SAN FRANCISCO EMA RYAN WHITE HIV 2024 STANDARDS OF CARE UPDATE PROJECT

MEDICAL & NON-MEDICAL CASE MANAGEMENT STANDARDS OF CARE

NOTE: The draft standards below describe only service elements specific to Ryan White-funded case management services. Overarching standards common to all programs - such as standards related to client eligibility, insurance and benefits screening, facility standards, staff qualifications, evaluation, and use of Ryan White funds as the payor of last resort - will be included in a separate Common Standards document. This document will also be fully formatted in a future version.

OVERVIEW AND PURPOSE OF CASE MANAGEMENT SERVICES STANDARDS

The purpose of the San Francisco Eligible Metropolitan Area (EMA) Medical and Non-Medical Case Management Health Standards of Care is to ensure consistency among the Ryan White-funded case management services provided as part of the San Francisco EMA's continuum of care for persons living with HIV These minimally acceptable standards for service delivery provide guidance to programs so that they are best equipped to:

- Provide client-centered services that respect the client's rights, values, and preferences;
- Coordinate any and all types of services and assistance to meet the client's identified needs;
- Minimize barriers to needed medical and wraparound support services;
- Meet the specific and varied needs of HIV-positive clients using a multidisciplinary team approach;.
- Provide continuity of care for people with HIV within a comprehensive system of services throughout the course of their infection; and
- Appropriately address issues of consent, confidentiality, and other client rights for clients enrolled in services.

DESCRIPTION OF CASE MANAGEMENT SERVICES

Case management for persons living with HIV is a service that links and coordinates assistance from multiple agencies and caregivers who provide psychosocial, medical, behavioral health, and practical support to low-income and disabled persons living with HIV. The purpose of case management is to assist clients in obtaining the highest level of health, wellness, independence, and quality of life possible consistent with their functional capacity and preferences for care. Both medical and non-medical case management continually assess client needs and barriers to care and provide guidance, assistance, and advocacy to help clients access needed medical, psychosocial, community, legal, financial, and other needed services. Case management services can be delivered through many methods of communication including face-to-face contact, internet-based meetings, phone contact, and any other forms of communication deemed appropriate. **While both medical and non-medical case management assess clients and support access to and engagement in services, medical case management services are designed specifically to coordinate care to improve client health outcomes, with a focus on**

medical and healthcare service access and treatment adherence support, and are generally delivered in the context of clinical facilities and programs. Non-medical case management services have a more general focus and are designed to provide guidance and assistance in improving access to all needed services without a medical focus.

Case management encompasses the following activities or services as part of a multidisciplinary care team:

- Conducting an initial interview to confirm eligibility and collect basic client data;
- Conducting a comprehensive assessment of the client's existing health and functional status, social and familial support systems, income and insurance status, and housing and employment status, among other factors, while identifying psychosocial, medical, and social and practical support service needs and gaps;
- Developing and coordinating an individualized care plan in collaboration with each client based on the results of the assessment and on input from the multidisciplinary team, including an outline of goals, objectives, and activities to meet the client's needs in the context of the client's preferences for services and support;
- Continually implementing the care plan through ongoing accomplishment of the goals and objectives laid out in the Plan by the client and the case manager, including addressing critical and pressing client needs first;
- Ensuring timely and coordinated access to medically appropriate levels of healthcare and support services;
- Coordinating the services that the client receives from various service providers to ensure that the client receives the most appropriate combination of services possible and while avoiding unnecessary service duplication;
- Continually following-up and monitoring the client's care plan with client's caregivers and family members and with members of the multidisciplinary team as appropriate;
- Being available to respond to questions from clients or address emerging barriers and challenges in accessing or remaining in services;
- Assessing client satisfaction with services received to ensure that both the care plan and services are of high quality and that they continue to meet client needs in the most effective way possible; and
- Advocating for the client's access to needed services and support programs wherever appropriate.

Medical case management may also provide benefits counseling services that assist clients in obtaining access to public and private benefits and insurance programs for which they may be eligible when these services specifically support the goal of improving client health care outcomes.

UNITS OF SERVICE:

- **A Case Management Unit of Service is defined as:**

- ✓ 15 minutes of face-to-face, web-based, or telephone contact between a client and a case management provider or 15 minutes of activity that directly supports client health and access to services, such as researching client service options, advocating for expedited entry into essential programs, or securing and confirming initial client appointments.

CASE MANAGEMENT REQUIREMENTS:

All medical and non-medical case management programs and providers must provide the key activities listed below:

- **Initial Screening and Assessment:**

All clients referred to case management services will complete an **initial eligibility screening and comprehensive needs assessment interview** conducted by the case manager, generally but not always in the context of a face-to-face interview. The preliminary screening process is designed to ensure client eligibility and appropriate for case management services and to inform the client about the scope of services available through a case management program. During the preliminary screening, providers should:

- Determine whether the client is in a crisis situation and requires immediate service referral and assistance, and work to connect the client to emergency services;
- Determine whether the client's needs for social and practical support can be well served by the specific case management agency or provider and consider whether the case management program is culturally and otherwise appropriately matched to the client;
- Inform the client of the scope of services offered by the case management program, including the program's benefits and limitations;
- Inform the client of their rights and responsibilities as a participant in the program;
- Obtain the client's informed consent to participate in the case management program;
- Gather appropriate client information, including verification of client's HIV status and county address, and determine program eligibility; and
- In collaboration with the client, mutually agree on a decision to go forward with
- the client's enrollment in the case management program.

