services and treatment by providing:

- ⇒ Assistance accessing health insurance/medical treatment payment programs such as Utah Medicaid, Medicare, ADAP, and pharmaceutical patient assistance programs.
- ⇒ Assistance accessing primary and HIV-specific medical care, including HIV medications.
- ⇒ Screening, assessment, referral and appropriate intervention for: oral health care; medical nutritional services; mental health services; and outpatient substance abuse treatment.

**Secondary** activities of Medical HIV Case Management include assistance with applying and accessing the following support services:

- ⇒ Housing assistance
- ⇒ Medical transportation
- ⇒ Food and nutrition
- ⇒ Linguistic/translation services
- ⇒ Oral health care
- ⇒ Mental health care
- ⇒ Substance abuse treatment services
- ⇒ Home health services
- ⇒ Food vouchers

## **Psychosocial Case Manager Qualifications**

Case Management services may be provided by a service provider who holds and maintains appropriate licensure to provide case management services; i.e., RN, LCSW and/or BSW/SSW/LPC under the direction of a physician, RN and/or LCSW as outlined in Department of Occupational and Professional Licensing. Service providers must have received training and continue to receive training and maintain up to date information regarding Ryan White programs and services as approved by the Supportive Services Program. Service providers must also have experience in the field of case management and understand the legal, social, and clinical aspects of case management.

## **Case Manager Education Requirements & Training**

As the "front line" in providing vital service linkages for people living with HIV disease and AIDS, case managers must be adequately and appropriately experienced and trained. To achieve this end, the following will guide the training and certification process:

1. The minimum education and/or experience requirements for case managers is:  
Psychosocial Case Manager: Bachelor of Social Work, or other related health or human service degree from an accredited college or university, OR; related experience for a period of 2 years of full time (or equivalent), regardless of academic preparation.
2. All case managers must complete the designated annual HIV Case Manager Update and Training with the Utah Department of Health (UDOH) HIV Treatment and Care program.
3. All HIV case managers may complete UDOH designated on-going training.

## **HIV Medical Case Management Standards**

These standards are intended to provide a direction to the practice of HIV Medical Case Management in the State of Utah. They are also intended to provide a framework for evaluating the practice of HIV Medical Case Management and to define the professional case manager's accountability to the client and to the public to whom the profession is responsible. The following standards incorporate both Standards of Care and Standards of Performance. Standards of Care delineate a competent level of services as demonstrated by the process of delivering the service. Standards of Performance define a competent level of behavior in the professional role that includes quality of care, qualifications, collaboration, legal ethics, advocacy, and resource utilization. This document should not be literally interpreted but is intended to provide a framework for providers to begin developing their own quality improvement outcome measures.

The core activities of case management are addressed below:

- ⇒ Intake
- ⇒ Assessment
- ⇒ Reassessment
- ⇒ Service Planning
- ⇒ Referral and Advocacy
- ⇒ Follow-up and Monitoring
- ⇒ Transfer and Inactivation
- ⇒ Evaluation of Client Satisfaction

## Intake

**Standard:** Each prospective client who is referred and desires or who requests case management services will be properly screened and evaluated through a brief face-to-face intake process designed to gather information for future service delivery and assist in decision-making regarding immediate needs.

### Purpose of the Initial Interview/Intake

The Initial Interview is necessary to determine whether the client is in a crisis situation and/or requires immediate direct service referral. It provides the Intake staff with important first impressions about the client and their needs. Also, it allows the client to interact with agency staff and to consider the ramifications of his or her participation in the program. With this information the interviewer can choose to:

- 1) provide immediate assistance through the resources of the agency;
- 2) refer the client to another agency; and/or
- 3) continue the enrollment process by completing the client Intake.

The first contact between the client and the Intake staff also establishes the basis for development of rapport and trust, which are essential elements of successful case management. The Intake interview is a screening process. It also serves as the primary source of demographic information gathering.

Enrollment into a case management program is often the client's first encounter with the HIV services system. The client's **Informed Consent** to participate in the case management program should be obtained at this time. In the process of acquiring the client's informed consent, it is important to ensure that the client understands the **Grievance Procedure** as well as the right to refuse any and all services. The client may exercise this right at any time during his or her participation in the case management program.

Additionally, as part of the enrollment into the case management program, clients are informed of their right to **Confidentiality**. It is important not to assume that anyone - even a client's partner or family member - knows that the client is HIV positive. Part of this discussion should include inquiry about how the individual prefers to be contacted (at home, work, by mail, code word on the telephone, etc.) Case managers should identify themselves only by name, never giving an organizational affiliation that would imply that an individual has HIV/AIDS or receiving social services.

