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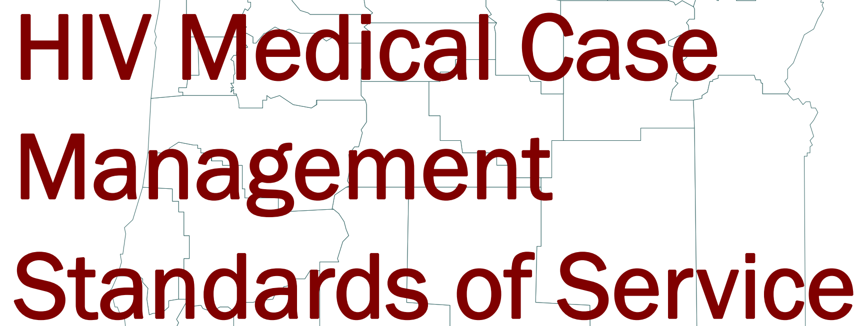

HIV Medical Case Management Standards of Service

HIV Case Management and Support Services Program

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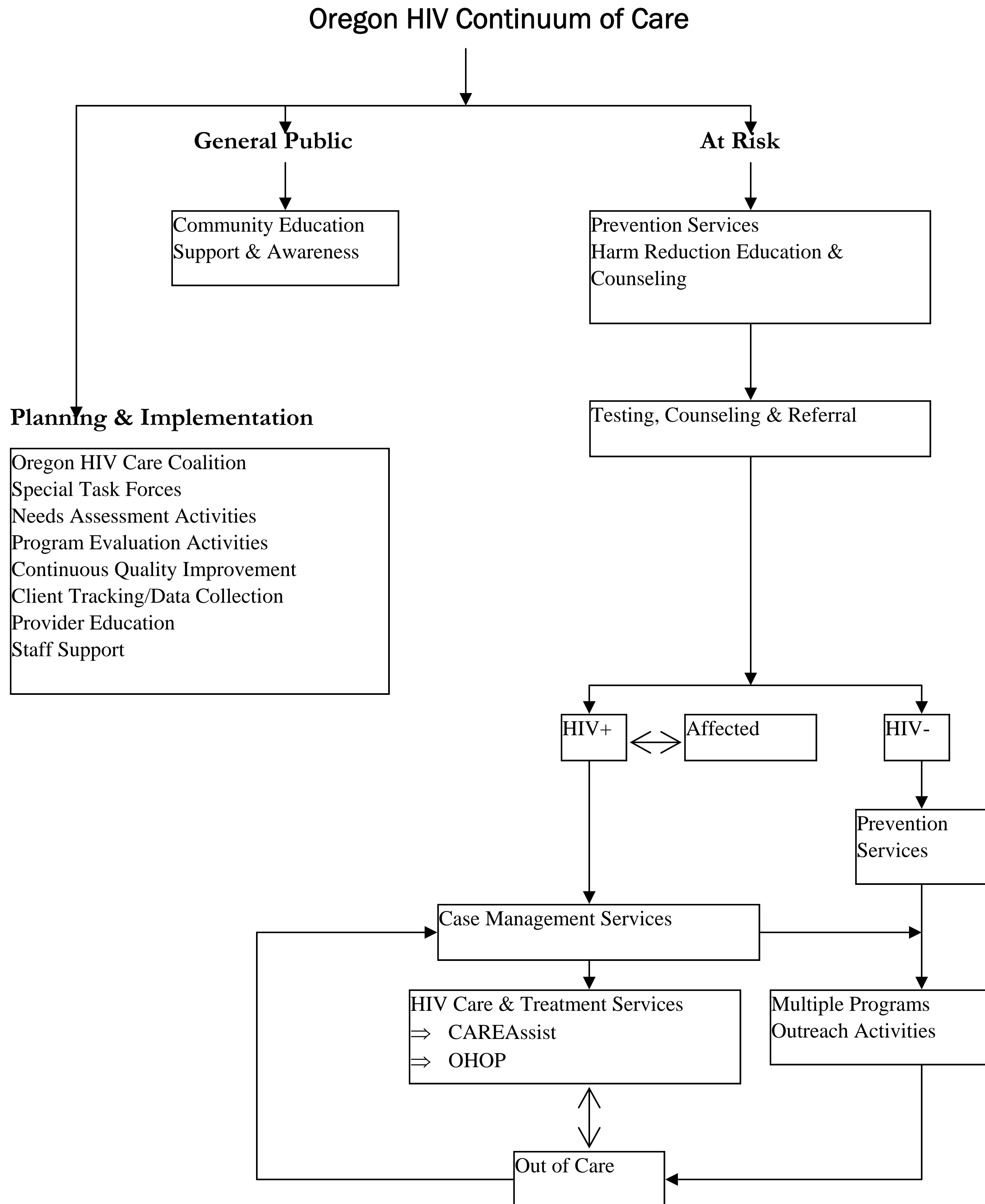
Oregon Overview

Oregon has a total population of 3,791,060 (Certified Population Estimate, July 1, 2008), most of which is clustered along a north-south highway corridor running the entire length of the state. The I-5 corridor runs between two mountain ranges (the Siskiyou Mountains and the Cascades) in the western third of the state. Portland is the largest metropolitan area and is located at the "top" of the State and is the city furthest north. Salem, the State capitol, is located about 1 hour south of Portland on I-5, followed by Eugene, Roseburg and Medford. Most Oregonians live in cities located along this corridor. Rural Oregon is composed of coastal communities with Coos Bay as the largest population center and Eastern Oregon with Bend, Pendleton and La Grand as the largest population centers. The largest geographic area of Oregon (almost 2/3 of the geographic area) is sparsely populated and is considered remotely rural.

According to the 2008 county certified population estimates, the Portland Transitional Grant Area (TGA) (Clackamas, Columbia, Multnomah, Washington, Yamhill counties) has a total population of 1,756,885 or 46% of the total state population. The I-5 corridor area (Marion, Polk, Benton, Linn, Lane, Douglas, Josephine and Jackson counties) has a total population of 1,319,120 or 35% of the total state population. All the rest of the counties represent 19% of the state population or a population of 715,055. (Deschutes has 23% of the remaining statewide total with a 2008 certified estimated population of 167,015, up from 115,367 in 2000.)

