STANDARDS OF CARE

FEBRUARY 2006

Oakland Eligible Metropolitan Area Care and Treatment Services

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CASE MANAGEMENT STANDARDS

AREAS OF REVIEW

I. DEFINITION OF SERVICES

OAKLAND EMA

Case management is defined as a range of client-centered services that links individuals with health care, psychosocial and other services through a plan which ensures timely and coordinated access to services.

HEALTH RESOURCES AND SERVICES ADMINISTRATION–HRSA

HRSA offers a range of client-centered services that links clients with health care, as well as, psychosocial and other services. Timely and coordinated access to medically appropriate levels of health and support services and continuity of care are provided through ongoing assessment of the client's and key family members' needs and personal support systems.

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.

CASE MANAGEMENT SUB–CATEGORIES

1. **Nurse Case Management:** A multidisciplinary team, usually at minimum a nurse and a medical social worker, co-manages care for clients with the most intense medical needs. Clients may be at home or in skilled nursing facilities. The nurse case manager monitors the medical status of the client in the home, assesses the client's functional capacities in relation to medical status, and organizes care in the home with referrals for nursing, attendant and hospice care services. The social worker arranges or plans for counseling, emotional and practical support, referrals and other assistance to the client and family members to promote self-management and maintenance in primary care. (Contra Costa)

2. **Psychosocial Case Management:** The primary role of the psychosocial case manager is to promote self-management to help more stable clients focus on staying well. Psychosocial case

managers encourage the reduction of self-destructive behavior (e.g., alcohol, drugs) by interacting with and facilitating family support and by advocating maintenance in primary care, support services and risk reduction.

3. **Short-Term Assistance:** Clients who access HIV/AIDS services at a minimum twice per year can receive either clinic-based or home-based services from medical social workers, who provide a blend of case management and entitlement advocacy services. (Contra Costa)

4. **Medical Case Management:** Clients may receive case management from clinic-based nurses and social workers during their primary care visits. (Alameda)

Staff Qualifications: Case managers may have a Bachelor's Degree in Social Work or related field, up to a Master's or Doctorate in Social Work. Three years of short-term assistance experience without a degree in social work or related field is acceptable. Positions that require a license will include the following: Licensed Clinical Social Worker, Marriage and Family Therapist (MFT), or Registered Nurse. Training in Disclosure Assistance Programs and/or Prevention with Positives may be required as part of service expectations.

II. PURPOSE OF SERVICE

The purpose of case management is to facilitate clients' access to the array of preventive health care and supportive services funded by the Ryan White CARE Act and other sources. Case management services should strengthen client and family member capacity to cope with the impact of HIV on their lives, and initiate and improve access to primary health care.

III. GOALS OF SERVICE

- To provide coordinated HIV services that improve the quality of health for clients in the Oakland EMA.
- To reduce the transmission of HIV in the Oakland EMA through prevention and education.
- To ensure that individuals, their families and significant others receive the services they require to cope with the impact of HIV on their lives.

IV. CLIENT CHARACTERISTICS, ACUITY LEVELS, AND NEEDS

Types of clients for case management services:

- **Active clients**: clients who have had a successful contact with HIV/AIDS services within the last 3-6 months. Agency caseloads should be largely comprised of active clients.
- **Inactive clients**: clients who have not had a successful face-to-face contact with HIV/AIDS case management services in 6-12 months.
- **Short-term clients:** clients who access HIV/AIDS services once per year. This criterion applies largely to clinic-based assistance and not to routine agency caseloads.

Acuity levels are assessed and assigned to each client to determine the type of case management services needed. An acuity scale, such as the Cognitive Functional Ability (CFA) Scale used by nurse case managers, may be used to determine level of care. Knowledge of a client's level of need may assist agency staff in determining the caseload, Full Time Equivalents (FTE) and Units of Service.

LEVEL I: (Functioning well)

Client level of need: Episodic.
Clients may be newly diagnosed and require short-term assistance; asymptomatic with no expressed stress or anxiety; seeking a primary care provider or support in accessing health care while maintaining health, employment, and daily living tasks.