Another element of the enrollment process is the **Release of Information** form in which a client authorizes in writing the disclosure of certain information about his/her case to another party (including family members). Included in the form are the purpose of the disclosure, the types of information to be disclosed, entities to disclose to and the expiration date of client authorization. Because this program requires an annual reassessment it is expected that a Release of Information will be obtained annually. Part of the discussion should include information about the intent of the Release of Information, its components, and ways the client can nullify it.

## INTAKE - STANDARDS OF SERVICE

An additional document presented to the client is the Client's Rights and Responsibilities Form. The case manager reviews all of the rights and discusses the responsibilities as part of the overall discussion of a client's participation in the case management system. A signed copy (by the client) of the Client's Rights and Responsibilities Form should remain in the client's file and a copy should be given to the client to keep.

While there is no income eligibility requirement for HIV case management services, many of the other programs and services available to assist clients do have income eligibility requirements. Therefore, an important part of the Intake process is determining the income level of clients and assembling the income documentation that will be necessary for client access to other programs, including Part B-funded supportive services managed by the HIV Treatment and Care program at the Utah Department of Health. Verification of income must happen before the case manager can refer a client to other critical services.

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

The Initial Interview/Intake may be performed by a variety of personnel. The intake interview should be performed by someone with a high degree of interpersonal skill and empathy who has an in-depth knowledge of the HIV/AIDS social service system. They should also have the ability to assess for immediate need, with referral to the appropriate professional resource as necessary. Each agency will make the determination who, with appropriate training, will perform Intake based on the agency's particular circumstances. It will also be an agency decision whether to allow drop-in Intake, whether to combine Intake and Assessment, and whether to have multiple sessions based on agency particulars and on client need.

### Process

1. All new clients automatically receive an Intake.
2. A designated individual with appropriate training and skill screens the service request/referral for basic admission criteria and assesses the need for immediate intervention.
3. Critical demographic and case specific information is collected from the client.
4. A client will be referred to Assessment.

### Criteria

1. Intake will be initiated as soon as is possible. The intent of this standard is to insure that clients are processed into the system in a timely manner and, whenever possible, should receive an Intake within 2 weeks of initial client contact. Prior to the Intake, the client should be provided a list of information/documentation they will need to bring to the Intake interview. Some level of crisis triage screening should be done with the client on the first contact. If the client is experiencing a medical crisis or is facing eminent interruption of HIV

## INTAKE - STANDARDS OF SERVICE

medication therapy, some level of case management intervention may need to happen prior to the formal Intake and Assessment processes.

2. The person conducting the intake provides prospective clients with a description of the services available from the agency, as well as services available from other agencies, as appropriate to the client.
3. The Intake is documented on the standardized "Intake/Update" form included in the HIV Medical Case Management Standards of Service Forms.
4. The person conducting the interview documents recommendations identified in the Intake process, and any recommendation and referrals in the client file.

### **Information to be documented:**

- a. Documentation of HIV status (required)
  - b. Documentation of financial information/verification/proof of income/Affidavit of Zero Income (based on program income requirements)
  - c. Release of Information (required)
  - d. Client Rights and Responsibilities (required)
  - e. Informed Consent (required)
  - f. Client grievance procedures (required)
  - g. Date/Source of referral, date of intake
  - h. Name, address (mailing if different), phone, message phone emergency contact information
  - i. Location where client prefers/declines to be contacted
  - j. Emergency contact information
  - k. Age/Date of Birth
  - l. Gender
  - m. Racial and/or ethnic identification
  - n. Primary Care Physician/clinic, address, phone
  - o. Other health care providers (present and recent past), address, phone
  - p. Key contacts
  - q. Household members
  - r. Employment
  - s. Documentation of health insurance
  - t. Living situation
  - u. Education
  - v. Legal issues
  - w. Transportation
  - x. Availability of basic needs
  - y. Photo ID
  - z. Social Security Number (if available)
5. Verification of Eligibility: Within 30 working days from the date of Intake, verification of client HIV status must be obtained. Client reported HIV status is not acceptable to meet this requirement. Verification of HIV status, through a Western Blot test or detectable viral load,

## Psychosocial Assessment

**Standard:** Each client of case management services will participate in at least one (1) face-to-face interview to assess their biopsychosocial needs.

### Purpose of the Assessment

An assessment is an information gathering process which includes a face-to-face interview between a client and case manager and acquisition of secondary data from health and human services professionals and other individuals. It is a cooperative and interactive process during which a client and case manager collect, analyze, synthesize and prioritize information which identifies client needs, resources, and strengths, for purposes of developing a plan to address the needs identified. The main purpose of the history taking and assessment processes is to identify areas of client need that require action. The forms required are tools to assist in identifying and prioritizing the areas of greatest need for each client, so that a care plan can be developed that identifies specific activities and who is responsible for completing the identified activities. The purpose of the assessment process is not to simply fill out the required forms.