These 2008 numbers represent a shifting population in Oregon as more people are moving outside the Portland metropolitan area. However, HIV/AIDS prevalence does not necessarily follow these population trends, nor do health care delivery systems. Seventy (70%) percent of the Oregonians living with HIV who access the AIDS Drug Assistance Program (CAREAssist) live in the Portland metropolitan area. Twenty (20%) percent of people accessing CAREAssist live in the Corridor communities and the remaining ten (10%) percent live in rural Oregon.

Determining an exact analysis of where people living with HIV/AIDS (PLWH/A) live and access health care is problematic. Rural clients often have lower incomes and therefore qualify in greater numbers for the Oregon Health Plan (State Medicaid program). These clients would not be reflected in the CAREAssist numbers. AIDS counts per county are based upon place of diagnosis, not where the person is currently residing and receiving health care. Roughly, it is estimated that 2,000 PLWH/A are accessing Ryan White Part A services in the Portland TGA. The current reported HIV prevalence for the Part B service area is 1,301. Through RW CAREWare data reporting, we know that 884 unduplicated clients (68% of estimated prevalence) are accessing Ryan White Program, Part B services in area outside of the Portland metropolitan area.


Oregon HIV Continuum of Care
General Public
At Risk
Community Education
Support & Awareness
Prevention Services
Harm Reduction Education &
Counseling
Planning & Implementation
Oregon HIV Care Coalition
Special Task Forces
Needs Assessment Activities
Program Evaluation Activities
Continuous Quality Improvement
Client Tracking/Data Collection
Provider Education
Staff Support
Testing, Counseling & Referral
HIV+
Affected
HIV-
Prevention
Services
Case Management Services
HIV Care & Treatment Services
⇒ CAREAssist
⇒ OHOP
Multiple Programs
Outreach Activities
Out of Care

Oregon HIV Continuum of Care

The proceeding graph represents the HIV Continuum of Care in Oregon, as described by the Oregon HIV Care Coalition (OHCC) in its planning process. HIV impacts all Oregonians and community education, HIV support and awareness are issues impacting the general public in Oregon. Oregonians at risk for HIV infection are targeted for HIV Prevention Services and Harm Reduction Education and Counseling Services. Additionally, persons at risk for HIV are encouraged to access the HIV Testing, Counseling and Referral services available throughout the state. Oregonians who test negative for HIV continue to receive HIV Prevention Services. Oregonians who test positive for HIV are directed into the HIV care and treatment programs available in the state.

There are three Ryan White Programs providing HIV care and treatment services in Oregon: Ryan White Program, Part A; Ryan White Program, Part B and Ryan White Program, Part C. HIV service delivery in the five county Part A, known as the Portland TGA, (Columbia, Washington, Clackamas, Multnomah, Yamhill Counties and Clark County in the state of Washington) is administered by Multnomah County Health Department. A local HIV Planning Council sets service priorities and allocates Part A resources to the TGA. Ryan White Program, Part C funds an HIV Clinic located in Portland, also administered by Multnomah County.

Outside of the Portland TGA, local county public health departments are the primary providers of Oregon Part B HIV Continuum of Care services. This includes HIV Counseling, Testing and Referral (CTR), and HIV Medical case management, that creates an important link between public HIV testing and HIV care and treatment. All HIV clients outside of the Portland Part A TGA area are required to have an HIV medical case manager in order to access Ryan White Program, Part B-funded services. The allowable core services include medical care, medications/treatment, mental health treatment, outpatient substance abuse recovery, oral health and any of the available supportive services such as housing, medical transportation, and nutrition. A new HRSA grantee, HIV Alliance in Eugene, receives funds to provide dental services to 15 Southern Oregon counties.

The support services funded under Ryan White Program, Part B are administered through two processes: (1) eligibility determination, authorization and payment by the HIV case managers at the local level and (2) payment reimbursement for HIV case manager authorized services by the state through a program called "State Managed Services." Services funded at the local level include: ambulatory/outpatient medical care which includes medical practitioner visit, prescription drug reimbursement, and laboratory costs; housing services to include rental assistance and deposits; nutritional services; oral health care; and medical transportation services. Services funded through State Managed Services include: home health care, mental health treatment, oral health care, and substance abuse treatment.

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/AIDS disease 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 disease 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 disease and its treatment
⇒ Understanding of and assistance with self-management skill building
⇒ 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

- ⇒ Medication use and control of side effects
- ⇒ Behavioral change related to lifestyle and activities
- ⇒ Pain control
- ⇒ Adjustment to change
- ⇒ Coping skills
- ⇒ Effective use of community resources
- ⇒ Changes in disease/symptoms

Approaches to self-management

- ⇒ Education and training
- ⇒ Interventions (i.e. nurse 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.
- ⇒ Symptom and medication side-effects action plan
- ⇒ 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. All people with HIV/AIDS accessing any Ryan White Program, Part B funded service must have a case management system Intake and an RN Assessment. Additionally, clients are required to participate in an annual RN Reassessment in order to maintain active status in the program.

2. All clients must have an identified medical payer documented in their client record within 30 days of Intake or clear documentation in the progress notes about why this program expectation was not met and what is being done to accomplish this priority.

3. Clients are required to receive services in the county of their residence. Clients are not allowed to be co-managed across multiple case management jurisdictions or to arbitrarily change case management providers without prior approval from the program. For case managers, program approval must be received prior to providing any case management services to a client who does not live the case manager's jurisdiction.

4. Oregon Ryan White Program, Part B funded HIV case managers may provide case management services to facilitate an HIV positive inmate's transition from a correctional facility to the community under the following circumstances:
   i. The incarcerated person will be released within 180 days; and
   ii. There are no other transitional case management or discharge planning services provided by the correctional facility.

   This case management service must include an Intake, a Psychosocial Assessment, a Nurse Assessment and the development of a transition Care Plan. Additionally, the case manager may determine that the incarcerated person will be released to another case management jurisdiction and then will facilitate the transition and referral to the other case manager, following the "Transfer Standards and Process" in the Oregon HIV Medical Case Management Standards of Service. 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, 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.

Oregon Case Management Values

The case management system should be:

- Client centered
- Committed to empowering the client
- Goal-oriented
- A flexible model
- Culturally proficient
- Efficient
- Cost-effective
- Accessible
- Collaborative

Supporting Values:

1. The system should assess different stages of need, provide different services based upon need, and should provide multiple access points to care.
2. Case management should be available to all clients free of discrimination based on gender, age, sexual orientation, race, ethnicity, religion, educational level, language, criminal history, substance use history, or ability to pay for services.
3. Case management should contribute to strengthening the community continuum of care.