Interventions at this level include:

- Client screening, intake, and identification of needs through a comprehensive assessment
- Orienting clients to case management
- Developing and reassessing care plans
- Collecting and documenting outcomes
- Providing information, education and counseling
- Arranging for or providing disclosure assistance and/or prevention with positives counseling
- Arranging for or providing assistance with clinic navigation
- Making appropriate referrals with proper consent and forwarding intake information to other service providers
- Supporting service coordination across the system of care

Client Caseloads: 100-125 active, unduplicated clients per 1 FTE (Full Time Employee)

LEVEL II: (Needs some assistance)

Client level of need: Repeated contacts presenting with multiple problems, may be experiencing early symptoms.

Interventions at this level include Level I and the following:

- Providing crisis intervention
- Assessing and assigning clients to appropriate level of care and nurse consultation

Client Caseloads: 50-100 active, unduplicated clients per 1 FTE

LEVEL III: (Fluctuating between severe episodes and periods of functioning in the community)

Client level of need: All clients enrolled at this level should have a nursing assessment to determine their eligibility for nurse case management services and eligibility for Medi-Cal Waiver or other State funded AIDS case management services.

Interventions at this level include Level II interventions and the following:

- Home assessment
- Health history
- Treatment adherence assessment

Criteria for referral include:

- A diagnosis of symptomatic HIV disease or AIDS
- A T-Cell count <200
- A significant reduction in ability to manage activities of daily living
- Have an attending physician willing to accept full professional responsibility for his/her medical care
- Not simultaneously enrolled in the Early Intervention Program, (EIP), State funded Case Management Program (CMP), AIDS Waiver, or similar program

Client Caseloads: The average caseload for the nurse case manager and the social worker is 25-40 clients and their respective families per 1 FTE.

LEVEL IV: (Severely impacted)

Client level of need: Health care needs at this level are considerable and are related to the progression of the illness. Case management recipients include all Level III individuals who have special needs, and new and ongoing clients with terminal-stage AIDS. Level IV clients have significant medical needs and may require referrals for Hospice care and/or end-stage disease planning. The case management team should provide the psychosocial resources for clients not receiving comprehensive hospice services. However, Level IV clients accessing comprehensive hospice services should not be denied access to psychosocial service providers with whom they have developed rapport.

Interventions at this level include Level III interventions and the following:

- Spiritual bereavement counseling
- In-home care, attendant/skilled nursing
- Pain management
- Nutritional supplements
- Durable medical equipment

Client Caseloads: The average caseload for both the nurse case manager and the social worker is 25-40 clients and their respective families per 1 FTE.

CLIENT ACUITY AND CASELOAD

STANDARD	MEASURE
0.1 Client acuity must be assessed at intake by using an approved EMA functioning scale or other acceptable tool (GAF, ASI, etc.).	0.1 Documentation in client record of the acuity level
0.2 Client caseload is determined by level of acuity, service activity and funding amount.	0.2 Supervisor determines appropriate mixture of acuity levels.

V. UNITS OF SERVICE

Services include all activities that are conducted with the client (e.g. face-to-face and telephone encounters), activities conducted on behalf of the client, appointment arrangements, referral follow-ups, case conferencing, etc. Multiple units of service per client are possible during any encounter. A case management Unit of Service (UOS) used for reporting purposes and for tracking service utilization is defined in the service contract by each local jurisdiction within the Oakland EMA and is defined as 15 minutes of service.

STANDARD	MEASURE
0.3 FTE per caseload and Units of Service must be reflected in the case management workplan.	0.3 Documentation of FTE caseload and Units of Service.

VI. HIV CASE MANAGEMENT SERVICE ACTIVITIES

1. INITIAL ASSESSMENT OF SERVICE NEEDS

A. Client Outreach, Screening, Intake and Orientation

Services are offered in a way that overcomes barriers to access and uses resources to support positive health outcomes.

STANDARD	MEASURE
1.1 Agency staff screen each client for eligibility and conduct an intake assessment.	1.1 Documentation of HIV+ status, residence, identification and income in the client record within 30 days. Completed EMA form.
1.2 Staff schedules intake appointments within five (5) days of first contact for an on-site appointment and within ten (10) days for an off-site appointment, or documentation of why this has not occurred.	1.2 Documentation of initial intake appointment.
1.3 Each agency provides an orientation to enrolled clients.	1.3 Documentation of orientation. Signed consent, release of information, rights and responsibility form and grievance procedure.
1.4 Ineligible clients must be referred to another CBO or safety net provider must be provided.	1.4 Documentation of referral.
1.5 One case manager will be designated as the primary case manager and all decisions related to treatment planning should be coordinated through that staff person to other members of the treatment team.	1.5 Documentation of the primary case manager.