#### Assessment Identifiers

1. The extent and nature of client's needs
2. The capacity of the client to meet their personal needs
3. The capacity of the client's social network to address client's needs
4. The capacity of available human services agencies/organizations to address the client's needs

The Assessment is directed at reaching mutual agreement between the case manager and client concerning priority needs and client strengths and limitations.

### Process

1. The Assessment is conducted by the case manager(s) and is performed in accordance with the standards and any written policies and procedures established by each respective agency, especially those related to confidentiality requirements. The Assessment is documented on the standardized "Psychosocial Assessment Form" included in the **Forms Package**. The assessment process utilizes the "Utah Client Acuity Scale Worksheet" included in the **Forms Package**, which is a tool to assist in summarizing the results of the assessment. Informed consent from the client is necessary to utilize additional consultations in the assessment process and the case manager should be guided by their agency policy regarding **Informed Consent**.
2. The face-to-face interview is conducted at a site mutually acceptable to the client and case management staff.
3. The process of identifying client needs and strengths should be a participatory activity that involves client self-assessment and supports client self-determination. Equally important is ongoing collaboration between the case manager and other health and human service providers and individuals involved with the client. Case conferencing and consultation with other agencies providing services to the client should be an ongoing activity of case management and appropriate documentation of these activities should be included in a

consistent way in the client's file.

4. Building strong communication between the HIV case manager and the client's primary care provider is important to the client's overall quality of life, the client's ability to adhere to treatment regimens and the success of care coordination on behalf of the client. This communication could be enhanced if a copy of the completed Assessment is sent to the client's primary care provider by the HIV case manager.

### Criteria

1. If the Assessment was not scheduled during the intake process, the client is contacted to schedule an appointment for the assessment. The client assessment is conducted in face-to-face meeting(s) between the client and case manager. The intent of these standards is to help case managers provide clients with timely access to services. It is necessary to assess a client's needs before the appropriate referrals to services can be made. Ideally, the Assessment should commence no later than seven (7) working days following intake and should be completed within two (2) weeks of intake. However, there may be factors which require a longer period of time to complete the assessment and these should be documented in the client record.
2. Client needs are systematically assessed and documented. This involves the active participation of the client, health and human services professional, and other individuals, as agreed to by the client. Client needs should be identified in the following areas:
  - ⇒ Self-report of health status and history of HIV/AIDS complications and treatments, including adherence concerns/issues;
  - ⇒ Current medications and side effects;
  - ⇒ Physical and dental health status, considerations of potential for rehabilitation;
  - ⇒ Mental health and emotional status;
  - ⇒ Cultural, ethnic, or racial considerations;
  - ⇒ Communication skills, literacy, and/or translation requirements;
  - ⇒ Social relationships and support (informal care givers; formal service providers; significant issues in relationships, social environments);
  - ⇒ Transportation;
  - ⇒ Knowledge of HIV disease transmission and risk reduction strategies;
  - ⇒ Accessibility of health and community resources which the client needs or wants;
  - ⇒ Assessment of alcohol, tobacco, and other drug use;
  - ⇒ Medication adherence assessment; and
  - ⇒ Oral health.

Optional Assessment Areas include:

- ⇒ Recreation and leisure;
- ⇒ Spirituality/religion; and/or
- ⇒ Knowledge of legal rights and responsibilities regarding ADA and other pertinent HIV/AIDS laws.

### The Acuity Scale

Utah's Ryan White Part B-funded HIV Case Management and Support Services Program is a needs-based program which strives to provide the greatest level of support to clients with the greatest need. The Health Assessment process is utilized to determine level of need. A four-stage acuity scale is used as an additional part of the assessment process and is completed ONLY AFTER the Assessment

Interview is completed and the “Intake/Health Assessment Form” is complete.

- The Acuity Scale is a tool for the case manager to use, which complements the professional, needs-based assessment interview.
- The Acuity Scale is intended to provide a framework for documenting important assessment elements and for standardizing the key questions that should be asked as part of a professional assessment.
- The Acuity Scale helps provide consistency from client to client and is a tool to assist in an objective assessment of a client's need, thereby minimizing inherent subjective bias.
- The Acuity Scale translates the assessment into a level of programmatic support designed to provide the client assistance appropriate to their assessed need and functioning.

### **The Acuity Stage Guidelines**

#### **Level 1: 14-23 points**

- ⇒ Information & Referral, as needed and/or requested.
- ⇒ Initial face-to-face psychosocial assessments.
- ⇒ Psychosocial reassessments, as needed.
- ⇒ Documentation in progress notes or CAREWare case notes.
- ⇒ No requirement for a Service Plan.

#### **Level 2: 24-46 points**

- ⇒ Initial face-to-face psychosocial assessments.
- ⇒ Annual face-to-face psychosocial reassessments.
- ⇒ Minimum contact (telephone or face-to-face) every 6 months to verify address/ phone number and to check on client's current status.
- ⇒ Completed and signed (both client and case manager) Service Plan Form, with appropriate documentation showing that it has been updated at least every 12 months.