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 the client is planning to harm themselves or others.

It is the case manager's responsibility to:
⇒ Offer accurate information to the client
⇒ Assist the client in understanding the implications of the issues facing them, and of the possible outcomes and consequences of decisions
⇒ Present options to the clients from which they may select a course of action or inaction
⇒ Offer direction when it is asked for, or when to withhold it would place the client or someone else at risk for harm

HIV Medical Case Management Program Requirements

Oregon Ryan White Program, Part B Model of HIV Medical Case Management
In Oregon the majority of HIV case managers are public health nurses who perform both nursing and social work activities. Some may use paraprofessionals to assist them with the intake process, psychosocial assessments, care planning and the referral and follow-up activities. A few sites also have trained social workers, mental health counselors or health educators as part of the HIV Medical case management team. The Oregon Part B 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 support 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.

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 the Oregon Health Plan (Medicaid), Medicare, CAREAssist, 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.
- ⇒ Nurse assessment, nurse plan and appropriate nurse intervention focusing on treatment adherence, nutrition, oral health, HIV transmission risk reduction and liver health.

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

Nurse Roles and Responsibilities
While the majority of Oregon's Part B funded HIV case managers are public health nurses who do both the nursing and psychosocial components of HIV case management, in a few sites the nurse does not do the primary case management functions but is responsible only for the required nursing components in this program: nursing assessment/reassessment, RN consultation, developing nursing plans, performing nursing interventions and providing client advocacy with the medical care system. The nurse is an integral part of a team focusing on positive outcomes for clients.

Functional roles of the nurse:

⇒ Face-to-face nursing assessment and reassessment to include history taking and an appraisal of the general overall appearance, demeanor and affect of the client. (Nursing Assessment Form and Nursing Assessment Acuity Form are required.)

⇒ Development of an individualized Nursing Plan, as appropriate.

⇒ Referral for medical evaluation and treatment.

⇒ Education and counseling about HIV transmission, disease management, risk reduction and harm education.

⇒ Case management of HIV medication therapy to include client education concerning risks and side effects, monitoring disease process to include lab values, monitoring client adherence and tolerance of medications.

⇒ Adherence, nutrition, liver health and oral health assessment (on Nurse Assessment Form) and interventions to include counseling, education and referral, as appropriate. (Mandatory: Adherence, nutrition, liver health and oral health assessment and action taken where "need for intervention" is identified.)

⇒ Nursing interventions and education about a variety of issues, as appropriate to both client assessed need for intervention and the nurse's trained skills. Interventions (education and/or counseling) may include (but are not limited to):

- Healthful living habits
- Holistic approach to wellness
- Safer sex practices
- Sexually transmitted diseases
- Partner notification and testing
- Prevention of exposure to opportunistic pathogens
- Teaching women to perform breast self exam
- Immunizations
- Managing a long-term chronic illness

Nurses are responsible for identifying the need for interventions and facilitating the client's access to an appropriate intervention. The nurse will either directly provide the intervention in the form of counseling and/or education and training or will refer the client to an appropriate resource to receive the intervention (for example, referral to a mental health counselor, a dietician, a substance abuse counselor, etc.)

(At a minimum, nursing activities should include: (a) treatment adherence counseling, (b) nutritional counseling, (c) oral health assessment, and (d) liver health assessment with education on Hepatitis in general and Hepatitis C in particular, for those clients with appropriate need identified during the Nurse Assessment.)

⇒ Providing information about available resources and services for clients and their support system.

⇒ Telephone triage (defined as a systematic way of prioritizing resources of medical treatment based on urgency of client needs.) The nurse receives calls from clients with complaints, questions, or reports of symptoms that require some action. The nurse will need to determine the seriousness of the encounter and decide on a plan of action. In some instances, immediate medical attention is advised, such that the client is directed to seek emergency department at-

tention. Other less urgent plans could involve advising the client to seek an immediate clinic or doctor's appointment.

⇒ Regular communication and client advocacy with the client's medical providers and other health and human service providers as appropriate.
⇒ Documentation in progress notes, on the required forms and in the CAREWare data base.

If a Ryan White Program, Part B funded HIV case management program requests the ability to provide the nursing component by utilizing RN staff outside of the Ryan White system, the following must apply:

1. A letter of agreement or understanding between each agency or provider employing the nurse) who will be providing the nurse requirement for the local case management program.
2. The nurse(s) will attend the HIV Care and Treatment New HIV Case Manager Training and perform all RN activities as identified in this document.
3. RN case management activities and time will be accurately entered in the client hard chart and RW CAREWare.

Psychosocial Case Manager Roles and Responsibilities

Psychosocial case management is provided by social workers, mental health counselors, health educators and any professional with related health and human service experience. The psychosocial case manager participating on a multidisciplinary team works in partnership with the nurse(s) to assess the needs of the clients, the client's family and support system, develops an individualized client care plan, arranges, coordinates, monitors, evaluates and advocates for a comprehensive package of services to meet the specific client's complex needs.

Functional roles of the psychosocial case manager:

⇒ Face-to-face Intake (Intake Form [and all required informed consent, confidentiality, grievance, release of information, and rights & responsibilities forms required] is required.)
⇒ Face-to-face psychosocial assessment and reassessment. (Psychosocial Assessment Form and Psychosocial Assessment Acuity Form are required.)
⇒ Development of a comprehensive, individualized Care Plan (to include the Nursing Plan and the Housing Plan, if appropriate.)
⇒ Coordination of the services and activities required in implementing the Plan.
⇒ Referral to appropriate agencies required to assist the client in achieving the goals and objectives identified in their Plan.
⇒ Client monitoring to assess the efficacy of the Plan.
⇒ Periodic re-evaluation and revision of the Plan as necessary over the life of the client.
⇒ Client-specific advocacy.
⇒ Review of client utilization of services.
⇒ Outreach and case finding activities.
⇒ Health education and risk reduction education and counseling.
⇒ Transfer and inactivation processes.
⇒ Documentation in progress notes, on the required forms and in the CAREWare data base.