B. Comprehensive Needs Assessment

The purpose of this comprehensive assessment is to gain understanding of the clients current functioning, identifying their strengths and weakness, resources, and/or stressors in order to develop a relevant treatment plan which promotes maximum independent function and self-management.

STANDARD	MEASURE
1.6 Each client is provided an initial assessment, including: Level I and II: • Primary care connection • Awareness of safe sex practices • Sexuality issues • Living situation • Substance abuse history • Mental health/Psychiatric history • Financial/program entitlement • Family composition • Social community supports • Self-Management • Emergency financial assistance • Spirituality issues Level III and IV also include: • Current health status/Medical history • Current medications/Adherence • Client's home environment/safety check • Nutritional status assessment	1.6 Documentation in client record on the comprehensive client assessment forms, signed and dated, or agency's equivalent forms.

2. DEVELOPMENT OF A COMPREHENSIVE, INDIVIDUALIZED SERVICE/CARE PLAN

Individual Service/Care Plan Development

Case managers developing a service plan will, at a minimum, set realistic goals, objectives and timelines, based on identified needs; develop a "compliance contract", if applicable; identify resources to attain the goals and objectives, including collaboration with other relevant providers (e.g., substance abuse counselors, physicians, housing specialists).

STANDARD	MEASURE
2.1 A service/care plan is developed at intake and updated at least every six to twelve months. • Client and case manager establish new goals as the	2.1 Completed service/care plan in client file, signed by client and provider.

client's status changes. • Each agency will have a quality management plan activity to conduct clinical supervisory chart review to assess documentation of each client's needs.	2.1.1 Documentation of clinical supervisor's review (date and findings).

3. COORDINATION OF SERVICES REQUIRED TO IMPLEMENT THE PLAN

To assist the client in the implementation of the plan, case managers provide psychosocial support, advocacy, consultation, crisis intervention, risk reduction, California Disclosure Assistance and Partner Services (CDAPS), and referral to and coordination with other service providers involved with the plan.

STANDARD	MEASURE
3.1 All case management activities, including but not limited to, all contacts and attempted contacts with or on behalf of clients, are documented in the client record within one working day of their occurrence, including coordination with referral agencies.	3.1 Legible signed and dated documentation in client record. 3.1.1 Documentation in client record of necessity of specialty referral, follow-up required, and desired outcome.

Case Conferences

Interdisciplinary case conferences should be held for any client to coordinate care. Memorandums of Understanding or other standardized agreements may be necessary to ensure participation by the multidisciplinary team.

The client and/or his/her caregiver or legal representative may provide input to the case manager during case conference and telephone contacts.

STANDARD	MEASURE
3.2 During case conferencing a review of the service plan and an evaluation of the services the client is receiving should be reviewed, as well as the client's current status (coordinating care, trouble shooting problems with maintaining the client in care, bringing into care).	3.2 Appropriate documentation will be maintained in the client chart including names and titles of those attending the case conference, relevant information discussed, and whether the client or legal representative has input into the conference and the service outcome.

4. CLIENT MONITORING TO ASSESS THE EFFICACY OF THE SERVICE/CARE PLAN

Monitoring is performed routinely to review the success in achieving service outcomes as outlined in the service plan, to measure progress in meeting goals and objectives, and to revise the plan as necessary.

STANDARD	MEASURE
4.1 Staff documents outcome of service activities.	4.1 Documentation in • client record • outcome form/log • database/client contact form.
4.2 Staff provides constructive feedback to clients when reviewing the care plan.	4.2 Documentation in chart/record.

5. PERIODIC REASSESSMENT, REEVALUATION AND REVISION OF THE CARE PLAN

This process is designed to adjust the plan as clients complete their goals, or as needs change and additional resources and/or providers are indicated. The minimum activities include:

Reassessment

Face-to face reassessments provide information on the client's health and psychosocial status necessary to update and maintain the service plan.

STANDARD	MEASURE
Levels I and II 5.1 The case manager will coordinate a psychosocial review (CBO-based) at least every 6-12 months.	5.1 Documentation in the client record.
Levels III and IV 5.2 Face-to-face reassessments must be made every 60 days (minimally), and the nurse case manager must make telephone contact every 60 days (if the client has not been seen within that time frame). Refer to State Standards for more information	5.2 Documentation in the client record.

6. CLIENT TRANSFER OR GRADUATION

To transition clients through the various stages of the continuum case managers should refer to the case management manual.