#### **Level 3: 47-69 points**

- ⇒ Initial face-to-face psychosocial assessments.
- ⇒ Minimum annual face-to-face psychosocial reassessments.
- ⇒ Minimum contact (telephone or face-to-face) **every 3 months**.
- ⇒ Minimum evaluation of goals, activities and outcomes **every 30 days**.
- ⇒ Completed and signed (both client and case manager) Service Plan Form, with appropriate documentation showing that it has been updated at least every 12 months.

#### **Level 4: 70-92 points**

- ⇒ Initial face-to-face psychosocial assessments.
- ⇒ Minimum annual face-to-face psychosocial reassessments.
- ⇒ Minimum contact (telephone or face-to-face) **every 30 days**.
- ⇒ Minimum evaluation of goals, activities and outcomes **every 30 days**.
- ⇒ Completed and signed (both client and case manager) Service Plan Form, with appropriate documentation showing that it has been updated at least every 6 months.

## ASSESSMENT - STANDARDS OF SERVICE

At the discretion of the case manager, release from a correctional facility, during the first 90 days after release, or a client history of chronic substance abuse or mental health issues, or a history of chronic difficulty accessing or following through with medical care may be conditions warranting a change to an overall Acuity Stage of 3 or 4.

### **Documentation of Elements of the Assessment**

(To be taken into consideration as part of the Assessment)

- a. Psychosocial assessment conducted face-to-face with the psychosocial case manager and form completed.
- b. Other assessment data acquired from other professionals and sources, if necessary, and documented in client file progress notes.
- c. Acuity Level.
- d. Completed Program Requirements Checklist.
- e. Documentation of the assessment process, findings, recommendations, referrals and care planning goals in the client file progress notes.
- f. Development of a Service Plan and documented utilizing the Service Plan Form.

## Psychosocial Reassessment

**Standard:** At least every 12 months, all clients receiving case management services will have their needs reevaluated through a comprehensive face-to-face biopsychosocial reassessment.

### Purpose of the Reassessment

Clients are reassessed to identify unresolved and or emerging need, guide appropriate revisions in the care planning and informed decision making regarding discharge from case management services and/or transition to other appropriate services. Reassessment is conducted in the event of significant changes in the client's life.

### Process

Reassessment is conducted by the case manager and is performed in accordance with the standards and any written policies and procedures established by each respective agency. The process of reassessment should encourage active participation by the client and/or significant others, to include legal guardians, parents of minor children, as well as partner or spouse. The process of reassessment may involve the collaboration between case manager and other health and human service providers, individuals actively involved with the client, and through client record review.

### Criteria

1. Active clients in case management will be reassessed, at a minimum, every 12 months.
2. Case managed clients will be reassessed more frequently in the event of significant changes in the client's life or as defined in process.
3. Reassessment will include, but not be limited to, the original assessment areas and include progress on meeting care plan goals, changes, and additional mutually agreed upon goals.

### Documentation

1. Updated demographic data.
2. Updated financial information.
3. Updated Psychosocial Assessment and Acuity Scale completed.
4. Updated assessment data acquired from health care providers and other professionals and sources.
5. Updated goals and activities reflecting the above input and review.
6. Updated Acuity determination.
7. Updated information on the "Program Requirements Checklist" form.

## Referral & Advocacy

**Standard:** Each client receiving case management services will receive assistance to facilitate access to those services critical to achieving optimal health and well-being; and will receive advocacy assistance to help problem solve as necessary when barriers impede access.

### Purpose of Referral & Advocacy

Referrals to outside agencies for specified services are often needed in order to meet planning goals. Advocacy, or the act of assisting a client to obtain necessary services, is the logical complement to referral activities. Both of these activities are integral to the delivery of quality case management.

### Process of Referral

The act of directing a person to a service, in person or through telephone, written, or other type of communication. Referral may be made:

- (1) from one clinical provider to another;
- (2) within the HIV case management system;
- (3) by other professional case managers;
- (4) by program staff; or
- (5) as part of an outreach program.

Referral agencies should be assessed for appropriateness to the client situation, lifestyle and need. The referral process should include timely follow-up of all referrals to ensure that services are being received. Agency eligibility requirements should be considered as a part of the referral process. Any referral made should be appropriately documented in the client record (CAREWare can also be used to track referrals).

### Process of Advocacy

Advocacy is the act of assisting someone in obtaining needed goods, services or benefits, (such as medical, social, community, legal, financial, and other needed services), especially when the individual has had difficulty obtaining them on his/her own. Advocacy does not involve coordination and follow-up on medical treatments. Whenever possible, advocacy should build upon, rather than fragment, agency cooperation and collaboration.