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:
   a. Nurse Case Manager: Oregon licensed RN (BSN preferred)
   b. 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 Department of Human Services (DHS), HIV Care and Treatment-designated HIV Case Manager Training within 6 months of beginning employment as an HIV case manager.
3. All HIV case managers must complete DHS-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 Oregon. 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 public and to the client 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
Care Planning
Referral and Advocacy
Follow-up and Monitoring
Transfer and Inactivation
Evaluation of Client Satisfaction

Each of the following standards defines the PURPOSE of the Standard, the PROCESS or step-by-step method to conduct the activity, the CRITERIA, which further defines the specific activities required to meet the Standard. Where appropriate, the Standards also include a list of the appropriate DOCUMENTATION required.

Intake

Standard: Each prospective client who is referred and desires or who requests Ryan White Program, Part B funded 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 (as required under ORS 192.518-192.524) 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.

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 support services managed both by the local case manager and by the HIV Care and Treatment program at the State of Oregon Department of Human Services. 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 a local 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. Intake is initiated by a prospective client, his or her representative, or by a third party referral (verified at least verbally by client) to the case management agency.

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 directly or indirectly from the client/referral source and the prospective client is informed of agency services and limitations.
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 referral or 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 medication therapy, some level of case management intervention may need to happen prior to the formal Intake, Screening 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 DHS 8395** 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. Date/Source of referral, date of intake
b. Name, address (mailing if different), phone, message phone emergency contact Information
c. Location where client prefers/declines to be contacted
d. Emergency contact information
e. Age/Date of Birth
f. Gender
g. Racial and/or ethnic identification
h. Primary Care Physician/clinic, address, phone
i. Other health care providers (present and recent past), address, phone
j. Key contacts
k. Household members
l. Employment
m. Documentation of HIV status **(Mandated)**
n. Documentation of financial information/verification/proof of income* (**Mandated)** * (Visual verification is allowed with appropriate note on Program Requirements Checklist DHS 8391.)
c. Documentation of health insurance
d. Living situation
e. Education
f. Legal issues
g. Transportation
h. Availability of basic needs
i. Photo ID

j. Social Security Number (if available)
k. Release of Information **(Mandated)**
l. Client Rights and Responsibilities Form DHS 8392 **(Mandated)**
m. Informed Consent **(Mandated)**
n. Client grievance procedures **(Mandated)**

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, must include verification of at least one of the following:
   a. A current CAREAssist client.
   b. A copy of HIV+ test results sent directly to you from a lab or physician.
   c. Lab results at any time during the client's lifetime that show the presence of the human immunodeficiency virus (a detectable viral load) sent directly to you.*
   d. Written verification from another HIV case manager who has one of the above documents in the client's file.

   *If a copy of test results is not available or the lab work shows undetectable viral load, a new antibody screening must be performed.

   Exemption from the requirement to secure verification of HIV status is granted when a person who is affected, but not infected, is determined to be appropriate for case management services. However, as per HRSA guidelines, **if case management services are provided to a client who is affected, but not infected, there must be clear rationale documented in the client file that the services offered will directly benefit a person living with HIV/AIDS.** Specifically, rationale will address one or more of the following:
   a. How the delivery of case management services to the affected client will allow him/her to participate in the care of someone with HIV/AIDS.
   b. How case management of the affected client will enable a person living with HIV/AIDS to receive needed medical, support or housing-related services by removing identified barriers to care.
   c. How case management of the affected client will promote family stability in coping with the unique challenges posed by HIV/AIDS.

6. Program Requirements Checklist: The **Program Requirements Checklist form DHS 8391** is begun during the Intake process. Income and HIV Verification are documented on this form. The Program Requirements Checklist also provides documentation that the following Intake forms have been reviewed, and signed where appropriate, with the client: Informed Consent, Client Rights & Responsibilities, Grievance, and Release of Information.

Psychosocial Screening and Nurse Assessment

Standard: Annually, each client of case management services will participate in at least one (1) face-to-face interview with a case manager for a psychosocial screening and at least one (1) face-to-face interview with a nurse for a nurse assessment.

Purpose of the Health Screening/Assessment

A Screening/Assessment is an information gathering process which includes a face-to-face interview between a client, nurse and case manager and may include the acquisition of secondary data from health and human services professionals and other individuals. It is a cooperative and interactive process during which a client, nurse 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 screening/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 Screening/Assessment process is not to simply fill out the required forms.

There are two components in the Oregon HIV case management Screening/Assessment process: a Psychosocial Screening and a Nurse Assessment. Both the Screening and the Assessment are required. In the majority of Oregon's HIV case management programs, the HIV case manager is a public health nurse and they are responsible for doing both components. In programs with multidisciplinary teams of both nurses and psychosocial case managers, the appropriate professional does their component of the Screening/Assessment. The results of both are then integrated in the development of the client's Care Plan and in the final acuity determination.

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

Process

1. The Screening and Assessment are conducted by the nurse and case manager and are

performed in accordance with the standards and any written policies and procedures established by each respective agency, especially those related to confidentiality requirements. The Screening and Assessment are documented on the standardized **Psychosocial Screening Form DHS 8401 and the Nurse Assessment Form DHS 8402** included in the **Forms Package**. The process also utilizes the **Oregon Acuity Worksheet Form DHS 8397** included in the **Forms Package,** which is a tool to assist in summarizing the results of the process. Case managers may use professionals outside their agency to assist with the Screening/Assessment process (for example, a Housing Coordinator, a mental health counselor, a benefits specialist, etc.) Informed consent from the client is necessary to utilize additional consultations in the screening/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, nurse and case manager.
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 nurse, 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 medical case manager (nurse) 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 is enhanced if a summary of the Nurse Assessment findings and any areas recommended to be discussed with the medical provider are provided to the medical provider in a letter after the Nurse Assessment is completed.