Transfer of clients between case management programs

STANDARD	MEASURE
6.1 Transfer of clients between agencies will be initiated when (a) the client notifies the case manager that he/she has moved to a different service area or out of the EMA; (b) the client notifies the case manager of his/her intent to transfer services; (c) Client has followed the grievance procedure or (d) when agency no longer receives funding.	6.1 Documentation in client record.
6.2 Agency staff will have a system to graduate clients into a lower level of care as clients learn to manage themselves.	6.2 Graduation system included in agency procedure manual.

Discharge/Case Closure

A file should be closed when there has been a request for closure or when there has been no client contact for over 1 year. Prior to closure (with the exception of death), the agency shall attempt to inform the client of the reentry requirements into the system, and make explicitly what case closing means to the client.

STANDARD	MEASURE
6.3 The agency shall close a client's file according to the written procedures established by the agency, for reasons including, but not limited to: death, relocation, transition to another provider, or request of the client.	6.3Documentation in client record. 6.3.1 Retain files in a secure place for a minimum of five (5) years after the case is closed, seven (7) years for hospital records.

Client Disenrollment Process

Disenrollment may occur due to client death, client request, discovery of fraudulent documents, or no contact in 1 year. If the client is in agreement with or requests the disenrollment, it is not necessary to give the ten (10) day notice.

STANDARD	MEASURE
6.4 The client will be given notice, at least ten (10) days prior to date of disenrollment of services, or as soon as it is determined that the client is no longer eligible for services. A letter shall be sent to the client verifying the disenrollment date and reasons for the action.	6.4 Legible, signed and dated documentation in client record, e.g., copy of disenrollment letter.

7. ADDITIONAL KEY ACTIVITIES AND REQUIREMENTS

Emergency Financial Assistance (EFA)

Every client receiving EFA in the Oakland EMA must be seen by a case manager before disbursement of vouchers. (food, transportation, utilities, or housing)

STANDARD	MEASURE
7.1 Staff assesses clients for EFA eligibility and documents the need and referral in the care plan and/or progress notes.	7.1 Documentation in client record.

Waiting List

Waiting lists are required for those agencies with limited capacity to provide services. Clients must be informed about the agency's policy when asked to provide their name for a waiting list.

STANDARD	MEASURE
7.2 Agency staff maintains a current waiting list for case management services and a system to move clients off the list, including notification of community case managers.	7.2 Agency waiting list policy included in agency's procedure manual.
7.3 Staff refers clients to the intake coordinator or another case management agency when current agency's capacity for services is at the limit or is no longer funded.	7.3 Documentation in case record.

Crisis Intervention

Clients are offered a process that focuses on resolution of the immediate problem through the use of personal, social and environmental resources. The goals of crisis intervention are rapid resolution of the crisis to prevent further deterioration, to achieve at least a pre-crisis level of functioning, to

promote growth and effective problem solving, and to recognize danger signs to prevent negative outcomes.

STANDARD	MEASURE
7.4 The case manager at the earliest available appointment will see a client in crisis.	7.4 Documentation of incident and staff involved in client record. Documentation of resolution.
7.5 Agency staff may provide crisis and short-term counseling to clients or refer to appropriate provider.	7.5 Documentation of incident and staff involved in client record. Documentation of resolution.

- ***See Administrative Standards for additional requirements of all Ryan White Care Act service providers.***
- ***The Standards of Care will be reviewed every two years by the Oakland EMA Grantee Quality Management Staff to address changes in the scope of practice***.

Client Level Outcomes

Outcomes are benefits or other results (positive or negative) for clients that may occur during or after their participation in a program. Outcomes can be client-level or system-level. An **Indicator** is a measure used to determine, over time, an organization's performance of a particular element of care. The indicator may measure a particular function, process or outcome. An indicator can measure: accessibility, continuity, effectiveness, efficacy, efficiency, and client satisfaction. Data collected should be fed back into the quality management process to assure that goals are accomplished and improved outcomes are realized. The following indicators are recommended for **Case Management Services.**

- Increase in the number and percent of case managed HIV+ clients who keep primary medical care appointments consistent with their treatment plan.
- Increase in the number and percent of HIV+ clients who access community referral sources
- Increase in the number and percent of HIV+ clients with self-management goal setting
- Increase in the number and percent of HIV+ clients who complete at least 50% of their Individual Care Plan objectives