### Criteria

1. Referral and advocacy
  - Making referrals
  - Reducing barriers/facilitating access
  - Referral follow-up
  - Advocating with referral agencies when needed
  - Emotional support (Defined under "Definitions" section attached.)

## REFERRAL & ADVOCACY-STANDARDS OF SERVICE

2. The case manager and client will work together to decide what actions are necessary to accomplish each goal and who will take responsibility for each task. The case manager will encourage and support clients to act on their own behalf whenever possible.

### **Documentation**

Referrals and Advocacy activities should be documented in the progress notes. Dates of referral, contacts referred to and specific advocacy activities should be included in the documentation RW CAREWare can also be used to track Referrals.

## Follow-up & Monitoring

**Standard:** Client and case manager will reassess the goals and activities identified with the client during the planning process to comply with the requirements under “Acuity Scale” to assess for progress and the need for appropriate changes. The Care Plan Form will be updated accordingly. .

### Purpose of Follow-up & Monitoring:

Follow-up and monitoring are inseparable. It is through systematic follow-up that the case manager and client discover whether their planning effort is working and when they need to make revisions. The goals and activities developed during the planning process should be regularly reviewed to determine whether any changes in client’s situation warrant a change in the plan and also to determine whether the goals and activities are being completed in a timely manner and, if not, why not. Each agency providing case management should incorporate care planning review in their Quality Assurance (QA) protocol.

Additionally, monitoring client satisfaction is an ongoing process throughout the delivery of case management services. It determines whether the mutually agreed upon goals of the care plan are truly meeting the needs of the client. The agency QA protocol may include a process for formally assessing client satisfaction, which could include an anonymous suggestion/feedback process in addition to the statewide client satisfaction survey conducted by UDOH biannually.

Monitoring is an ongoing process that involves collection and analysis of data and information that results in:

- ⇒ evaluation of the effectiveness and relevance of the planning process;
- ⇒ evaluation of the level of client satisfaction;
- ⇒ measurement of client progress toward stated goals and activities; and
- ⇒ determination of the need for revisions.

The overall goals of follow-up and monitoring are to:

- ⇒ ensure the goals and activities identified during the planning process are adequate to meet client service needs;
- ⇒ make sure the care and treatment the client receives from different providers are being coordinated to avoid needless duplication and/or gaps in services;
- ⇒ ensure any changes that have emerged in the client’s condition or circumstances are being adequately addressed in order to avoid crisis situations; and
- ⇒ maintain client and case manager contact on a regular basis to build trust, communication and rapport.

### Process

1. Either the case manager or the client can initiate follow-up.
2. Clients should be encouraged to contact the case manager when changes occur in their health condition, in social factors that impact their day-to-day living, or in their practical support systems. Careful planning by the client and the case manager can determine how often contact is needed to minimize crisis situations and to best meet the client's anticipated needs.
3. Follow-up and monitoring activities can occur through direct contact with the client, the client and their caregiver, parents or guardian (i.e. face-to-face meetings, telephone communication). Client contact with the case manager can occur on an ad hoc or drop-in basis. Follow-up can occur in the case manager's office, at the client's home or temporary residence, in the hospital or at other sites in the community.
5. Indirect contact with the client's family or caregiver, primary medical provider, service providers and other professionals also provides follow-up and monitoring information. This can happen through meetings, telephone contact, written reports and letters, review of client records, and through client and/or agency staffing.
6. To build a client-centered relationship, it is important that at least some of the follow-up and monitoring happen as face-to-face meetings with the client.
7. Identifying and contacting people with HIV/AIDS who were previously enrolled in HIV care and treatment services, and have been lost to follow-up or are not responding, may be a component of the monitoring. This is accomplished through periodic review of client files; requests from medical provider or referral from other outreach activities. Results of this activity will be reportable and evaluated periodically for effectiveness in getting clients with HIV/AIDS re-enrolled in case management and primary care.

### Criteria

1. The case manager will document any review of care planning activities that happened with the client, either in their progress notes, on the Care Plan form or in RW CAREWare.
2. Client and case manager will reassess the care planning goals and activities to comply with the requirements based upon the client's acuity level.

### Documentation

Follow-up and Monitoring activities should be documented in the progress notes. Dates of follow-up, any contacts referred to and specific activities should be included in the documentation. RW CAREWare can also be used to track follow-up within the referrals screen.

## Service Planning

**Standard:** All clients of case management will have documentation of service planning as described above whose goal(s) may be as simple as a goal to schedule the semi-annual Reassessment.

Every client in HIV Medical Case Management will have a current Service Plan Form completed, dated and signed by both the client and the case manager (see “Acuity Scale” for definitions of current under each acuity level) . Additionally, documentation of goals, assigned activities and the outcomes may be included in the progress notes (either written in the client file or in RW CAREWare, with signed, dated copies also kept in the client file.)