Criteria

1. If the Screening and Assessment were not scheduled during the Intake process, the client is contacted to schedule an appointment. The Screening/Assessment is conducted in face-to-face meeting(s) between the client, nurse 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 Screening/Assessment should commence no later than seven (7) working days following Intake and should be completed within two (2) weeks from commencement. However, there may be factors which require a longer period of time to complete the Screening/ 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
   - ⇒ Cognitive Status
   - ⇒ 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)
⇒ Client's physical environment, questions regarding mobility in home and accessibility
⇒ Recreation and leisure
⇒ Activities of daily living
⇒ Transportation
⇒ Spirituality/religion
⇒ 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
⇒ Knowledge of legal rights and responsibilities regarding ADA and other pertinent HIV/AIDS laws
⇒ Intimate partner violence assessment
⇒ STD risk assessment
⇒ Medication history
⇒ Medication adherence assessment
⇒ Nutritional assessment
⇒ Immunization status
⇒ PPD test status
⇒ Hepatitis A,B,C tests status
⇒ At a minimum, annual CD4 and VL lab values (client self-reported not allowed)
⇒ Oral health

The Acuity Scale

Oregon's Part B-funded HIV Care and Treatment Program is a needs-based program which strives to provide the greatest level of support to clients with the greatest need. The Psychosocial Screening and Nurse Assessment process is utilized to determine level of need. A four-stage acuity scale is used as an additional part of the process and is completed **ONLY AFTER** the Screening and Assessment Interviews are completed.

- The Acuity Scale is a tool for the case manager/nurse to use, which complements the professional, needs-based Screening and Assessment interviews.
- The Acuity Scale is intended to provide a framework for documenting important Screening and Assessment elements and for standardizing the key questions that should be asked as part of a professional Screening and 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 Screening and Assessment processes 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: **13-22 points**

⇒ Initial face-to-face nursing assessment and psychosocial screening.
⇒ Annual face-to-face nursing reassessment and psychosocial rescreening.
⇒ Documentation in progress notes or CAREWare case notes.
⇒ Ongoing nurse consultation as needed.
⇒ Nurse and psychosocial Care Plan developed, appropriate interventions identified and ongoing follow-up provided.
⇒ **Care Plan Form DHS 8400** updated annually.

Level 2: **23-42 points**

⇒ Initial face-to-face nursing assessment and psychosocial screening.
⇒ Annual face-to-face nursing reassessment and psychosocial screening.
⇒ Minimum contact (telephone or face-to-face) every 6 months to verify address/phone number and to check on client's current status.
⇒ Ongoing nurse consultation as needed.
⇒ Nurse and psychosocial Care Plan developed, appropriate interventions identified and ongoing follow-up provided.
⇒ Care planning, goals, activities and outcomes documented on the **Care Plan Form DHS 8400** and updated every 6 months.

Level 3: **43-63 points**

⇒ Initial face-to-face nursing assessment and psychosocial screening.
⇒ Minimum annual face-to-face nursing reassessment and psychosocial re-screening.
⇒ Minimum contact (telephone or face-to-face) **every 30 days**.
⇒ Minimum evaluation of goals, activities and outcomes **every 30 days.**
⇒ Nurse must be consulted (see Nurse Roles and Responsibilities in Standards) on client's care planning goals, activities and outcomes (care plan). A nursing note and signature to show consultation must be in the client's file a minimum of **every 90 days.**
⇒ Nurse and psychosocial Care Plan developed, appropriate interventions identified and ongoing follow-up provided.
⇒ Care planning, goals, activities and outcomes documented on the **Care Plan Form DHS 8400** and updated every 6 months.

Level 4: **64-84 points**

⇒ Initial face-to-face nursing assessment and psychosocial screening.
⇒ Minimum annual face-to-face nursing reassessment and psychosocial rescreening.
⇒ Minimum contact (telephone or face-to-face) **every 2 weeks.**
⇒ Minimum evaluation of goals, activities and outcomes **every 2 weeks**.
⇒ Nurse is consulted (see Nurse Roles and Responsibilities in Standards) on client's care planning goals, activities and outcomes (care plan). A nursing note and signature to show consultation must be in the client's .

le a minimum of **every 30 days.**

⇒ Nurse and psychosocial Care Plan developed, appropriate interventions identified and ongoing follow-up provided.

⇒ Care planning, goals, activities and outcomes documented on the **Care Plan Form DHS 8400** and updated every 6 months.

Exceptions: * At the discretion of the Nurse Case Manager, release from a correctional facility may be a condition warranting an Acuity Level 3 during the first 90 days after release.
The Nurse Case Manager may assign an overall acuity of 3 or 4 if a client is assessed a level 3 or level 4 in the "Medical Needs" life area. Follow-up standards for these acuity levels will apply.

Documentation of Elements of the Screening and Assessment
(To be taken into consideration as part of the Screening and Assessment)

a. Nurse assessment conducted face-to-face with the nurse/nurse case manager and **Nurse Assessment Form DHS 8402** completed.
b. Psychosocial screening conducted face-to-face with the psychosocial case manager and **Psychosocial Screening Form DHS 8401** completed.
c. Other screening and assessment data acquired from other professionals and sources, if necessary, and documented in client file progress notes.
d. Completed **Acuity Worksheet Form DHS 8397** and Acuity Level assigned.
e. Completed **Program Requirements Checklist DHS 8391**.
f. Documentation of the screening and assessment process, findings, recommendations, referrals and care planning goals in the client file progress notes.
g. Development of a Care Plan and documented utilizing the **Care Plan Form DHS 8400**.

Psychosocial Rescreening and Nurse Reassessment

Standard: At least annually, all clients receiving case management services will have their needs reevaluated through a comprehensive face-to-face Psychosocial Rescreening and a comprehensive face-to-face Nurse Reassessment.

Purpose of the Rescreening and Reassessment

Clients are rescreened and 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. Rescreening and reassessment activities are also conducted in the event of significant changes in the client's life.

Process

Psychosocial Rescreening is conducted by the case manager and the Nurse Reassessment is performed by the Medical Case Manager and both are conducted according to established standards and criteria (see "Case Manager Program Requirements"). The process of rescreening and 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 rescreening and reassessment may involve the collaboration between case manager, nurse and other health and human service providers, individuals actively involved with the client, and through client record review.

There are two components in the process: a Psychosocial Rescreening and a Nurse Reassessment. Both components are required. In the majority of Oregon's HIV case management programs, the HIV case manager is a public health nurse who is responsible for doing both components of this process. In programs with multidisciplinary teams of both nurses and psychosocial case managers, the appropriate professional does their component. The results of the rescreening and of the reassessment are then coordinated in updating the client's care plan and in the updated acuity determination.

