# UTAH CASE MANAGEMENT STANDARDS OF CARE

UTAH DEPARTMENT OF HEALTH

**2019-2020**
**Ryan White Part B Program**
**Prevention, Treatment, and Care Program**
**Bureau of Epidemiology**
**Division of Disease Control and Prevention**

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| **TITLE:** Medical/Non-Medical Case Management Service Standards of Care<br>**PROGRAM:** Ryan White HIV AIDS Part B<br>**SECTION:** Core Medical and Support Services | ☐New<br>☒Revised<br>☐Reviewed | **DATE:** 7/31/2019 |
| **Executive Sponsor:** Utah Department of Health<br>**Policy Owner:** Case Management Coordinator<br>**Approved by:** RWB Client Service Manager | **ORIGINATION DATE:** 2012 | |

| Review/Revise Date | Title of reviewer | Description or Location of Change in Document |
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| 7/31/19 | Case Management Coordinator | • Restructure the formatting in Section 1.<br>• Restructure the content in Section 6.<br>• Update Signatures. |
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## SECTION 1.0 INTRODUCTION

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| **Effective Date:** *June 2019* | **Revision:** *7/31/2019* |

### 1.1 ACKNOWLEDGEMENT

According to the National Alliance of State and Territorial AIDS Directors (NASTAD) HIV/AIDS program Standards of Care are important to various stakeholders and the goal of these Standards is to improve client and public health outcomes. NASTAD highlights the benefits of establishing Standards of Care and emphasizes why these Standards are essential to numerous parties including consumers, service providers, grantees, and quality management personnel. Implementing Standards of Care helps establish a minimum expectation of service provision for the consumers accessing and/or receiving services. It defines the core components of each service category to be included in the model of service delivery for each funded service. This benefits the consumer and the service providers. Standards of Care allow the program to ensure consistency in the development, provision and access of use for all service contracted agencies and also allow for quality control personnel to provide a framework for service provision from which process and outcomes are measured.

The Standards of Care were developed with the contributions of other existing States, Health Resources and Services Administration (HRSA), NASTAD, current Utah Case Management Standards of Care, and the Ryan White Part B Program (Program) team and providers. The collaborative efforts ensure that people living with HIV in Utah are receiving the highest quality care possible at all times.

| Utah Department of Health | |
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| Melissa Dimond Director, Bureau of Epidemiology | Written confirmation on May 1, 2019 |
| Amelia Self Program Manager | Written confirmation on April 22, 2019 |

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| Tyler Fisher Ryan White Part B Manager Client Services | Written confirmation on April 24, 2019 |
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| **External Partners** | |
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| Peter Danzig HIV Prevention and Case Management Supervisor (Clinic 1A) | Written confirmation on July 26, 2019 |
| Jared Hafen Program Director (Utah AIDS Foundation) | Written confirmation on June 3, 2019 |
| Patrick Rezac Founder/Executive Director (ONE VOICE Recovery) | |

**Mission/Purpose**

The Utah Department of Health's mission is to protect the public's health through preventing avoidable illness, injury, disability, and premature death; assuring access to affordable, quality health care; and promoting healthy lifestyles.

**Vision**

The vision for the Ryan White HIV/AIDS Program at the Utah Department of Health is for Utah to be a place where all people can enjoy the best health possible, where all can live and thrive in healthy and safe communities, and that people living with HIV (PLWH) will be identified, appropriately treated, and achieve optimal health status, along with a reduction in new HIV infections.

*If you have questions about the Standards of Care, contact:*

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| **Effective Date:** *June 2019* | **Revision:** |
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## 1.2 DEFINITIONS

**Action Step**
A plan that lists what steps must be taken in order to achieve a specific goal in the service plan. The purpose is to clarify what resources are required to reach the goal, formulate a timeline, and responsible person that will complete the task(s).

**AIDS Drug Assistance Program (ADAP)**
Is the Program within the Utah Ryan White Part B Program that provides two services: ADAP-Medication Assistance (ADAP-M) and ADAP-Health Insurance Assistance (ADAP-I). The "Utah ADAP" refers to both services unless otherwise specified.

**AIDS Drug Assistance Program Health Insurance (ADAP-I)**
Is terminology unique to the Utah Ryan White Program and refers to Health Insurance Assistance Services through the AIDS Drug Assistance Program (ADAP).