Every active client will identify at least one self-management goal to be included in their Service Plan. Documentation of the client’s success in achieving their self-management goal(s) must be included in the client’s file. Examples of self-management goals could include (but are not limited to):

- (1) completing the annual re-certification application on their own without assistance from the case manager;
- (2) successfully making an appointment with a mental health provider;
- (3) not missing any medical or dental appointments within a prescribed period of time; and/or
- (4) successfully keeping and submitting bills with the accompanying Explanations of Benefit (EOB).

### Purpose of Service Planning

For the most efficient use of time and for effective outcomes to occur, there must be a clear plan that directs the activities of the client and the case manager. This plan becomes the basis for evaluating what services were provided and whether they achieved the desired outcomes. Once the case manager has gathered sufficient information from the Intake and Health Assessment, it should naturally follow that this information will form the basis of service planning.

### Process

Service planning provides the basis from which the case manager and the client work together, as partners, to access the resources and services which will enhance the client’s quality of life and his/her ability to cope with the complexity of living with HIV/AIDS. The client and their support system play a vital role in the process of developing a plan of care. This utilizes existing supports the client brings to the case management relationship. The process supports client self-determination whenever possible and empowers a client to actively participate in the planning and delivery of services.

When setting up a Service Plan, no matter which format is chosen, it is necessary to come to an agreement about what tasks will be done by the case manager and what the client will do [Service Plan Form, goals & objectives in Progress Notes or CAREWare] . Most clients will count on the case manager to guide them through the health and human services system, and to present options and

help them develop contingency plans, should the initial efforts fail to produce the desired results. There should be ongoing joint assessment of the appropriateness of the plan.

The role of the case manager is primarily one of resource coordination. When, during service planning, specific knowledge or skills are needed beyond those of the case manager, consultation with other professionals should be sought after appropriate releases of information are obtained.

1. Set priorities for the goals and activities identified. The client should be involved in helping set the priorities to the fullest extent possible. Aim to accomplish one activity at a time while acknowledging the next tasks to be accomplished, except in emergency or highly urgent situations where multiple activities may need to be implemented early in the planning process.
2. Case conferences and other forms of care coordination can help ensure that all providers involved in a client's care and treatment work together to achieve the best mix of services and avoid duplication.
3. Successful completion of the goals and activities identified in planning may require the case manager to take a more active role in helping the client identify problems, that the he/she may not necessarily see, that could impact the client's ability to fulfill his or her obligations in the process.
4. The planning process should be used as an important tool for helping the client escape the crisis management mode of coping with his or her problems and service needs. With proper support many clients are able to increase their coping skills and stabilize their life situation to avoid the cycle of moving from one crisis to another.

### Documentation

In addition to the required Service Plan Form for each client, service planning includes documentation in the progress notes for each encounter with the client, persons in their support system, and other providers involved with the client's care. Dates of contact, information on who initiated contact, and any action that resulted from the contact should be included in the documentation. All documentation must be signed and dated by the case manager and placed in the client's chart.

## Transfer & Inactivation/Case Closed

**Standard:** A systematic process shall be in place to guide a transfer of the client to another program or HIV case manager, and/or to inactivate from case management services. This process includes clear documentation of the reason for inactivation, notifying the client of inactivation and the appeals process.

### Purpose of Transfer & Inactivation/Case Closed

The purpose of a transfer process is to minimize disruption and assist a client moving between programs. The intent of this Standard is to require case managers to work with the client and the new case manager; to forward copies of appropriate chart documentation; to assist the new case manager in understanding the client's needs; and to reduce barriers and "red tape" to the client's ongoing access to care.

Inactivation should occur in cases where a client is no longer participating in the program. Inactivation should be documented in accordance with the written policies and procedures established by each respective agency.

**Active:** Client is considered active within the agency when he/she actively seeks and receives services, and has been seen or contacted.

**Inactive/Case Closed:** The client's services have been completed at the provider agency and the client's record has been closed. This includes those persons who are "lost to follow-up" (see Criteria below).

### Conditions

Inactivation/Case Closure shall occur:

1. Death of the client
2. The client and/or client's legal guardian requests that the case be closed
3. Client makes fraudulent claims about their HIV diagnosis or falsifies documentation
4. Client moves out of the State of Utah.

Transfer/Inactivation/Case Closure may occur:

1. Client is "lost to follow-up";
2. Client moves into a system of care which provides institutional case management;
3. Client is unwilling to participate in care planning;
4. Client exhibits a pattern of abuse of agency staff, property or services;
5. Client needs are more appropriately addressed in other programs;
6. Client and Case Manager agree that the Client no longer needs ongoing follow-up and monitoring.

### **Process**

1. Reason for inactivation/case closure or transfer is discussed with the client and options for other service provision is explored and documented.