Criteria

1. Active clients in case management will be rescreened and reassessed, at a minimum, annually.
2. Case managed clients will be rescreened and reassessed more frequently in the event of significant changes in the client's life or as defined in process.
3. Rescreening and reassessment will include, but are not limited to, the original screening and 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 and completed **Nurse Assessment Form DHS 8402** and **Psychosocial Screening Form DHS 8401.**
4. Updated data and information acquired from health care providers and other professionals and sources.
5. Updated goals and activities reflecting the above input and review on the **Care Plan Form DHS 8400**.
6. Updated **Oregon Acuity Worksheet Form DHS 8397**.
7. Updated information on the **Program Requirements Checklist DHS 8391** including updated CD4 and VL values and date of lab test (client self-report is not allowed.)
8. Findings of both the rescreening and the reassessment summarized in the progress notes in the client file.

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 must 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 (this should not be confused with appropriate nursing intervention). 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.)

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. **The CAREWare Referral Module must 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 DHS 8400 must be updated annually for Acuity 1 clients and every six (6) months for Acuity 2,3 and 4 clients.

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 the 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 the statewide client satisfaction survey conducted by DHS 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.
3. 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.
4. 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 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 in their progress notes and on the **Care Plan Form DHS 8400**.
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 must be documented in the progress notes. Dates of follow-up, any contacts referred to and specific activities should be included in the documentation. **CAREWare must be used to track follow-up in the Referral Module**.

Care Planning

Standard: All clients of case management will have documentation of care planning as described above, including Level 1 clients, whose goal(s) may be as simple as a goal to schedule the annual Rescreening and Reassessment processes.

Every client in HIV Medical Case Management will have a current **Care Plan Form DHS 8400** completed, dated and the Medical Case Manager. The client may also sign the Care Plan, at the discretion of the case manager. The Care Plan Form DHS 8400 must be updated annually for Acuity Level 1 clients and every six (6) months for Acuity Level 2, 3 and 4 clients. 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 Care Plan. Documentation of the client's success in achieving their self-management goal(s) must be included in the client's file.

Purpose of Care 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, Psychosocial Screening and Nurse Assessment, it should naturally follow that this information will form the basis of care planning.

Process

Care planning provides the basis from which the nurse, case manager and the client to 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 Care Plan, it is necessary to come to an agreement about what tasks will be done by the case manager and what the client will do [Care 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 care 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.

Process

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 **Care Plan Form DHS 8400** for each client, care 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 file.

Incorporating Housing Plans in Care Planning

HIV Care and Treatment Program also administers a Housing Opportunities for People Living With AIDS (HOPWA) grant that provides for housing assistance to clients in HIV case management outside of the Portland TGA. Housing Coordinators are employed to assist HIV clients and their families find the most stable solutions to their housing needs across a wide spectrum of housing services available in Oregon. The Housing Coordinators will develop a Housing Plan with each client referred to them by an HIV case manager. A copy of this Housing Plan should be included in the HIV Medical Case Management file.

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 (s) 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. When inactivating you must change the "Vital Enrollment Status" in RW CAREWare. Enrollment Status in RW CAREWare is defined as "Active", "Inactive/Case Closed", "Deceased" or "Unknown". The "Unknown" option should not be used.

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 enters prison

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 moves out of the case manager's geographic service area
4. Client becomes self sufficient
5. Client is unwilling to participate in care planning
6. Client exhibits a pattern of abuse of agency staff, property or services
7. Client needs are more appropriately addressed in other programs

Process

1. Reason for inactivation/case closure or transfer is discussed with the client and options for other service provision is explored and documented.
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 and the client's Vital/Enrollment Status should be entered as "Inactive/Case Closed" in RW CAREWare. Clients who are suspended <u>must</u> 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 Oregon Ryan White Program, Part B area:
If a client informs a case manager that they will be moving to another area in the Part B-funded regions of Oregon 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.
3. At a minimum, a copy of the most current Intake/Update Form, Psychosocial Assessment/ Reassessment Form, Nurse Assessment/Reassessment Form, HIV verification documentation and physician's notes (if applicable) should be sent via fax or mail to the new case management program.
4. If the Intake/Update and Assessments/Reassessments have been completed within the past six

(6) months, the new case management program may choose to not complete the entire process. They may choose instead to do a modified intake process, and obtain enough additional information to assist them in developing an understanding of the current Care Plan Form DHS 8400.

5. If the Intake/Update and Assessments/Reassessments were completed more than six (6) months prior to the transfer, the new case management program should complete a new Intake and new a Psychosocial Screening Form DHS 8401 and Nurse Assessment Form DHS 8402.

Criteria

1. A client is considered "lost to follow-up" when a case manager has made a minimum of 2 good faith attempts to contact the client, with no response from the client. This can be done through either phone messages, letters, provider contacts, or home visits.
2. After the attempts, in cases where there has been no response from the client, a certified letter indicating intent to inactivate should be mailed to the client's last known mailing address. The letter should state that if the client has not responded within 2 weeks or at the discretion of the case manager, their file will be closed.

Documentation

The inactivation summary is included in the Progress Notes in the client's file. The client's Vital/Enrollment Status should then be entered as "Inactive/Case Closed" in CAREWare.

SAMPLE Suicide Threat: Guidelines & Policy

Disclaimer: *The Oregon HIV Care & Treatment Program (the Ryan White Program, Part B Grantee) requires that, as part of the required HIV Medical Case Management Psychosocial Screening and Rescreening, the screening questions related to suicide only be asked if there is a written agency policy on suicide threats in place. This "Sample Suicide Threat: Guidelines & Policy" document is offered only to assist contracted agencies providing HIV Medical Case Management to develop their own written agency policy. This sample document is not the final required policy. All contracted agencies should work with their own agency management and legal counsel to develop a written document that meets the requirements of the agency.*

Background

Transient suicidal thoughts are common in some people throughout the course of HIV disease and do not usually indicate significant risk of suicide. However, persistent suicidal thoughts with associated feelings of hopelessness and intent to die are very serious and must be assessed promptly and carefully. The risk of suicide is especially high for patients who are depressed and for those at pivotal points in the course of HIV infection.

Many events may trigger suicidal thoughts among persons with HIV. Such events may include learning about their positive HIV status, disclosing to family or friends, starting antiretroviral therapy, noticing the first symptoms, having a decrease in CD4 counts, undergoing a major illness or hospitalization, receiving an AIDS diagnosis, losing a job, experiencing major changes in lifestyle, requiring evaluation for dementia, and losing a significant relationship.