**AIDS Drug Assistance Program Medication (ADAP-M)**
Is terminology unique to the Utah Ryan White Program and refers to Medication Assistance Services through the AIDS Drug Assistance Program (ADAP).

**Benefit Specialist (BS)**
Works in cooperation with medical case managers (MCM) and non-medical case managers (NMCM) to ensure clients receive and/or maintain eligibility for the Program. BS also assists clients to access medical and supportive benefits and educate clients on Program services.

**Case Management Agency**
Agency contracted by the Utah Department of Health for the Ryan White Part B Program to provide case management services.

**Case Manager**
Is a social worker, social service provider, nurse or health providers that focuses on MCM or NMCM. The case manager is involved with a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's needs based on their circumstances.

**Enrolled Client**
Refers to an applicant who has applied, is eligible, and has been approved to receive Program services.

**Discharge**
A client is discharged from the Program if they have achieved self-sufficiency, upon their voluntary request, when they relocate outside of Utah, if they fail to meet eligibility requirements, if they've been lost to follow up, or if they engage in inappropriate behaviors that may negatively affect self or others.

**Follow up**
Further observation of a client's service plan that needs continued monitoring.

**Goal**
An idea of the future or desired result that a client envisions, plans, and commits to achieve.

**Health Resources and Services Administration (HRSA)**
Is the federal entity that administers Ryan White funding.

**Initial Intake**
When case managers administering the Psycho-Social and the Utah Acuity Scale Assessments identify needs and barriers to provide a referral, if necessary, as well as set a Service Plan.

**Medical Case Management (MCM)**
Is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV Care Continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. MCM includes all types of case management encounters (e.g. face-to-face, phone contact, and any other forms of communication).

**New Applicant**
An individual living with or affected by HIV/AIDS who is applying to access services through the Ryan White Program and has not yet enrolled in the Program.

**Non-Medical Case Management (NMCM)**
Provides client guidance and assistance in accessing medical, social, community, legal, financial, and other needed services.

**Re-certification**
To maintain eligibility for Program services, clients must recertify every six months.

**Re-engagement**
Clients who have fallen out of HIV primary care, but are able to reestablish care through a case management agency or HIV provider.

**Referral**
The process of connecting or assisting a client with appropriate resources based on identified needs/barriers.

**Responsible Person**
Can be either a case manager, nurse, case management specialist, benefit specialist, or anybody who is involved in client's case.

**Transition**
Is when a client requests to be moved to a different case management agency, or when a case manager requests that a client be moved to a different case management agency due to the client's best interest.

| Effective Date: *June 2019* | Revision: |
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## 1.3 ABBREVIATIONS

**ACA:** Affordable Care Act
**ADAP:** AIDS Drugs Assistance Program
**ADAP-I:** AIDS Drugs Assistance Program Health Insurance
**ADAP-M:** AIDS Drugs Assistance Program Medication
**ART:** Antiretroviral therapy
**BS:** Benefit Specialist
**CDC:** Centers for Disease Control and Prevention
**CM:** Case Manager
**CMS:** Case Management Specialist
**CD4:** Custer of Differentiation 4
**DPI:** Direct Purchase Health Insurance
**EFA:** Emergency Financial Assistance
**ES:** Eligibility Specialist
**HAB:** HIV/AIDS Bureau
**HIPAA:** Health Insurance Portability and Accountability Act
**HRSA:** Health Resources and Services Administration
**IDU:** Intravenous Drug Use
**IPV:** Intimate Partner Violence
**MCM:** Medical Case Management
**MSM:** Men who have sex with Men
**NMCM:** Non-Medical Case Management
**NASTAD:** National Alliance of State and Territorial AIDS Directors
**PCN:** Policy Clarification Notice
**PLWH:** People Living with HIV
**PrEP:** Pre-Exposure Prophylaxis
**PSA:** Psycho-Social Assessment
**SAMSHA:** Substance Abuse and Mental health Services Administration
**SP:** Service Plan
**UAF:** Utah AIDS Foundation
**UASA:** Utah Acuity Scale Assessment
**UDOH:** Utah Department of Health

| Effective Date: *June 2019* | Revision: |
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## 1.4 UTAH OVERVIEW

As of 2017 the estimated population in Utah is 3,101,833; this is a significant increase from the 2010 census which confirmed a population of 2,763,885. The total surface area of the state of Utah measures approximately 84,899 square miles. Utah encompasses 29 counties; Daggett County has the lowest population with 1,029 people residing there, while Salt Lake County is the most densely populated, with approximately 1,135,649 people residing there. The majority of the population in Utah (around 2 million people) live in cities and towns along the Wasatch Front, a Metropolitan area running north-south with the Wasatch Mountains. In recent years, Utah has experienced significant population growth outside of the Wasatch Front area, and St. George (Washington County) is currently one of the top 10 fastest growing Metropolitan areas in the country.