## TRANSFER & INACTIVATION- STANDARDS OF SERVICE

2. In instances where the case management agency initiates termination:
  - a. The case manager should consult with supervisor about their intent to inactivate client.
  - b. The client is informed of intent to inactivate and is provided with information regarding appeal of that decision.
  - c. The client is informed of other community resources available that may be able to meet their needs.
3. In some circumstances, Inactivation Summary is prepared, which includes documentation of reason(s) for inactivation and a service transition plan as appropriate.
4. In some circumstances, a client may be suspended from services for a specified period of time. Suspension can be used as a motivational strategy by case managers with clients who are not responding to care planning, are not fulfilling their commitments, are exhibiting behavioral problems or are refusing referrals to professional assistance. If the suspension is longer than one year, the client file should be inactivated. Clients who are suspended must have documentation in their file that shows:
  - ⇒ The reason for the suspension.
  - ⇒ What specific activities the client must complete to resume services.
  - ⇒ A timeline for completion of the activities.
  - ⇒ Date of review scheduled with the client.
  - ⇒ What will happen if the client does not meet their obligations to resume services (i.e., the client will be inactivated from the program.)

### **Process for Transfers within Utah Ryan White Program, Part B area:**

If a client informs a case manager that they will be transferring their care to a different medical provider/clinic in Utah and will be seeking case management services the following should occur:

1. Both case management programs must have current Releases of Information (ROI) from the client.
2. Communication between the two case management programs occurs to facilitate transfer of care.

### **Criteria**

A client is considered "lost to follow-up" when a case manager has made a minimum of 3 good faith attempts within a twelve month period to contact the client, with no response from the client. This can be done through either phone messages, letters, provider contacts, or home visits.

## Home Visit Safety Protocol

**Standard:** A written “Home Visit Safety Protocol” is required for every HIV Medical Case Management agency funded by Ryan White Program, Part B. A copy of this written protocol must be available upon request by Utah HIV Treatment and Care Program.

### Purpose of Home Visit Safety Protocol

Home visits are not required by this program. However, the majority of HIV Medical Case Managers conduct home visits for clients who are too ill to travel or have difficulty getting to the case manager’s office. Therefore, a written safety protocol is required for every HIV Medical Case Management program in Utah. HIV case managers conducting home visits have a duty to ensure reasonable care for their own health and safety. A safety protocol that clearly delineates the required standards and activities will assist HIV Medical Case Managers in Utah to safely provide home visits to clients.

### Process

If the local Utah Ryan White Program, Part B HIV case management contractor does not have a “Home Visit Safety Protocol” already developed, then one must be written and approved through the local approval mechanisms at the contractor site.

### Criteria

A written “Home Visit Safety Protocol” should be available at each HIV Medical Case Management agency .

### Documentation

A written “Home Visit Safety Protocol” should be available at each HIV Medical Case Management agency funded by Ryan White Program, Part B in Utah.

## Definitions

### Adherence (HIV Treatment Regimen)

Following the recommended course of treatment by taking all prescribed medications for the entire course of treatment, keeping medical appointments and obtaining lab tests when ordered.

Case managers can help clients identify and remove barriers that prevent them from taking medications properly and with a high degree of consistency. Maximizing the effectiveness of treatment is dependent upon identifying all of the elements in a client's life which affect their ability to follow the recommended course of treatment. This assessment should include six areas of client functioning: (1) Client education; (2) Motivation; (3) Self-efficacy; (4) Barriers to performance; (5) Remembering; and (6) Side effects.

### Advocacy

Advocacy is the act of assisting someone in obtaining needed goods, services or benefits, (such as medical, social, community, legal, financial, and other needed services), especially when the individual has had difficulty obtaining them on his/her own. Advocacy does not involve coordination and follow-up on medical treatments. (This should not be confused with appropriate Nursing intervention.) Whenever possible, advocacy should build upon, rather than fragment, agency cooperation and collaboration.

### Americans with Disabilities Act (ADA)

The ADA is a civil rights law passed by Congress in July of 1990 to protect people with disabilities from discrimination in public and private services and accommodations. Since HIV disease is considered a disability, the ADA protections apply to persons living with HIV/AIDS.

### Biopsychosocial

A comprehensive picture of a person containing information about her/his physical (bio), psychological and social health.

### Broker

To act as an intermediary or negotiate on behalf of a client.

### Service Plan

A written plan that directs the activities of the client and the case manager. The Care Plan delineates the case management goals and objectives required to coordinate and link the client to the continuum of health and support services required to manage their disease.

### Service Planning

An ongoing interactive process with the clients, where problems are identified and prioritized. Identified problems are addressed through a planning process that includes the development of goals, assigned activities and reporting on outcomes.

### CAREWare

Electronic database developed by Health Resources and Services Administration to collect

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Ryan White Program data.

### Client Record

A collection of printed and/or computerized information regarding a person using services currently or in the recent past.