Following mutual agreement to enter into a case management relationship, the comprehensive needs assessment process will outline the client's current health and service status and identify existing resources, strengths, and service and support needs in order to develop a relevant treatment plan which allows the client to function and manage their condition as independently as possible. This assessment must be thoroughly documented, and must be client-centered, with the client having the option to defer or not to discuss any specific issues during the assessment). Assessment topics should include the following:

- Current health care and psychosocial services being received and from what providers, including any case management provided elsewhere;
- Current health status / medical history, including last and next medical appointment and

most recent CD4 and VL levels;
- Oral health and vision care needs;
- Current medications, levels of adherence, and barriers to adherence;
- Immediate health concerns;
- Substance use history and patterns;
- Mental health and/or psychiatric history and current behavioral health needs;
- Level of HIV health literacy;
- Awareness of safer sex practices and biomedical prevention interventions;
- Sexual orientation and gender identity;
- Sexual history;
- Treatment adherence history, including assessment of ability to be retained in care;
- Self-management skills and history;
- Prevention and risk reduction issues;
- Family composition and level of support;
- Current living situation;
- Languages spoken;
- History and risk of abuse, neglect, and/or exploitation;
- Social community supports;
- Transportation needs;
- Legal issues;
- Insurance, benefits, and income status;
- Emergency financial assistance needs and history;
- Nutritional status assessment;
- Cultural issues, including ethnic, spiritual, cultural, etc.; and
- Summary of unmet needs.

- **Individualized Care Plan:**

An individualized care plan must be developed during the initial assessment and re-evaluated at least every six months with adaptations as needed. Case managers developing an individualized treatment plan should ensure that the plan, at a minimum:

- Is individualized and fully incorporates client input;
- Identifies and prioritizes needs identified through the initial assessment;
- Identifies resources to meet the needs identified in the initial assessment and provides referrals to other relevant medical, behavioral health, psychosocial, and support services;
- Includes specific and measurable goals, objectives, activities, with a reasonable timeframe to meet each objective;
- Incorporates client preferences to ensure culturally appropriate and sensitive services; and
- Encourages the client's active participation in the development and implementation of the care plan with the goal of empowering the client and helping them achieve self-sufficiency.

Care plans developed by medical case managers should also be medically-focused¸ and centered around ensuring the client's ongoing engagement and retention in medical services

and HIV treatment. Clients being assessed for non-medical case management services who face particular barriers or issues around accessing medical care or treatment should be referred to medical case management wherever possible.

- **Monitoring and Reassessment:**

Both medical and non-medical case management should be seen as an **ongoing process** rather than a finite or time-limited set of objectives**.** Case managers should continually solicit feedback from clients regarding their satisfaction with services, and individualized care plans should be reviewed and revised at each appointment or as required by contract terms, and generally at least **every 6 months** following the initial assessment process. Care plans should also be revised when clients are facing new challenges or life circumstances, or when they face new unmet needs. Ongoing follow-up and monitoring of client care plans ensure that:

- The resources being provided or accessed are sufficient to meet the client's needs;
- Both the case manager and client are working toward their identified care plan objectives; and
- New or changing needs are continually addressed.

Key elements to be addressed during the care plan reassessment process include the following elements:

- Conduct a comprehensive reassessment of the client's medical, psychosocial, and financial condition and service needs;
- Record any changes that have occurred in the client's physical, mental, and psychosocial status since the last formal assessment was conducted;
- Review with the client the adequacy of client's social support network, including adequacy of caregiver support and ability of caregivers to provide needed psychosocial and practical support in light of any changes in client's condition;
- Assess changes in client's financial status or benefits that may affect the client's ability to meet their expenses;
- Discuss with client any legal and financial arrangements such as durable power of attorney, living will, and guardianship of children/dependents if applicable;
- Determine to what extent the goals of the care plan have been achieved since the previous assessment was conducted, including any barriers or obstacles that were encountered;
- Assess the satisfaction of the client with the level of care and services they have been receiving; and
- Assess whether the client requires an increase or decrease in the intensity of case management services the client receives.

- **Transfer and Discharge**

Transfer or discharge from case management programs occur when the case management program no longer serves the needs of the client, such as when a client has progressed to a

more advanced stage of infection and requires more intensive case management; when a client's health status or life conditions have improved to the extent that they no longer need case management services; or when a client moves out of the area, refuses further participation in the program, or is no longer eligible for the program. It is important to ensure that transfer and discharge are not carried out in an abrupt or disruptive manner, but result from a **planned and progressive process** that takes into account the needs and desires of the client and their caregivers, family, and support network. Before undertaking to transfer or discharge a client from case management services, providers should take the following steps:

- If the case manager assesses that the agency is no longer able to meet the client's needs, consult with the supervisor and other members of the multidisciplinary care team to develop a plan for discharging or transferring the client.

- Discuss with the client and their caregivers the decision to discharge the client from the case management program.

- Inform the client of other agencies that might better meet their needs for treatment and support and make arrangements to refer the client to another agency.

- Document in the client's record for the planned transfer or discharge and document in progress notes discussion with the client about planned transfer or discharge.

- Set a reasonable timeline for discharge or transfer that allows sufficient time for the client or their caregivers to make other arrangements for care or treatment.

- Discuss and document process for reinstatement of services should that become necessary and appropriate in the future.