The majority of Utah residents are White/Caucasian, accounting for 79% of the population. The remaining 21% of the population identify under the following demographics: 2% Asian, 1% American Indian or Alaskan Native, 1% Black or African American, 1% Native Hawaiian or Other Pacific Islander, and 2% of the population identifies as two or more races. Members of the Latino community make up the fastest growing ethnic community in Utah, growing from 13% of Utah's total population in 2010 to 14% in 2016. Nationwide, those from minority ethnic groups are disproportionately affected by preventable, communicable, and chronic disease.

As reported from the Utah-National Electronic Disease Surveillance System (UT-NEDSS), or EpiTrax, from the beginning of the epidemic through 2017, approximately 4,613 individuals have been diagnosed with HIV in the state of Utah, with 88% of that population residing along the Wasatch Front. The most current data available indicates that per 100,000 people, those who are middle aged (35-44 years) account for the majority of people living with HIV (PLWH) in Utah at 208 cases per 100,000 people; older adults (55+ years) account for 143 cases per 100,000 people; while young adults (0-34 years) only account for 28 cases per 100,000 people. Non-Hispanic Black individuals account for 878 cases of PLWH per 100,000 in Utah, while individuals who identify as Hispanic of all Races account for 145 cases per 100,000 people, and several other groups each account for 76-86 cases per 100,000 PLWH in Utah. Men who have sex with Men (MSM) are considered to be at highest risk, accounting for 55% of the diagnosed cases of PLWH in Utah; those who report both MSM and intravenous drug use (IDU) as risk factors account for 12% of the diagnosed cases, while those report only IDU as a risk factor account for 8%, and those who report heterosexual contact as a risk factor account for 9% of the diagnosed cases of PLWH in Utah.

| **Effective Date:** *June 2019* | **Revision:** |
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## 1.5 UTAH CARE CONTINUUM

According to the Health Resources and Services Administration (HRSA): "The principle intent of the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan White HIV/AIDS Program) is to provide services to persons infected with the Human Immunodeficiency Virus (HIV), including those whose illness has progressed to the point of clinically defined Acquired Immune Deficiency Syndrome (AIDS)."

The Utah HIV Care Continuum is a model that creates a framework outlining steps or stages of HIV medical care for PLWH that align with Ryan White HIV/AIDS Program. These steps consist of diagnosis of HIV infection, linkage to care, retention in care, receipt of antiretroviral therapy (ART), and achieving viral suppression. Utilizing a Care Continuum model assists in identifying where gaps may exist in linking and retaining PLWH to care, as well as inspires the implementation of improvements and service enhancements that better support individuals.

The goal of the Utah Ryan White Part B Program is to provide for the development, organization, coordination and operation of an effective and cost-efficient system for the delivery of essential services to individuals and families affected by HIV disease. Utah has implemented a care continuum in an effort to better support people who are at risk for HIV infection and PLWH in navigating and overcoming the challenges and barriers which may prevent them from accessing services or care.

The Utah Care Continuum includes both Prevention as well as Treatment and Care Programs efforts. Prevention efforts focus on providing and implementing services including harm reduction, HIV testing, education, and counseling. Persons at risk are also encouraged to utilize the testing, counseling and referral services available through community resources. It is recommended that those who test negative for HIV continue to utilize HIV prevention services, particularly PrEP. Treatment and Care efforts focus on ensuring that PLWH and those who have recently tested positive for HIV have access to the medical care and resources they need to effectively manage their health and meet their basic needs.

The Ryan White HIV/AIDS Program has various parts focused on meeting specific needs communities and populations have when affected by HIV/AIDS:

- Part A provides emergency assistance to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) that are most severely affected by the HIV/AIDS epidemic.
- Part B provides grants to States and Territories.
- Part C provides comprehensive primary health care in an outpatient setting for people living with HIV disease.
- Part D provides family-centered care involving outpatient or ambulatory care for women, infants, children, and youth with HIV/AIDS.
- Part F provides funds for a variety of programs, including Special Projects of National Significance (SPNS), the AIDS Education and Training Centers (AETC), dental programs and the Minority AIDS Initiative program.