### Confidentiality

The process of keeping private information private. Information given by a client to a service provider will be protected and will not be released to a third party without the explicit written permission of the client or his/her representative. Information may be released only in the following circumstances: (1) When a written release of information is signed by the client; (2) When there is a clear medical emergency; (3) When there is a clear and imminent danger to the client, case manager or others; (4) Where there is possible child or elder abuse; and (5) When ordered by a court of law.

### Coordinated health care

Health care services related to the treatment of HIV/AIDS infection and HIV/AIDS associated complications, as well as the maintenance of health status.

### Criteria

Definition of specific, measurable outcomes expected from a Standard.

### Cultural Competency

Refers to whether service providers and others can accommodate language, values, beliefs and behaviors of individuals and groups they serve.

### Demographic Information

Descriptive information which may include, but *are* not limited to, age, race/ethnicity and gender. This information provides a profile of people receiving services from a specific agency.

### Emotional Support, Counseling and Therapy

While the terms emotional support, counseling and therapy are often used interchangeably, they suggest activities with somewhat different purposes in the context of HIV Medical Case Management. All, however, should have as their ultimate goal the empowerment of clients.

#### *Emotional support*

The ability of the case manager to listen and empathize is the essence of emotional support in the case management relationship. In cultivating a trusting relationship, it is important for the case manager to strike a balance between the empathetic role--utilizing active listening skills, developing rapport, and providing emotional support--and the objective role which requires engaging and encouraging the client toward concrete actions to achieve a desired outcome. Because case management is often defined as a task-oriented process, we tend to focus on the "doing" of tasks with the client,

and forget the importance of “being present”. Being truly available to offer emotional support is particularly important in situations where we do not have resources to meet the needs that clients present with.

### Counseling

Counseling is a solution-focused helping process that is outer-directed—the focus is on “here and now” problems in living—with the goal of improving the client’s ability to function in these areas. It is a strengths-based approach that enhances the client’s capacity to envision solutions and to recognize and utilize internal and external resources available to him or her, including resources that have worked in the past in overcoming difficulties. One of the most common examples of counseling in a case management relationship is crisis intervention.

### Therapy

Therapy refers to professional mental health interventions aimed at reducing clinical symptoms that interfere with an individual’s ability to meet the demands of daily life, and participate actively in his or her own health care. It falls outside the role of a case manager to provide mental health therapy to clients. Referring clients to appropriate mental health resources, and facilitating access to those services is the appropriate role for the case manager.

### Grievance

A verbal or written complaint or concern regarding a practice or policy of an individual or organization per the organization's policy.

### Health Education/Risk Reduction

Activities which include information dissemination about methods to reduce the spread of HIV; information about HIV disease progression; and information about the benefits of medical and psychosocial support services. This activity does not include medication or treatment information which is part of Adherence activities.

### HIPAA

Health Insurance Portability and Accountability Act, passed by Congress in 1996. This act is the first comprehensive federal protection of patient privacy. It also sets national standards to protect personal health information, standardize the way it’s used, and make health insurance more portable for consumers. Important changes include: (1) HIPAA will guarantee clients access to their medical records; (2) HIPAA will allow clients to limit the information that Oregon Department of Human Services (DHS) can disclose; (3) HIPAA will allow clients to review their records for accuracy and request changes; and (4) For certain national priority purposes, such as research or public health disease outbreaks, HIPAA will allow health information to be disclosed without authorization.

### May

Permissive, but not to be interpreted as an enforceable requirement.

### Must

Indicates condition, action, etc., as mandatory and enforceable.

### Multi-Disciplinary Team

A team that includes professionals representing the disciplines required for a holistic approach to meeting the needs of a client, as identified through the Assessment. At a minimum, the team consists

## DEFINITIONS

of the Medical Care Provider and the HIV Case Manager.

### Process

A step-by-step method to gather information or conduct an activity.

### Quality Assurance/Improvement

A method of program/service evaluation, which is designed to assure, as best possible, that the highest quality of services, are provided to the client.

### Ryan White Program

Passed by Congress in 1990, the purpose of this federal Act is to provide emergency assistance to communities that are most affected by the HIV epidemic and to make financial assistance available to state and other public or private nonprofit entities. This assistance provides for the development, organization, coordination and operation of more effective and cost efficient systems for delivery of essential services to individuals and families with HIV disease.

### Shall

Indicates condition, action, etc. as mandatory and enforceable, unless an exception is granted and/or required under funding regulations and/or Utah Department of Health discretion.

### Should

Indicates accepted industry standard and/or what is expected. May or may not be enforceable, but is subject to remediation.

### Standard

Authoritative statements by which a profession describes the responsibilities for which its practitioners are accountable. A rule or basis of comparison in measuring or judging capacity, quantity, content, extent, value and/or quality.

Treatment Plan -- A written plan of treatment and therapy developed by a medical provider.