Risk factors for suicide attempts include the following:

- Abandonment by, or isolation from family, friends, or significant others
- Age, especially teen years or >45 years of age
- Recent or current illness
- Any acute change in health status
- Fear of HIV-associated dementia
- Financial difficulty
- Hopelessness
- Multiple losses or recent stressors
- Pain
- Perception of poor prognosis
- Perception of poor social support
- Previous suicide attempts
- Substance abuse, especially alcohol
- Relapse into drug use after significant recovery
- Severe anxiety, depression, or other mental health disorder
- Social isolation (eg. Being single, divorced, or alone, or experiencing the death of a spouse)
- Stigmatization due to illness, sexual orientation, substance use history, or other factors.

SAMPLE Suicide Threat: Guidelines & Policy

Symptoms to Watch For

The client expresses or exhibits, or a personal care giver discloses:

- ⇒ Active suicidal ideation with intent and a plan, such as giving away significant person belongings, saying goodbye, gathering the means (eg. Gun, pills), writing a suicide note.
- ⇒ Passive withdrawal from therapy or medical care or decreased adherence (eg. Stopping medications, missing appointments.)
- ⇒ A desire for HIV disease to progress more rapidly.
- ⇒ Long periods of depression or other mental illness.
- ⇒ Previous suicide attempts.
- ⇒ Drug/alcohol abuse.
- ⇒ Apparent "change in personality."
- ⇒ Accident proneness.
- ⇒ Reckless or thrill-seeking behavior.
- ⇒ Clingy/dependent upon others.
- ⇒ Symptoms associated with Mood Disorders:
  - Low self-esteem / self denigration
  - Withdrawal from family/peers
  - Feelings of hopelessness and helplessness
  - Loss of interest in previously enjoyed activities
  - Loss of interest in personal hygiene and appearance
  - Agitated, irritable, aggressive
  - Inappropriate mood changes
  - Sleep disturbance
  - Low energy
  - Morbid thoughts

Management of Suicide Threat

Policy

The HIV Care & Treatment Program will address all suicide threats seriously and intentionally. The goal of the program is to screen all clients for mental health in a preventative manner to determine the need for treatment, to include questions about suicidal ideation during the annual assessment. Due to the level of professional relationship between clients and the HIV Medical Case Manager, case managers may recognize that a client is in crisis or exhibiting warning signs indicating contemplation of suicide. The following procedures pertain to two levels of intervention based upon the skills level of the responding staff: (1) response when the case manager is also a licensed mental health counselor or the case management team (if there is a multi-disciplinary case management team at the site) includes a licensed mental health counselor; and (2) response when the case manager is not a licensed mental health counselor and the case management team does not include a licensed mental health counselor.

First, and foremost, the client's safety must be ensured. Decisions as to how to safeguard the client should be made, whenever possible, with the client's active participation in the decision-making process. While it

is the intention of the program that all signs and indications of crisis be addressed immediately, high risk suicide threats should be directed to the appropriate suicide prevention hotline, non-emergency police, psychiatric crisis center, or appropriate crisis services available in the local community. Lower or medium risk suicide threats will, in most cases, be addressed through appropriate referral and follow-up. Case managers who have licensure to provide mental health counseling are advised to address suicide threats in compliance with the guidelines of their licensing organization.

All suicide threats, warning signs or crisis situations will be reported to the HIV Medical Case Management supervisor and to the other members of the HIV Medical Case Management team (if such a team exists). If a current Release of Information exists for the client's mental health provider, they will be notified of all suicide threats. The Nurse Case Manager will also notify the client's primary medical provider of all suicide threats.

Procedures

Suicide Risk Assessment

(This tool can be used to help assess the level of risk. Circle the appropriate item in each row. The category with the most items circled will determine the level of risk.)

	Lower Risk	**Medium Risk**	**High Risk**
1. Suicide Plan (a) Details	Vague	Some specifics	Well thought out; knows when, were, how
(b) Availability of means	Not available, will have to get	Available, has close by	Has in hand
(c) Time	No specific time or in the future	Within a few hours	Immediately
(d) Lethality of method	Pills, slash wrists	Drugs and alcohol, car wreck, carbon monoxide	Gun, hanging, jumping
(e) Chance of intervention	Others present most of the time	Others available if called upon	No one nearby; isolated
2. Previous suicide attempts	None or one of low lethality	Multiple of low lethality or one of medium lethality; history of repeated threats	One of high lethality or multiple of medium lethality

3. Stress	No significant stress	Moderate reaction to loss or environmental changes	Severe reaction to loss or environmental changes
4. Symptoms (a) Coping behavior	Daily activities continue as usual with little change	Some daily activities disrupted; disturbance in eating, sleeping, taking meds, work	Gross disturbances in daily functioning
(b) Depression	Mild; feels slightly down	Moderate; some moodiness, sadness, irritability, loneliness and decreased energy	Overwhelmed with hopelessness, sadness, and feelings of worthlessness
5. Resources	Help available; significant others concerned and willing to help	Family and friends available but unwilling or unable to help consistently	Family and friends not available or hostile, exhausted, injurious
6. Communication	Direct expression of feelings and suicidal thoughts	Interpersonal suicide goal (“They’ll be sorry – I’ll show them.)	Very indirect or nonverbal expression of internalized suicidal goal (guilt, worthlessness, hopelessness)
7. Life Style	Stable relationships, stable personality, interacts appropriately	Recent acting-out behavior and substance abuse; acute suicidal behavior in stable personality	Suicidal behavior in unstable personality, emotional disturbance; repeated difficulty with family, friends, health and social service providers, law enforcement
8. Medical Status	Responding well to treatment, no current significant medical problems	Acute medical problems but actively engaged in medical care and adherent to treatment	Acute catastrophic medical problems and not adherent to treatment (including chronic missed appointments)

Activities/Interventions

Lower Risk

Licensed mental health counselor is also the case manager or is part of the team

⇒ Continue monitoring/counseling.
⇒ Continue to use active listening and motivational interviewing techniques.
⇒ Client’s Care Plan includes goals and objectives to help reduce the risk level.
⇒ Refer to psychiatric/psychological counseling, as appropriate.
⇒ If the client is already engaged with a mental health provider and a current Release of Information exists, they will be notified.
⇒ The Nurse Case Manager will contact the client’s primary care physician.
⇒ Notify the case management program supervisor.

Case Manager who is not a licensed mental health counselor

⇒ Continue to use active listening and motivational interviewing techniques to encourage the client to access crisis services and on-going mental health services.
⇒ Refer client to mental health services.
⇒ If the client is already engaged with a mental health provider and a current Release of Information exists, they will be notified.
⇒ Case conference with the Nurse Case Manager attached to the program (if the case manager is not the Nurse Case Manager) immediately and prior to the client's next scheduled meeting with the client.
⇒ The Nurse Case Manager will contact the client's primary care physician.
⇒ Notify the case management program supervisor.

Medium Risk

Licensed mental health counselor is also the case manager or is part of the team

⇒ Interventions appropriate to the guidelines of their licensing organization.
⇒ Dialogue with client with the intent of client agreeing to not harm her or himself.
⇒ Verbal agreement is documented in the client file.
⇒ May develop a "Self Protection/No Suicide Contract" with the client.
⇒ Refer to psychiatric/psychological counseling, appropriate.
⇒ If the client is already engaged with a mental health provider and a current Release of Information exists, they will be notified.
⇒ The Nurse Case Manager will contact the client's primary care physician.
⇒ Notify the case management program supervisor immediately.

Case Manager who is not a licensed mental health counselor

⇒ Refer client to mental health services immediately.
⇒ If the client is already engaged with a mental health provider and a current Release of Information exists, they will be notified.
⇒ Case conference with the Nurse Case Manager attached to the program (if the case manager is not the Nurse Case Manager) immediately and prior to the client's next scheduled meeting with the client.
⇒ The Nurse Case Manager will contact the client's primary care physician.
⇒ Notify the case management program supervisor immediately.

High Risk

Licensed mental health counselor is also the case manager or is part of the team

⇒ Interventions appropriate to the guidelines of their licensing organization (could include scheduled telephone check-in with client; with client's consent, consultation with the client's family; voluntary hospital admission, etc.)
⇒ May develop a "Self Protection/No Suicide Contract" with the client.
⇒ Refer to psychiatric/psychological counseling, appropriate.
⇒ If suicidal ideation occurs when the office is closed or the client is unwilling to commit to not harming his or herself, the client will be given crisis services phone numbers and contact information.
⇒ For high risk threats to which the case manager cannot follow-up directly with the client, immediately contact the pre-determined crisis services (for example, non-emergency police) and request a safety check.
⇒ If the client is already engaged with a mental health provider and a current Release of Information exists, they will be notified.
⇒ The Nurse Case Manager will contact the client's primary care physician.
⇒ Notify the case management program supervisor immediately.

Case Manager who is not a licensed mental health counselor

⇒ Refer client to mental health crisis services immediately.
⇒ If suicidal ideation occurs when the office is closed or the client is unwilling to commit to not harming his or herself, the client will be given crisis services phone numbers and contact information.
⇒ For high risk threats to which the case manager cannot follow-up directly with the client, immediately contact the pre-determined crisis services (for example, non-emergency police) and request a safety check.
⇒ If the client is already engaged with a mental health provider and a current Release of Information exists, notify them immediately.
⇒ Case conference with the Nurse Case Manager attached to the program (if the case manager is not the Nurse Case Manager) immediately and prior to the client's next scheduled meeting with the client.
⇒ The Nurse Case Manager will contact the client's primary care physician.
⇒ Notify the case management program supervisor immediately.

Each HIV Medical Case Management program should insert the appropriate crisis service phone numbers into their procedures and make sure that all case managers have them readily available. It is further recommended that the key crisis services numbers (suicide/personal crisis / women's crisis services / child abuse) be available on a pre-printed card for all clients.

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 Oregon DHS, HIV Care and Treatment 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 Oregon. 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 Oregon to safely provide home visits to clients.

Process

If the local Oregon 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. The protocol should include the following information:

Standards of Home Visiting

1. All case managers should record where they are going in writing, according to local practices, such as in movement sheets/office diaries.
2. Staff at the HIV Medical Case Management agency should be notified about the planned home visit and should have a copy of information to include: the client's name, address, phone number and the expected return time.
3. Each case manager should report to a designated staff person on their return or telephone the designated staff person after they have left the home at the completion of the home visit.
4. A policy should include the steps to be taken if the case manager does not report in at the expected time. The policy should include specific steps, order of telephoning the case manager's cell phone, home number and the client's home number and the length of time that should elapse with no communication before contacting the police.
5. A code word that staff at the agency know and would be used during a phone check-in by the case manager during the home visit that indicates the case manager needs assistance should be identified.
6. All home visits should be scheduled during daylight hours.

1. Unless a risk assessment has been completed which indicates otherwise, initial home visits should be done in pairs.
2. All members of the staff doing home visits should carry a mobile phone, pager or personal alarm, or all of these.
3. The case manager should assess if the neighborhood or house appear unsafe. If the case manager is uncomfortable with the situation, the appointment should be rescheduled, and two staff member can return together at a later date/time. The client should be notified of the delay.
4. Case managers should not enter a home unless invited to do so.
5. It is the responsibility of each case manager to ensure their own safety, inform people of their whereabouts, and withdraw from situations where they feel at an unacceptable level of risk.

Criteria

1. A written "Home Visit Safety Protocol" should be available at each HIV Medical Case Management agency .
2. All HIV Medical Case Management agency staff will be familiar with the "Home Visit Safety Protocol" and will comply with the standards and rules of the protocol.

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 Oregon.

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.

Nurse 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.

Care 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.

Care 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 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 of the Medical Care Provider and the HIV Case Manager.

Outreach/Case Finding
Activities, which have as their principal purpose, identifying people with HIV disease so that they may become aware of and may be enrolled in care and treatment services. Outreach activities should be coordinated with the local HIV prevention outreach program. Activities should targeted to populations known to be at disproportionate risk; conducted at times and places where such individuals are likely to be reached; and be reportable and evaluated periodically for effectiveness in getting new clients with HIV enrolled in case management and medical care.

PHI
Protected Health Information. Health information, as defined by HIPAA and Oregon Department of Human Services (DHS) privacy policies, is much broader than "medical." It does include all aspects of physical and mental health information, alcohol & drug, and vocational rehabilitation. Federal Reg. 42, CRF 160.103 defines Health Information as: "any information, whether oral or recorded, in any form or medium, that relates to the past, present, or future physical or mental health or condition of an individual."

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 Oregon Health Division 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.

Department of Human Services
HIV Care and Treatment Program
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