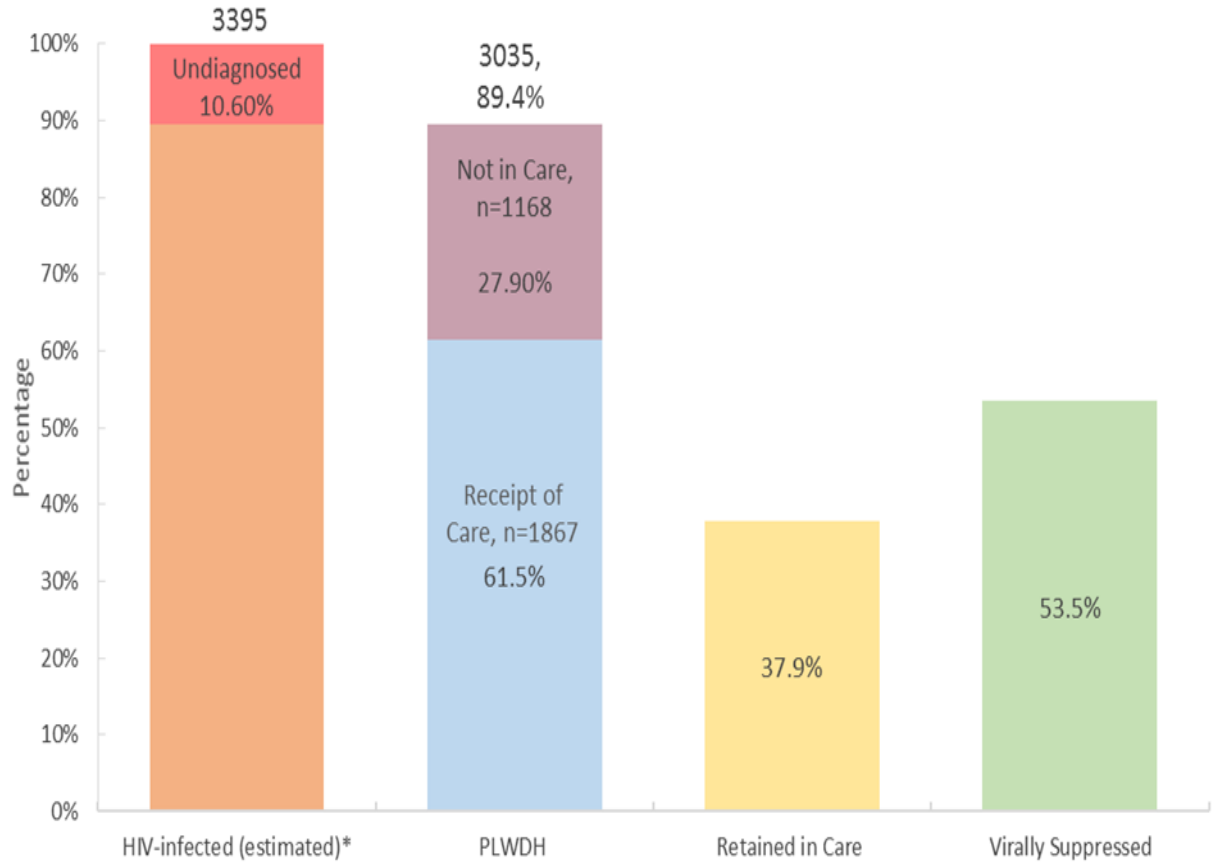
Currently, Utah receives Part B, Part C, Part D and Part F (AETC) funding. Please note the Standards of Care specifically address Part B Program expectations and requirements. For more information regarding Part C, Part D and Part F, please contact The University of Utah Hospitals and Clinics.

The University of Utah, Division of Infectious Disease at Clinic 1A and the Utah AIDS Foundation, both located in Salt Lake County, are the contracted providers for the Ryan White Part B Program care services for individuals who do not have sufficient health care coverage or financial resources for coping with HIV disease. The Program fills gaps in care not covered by other sources, which include AIDS Drug Assistance Program Insurance/Medication (ADAP-I and ADAP-M), Core Services (Ambulatory/Outpatient Care, Medical Case Management, and Oral Health) Supportive Services (Transportation, Emergency Financial Assistance (EFA)), and non-medical case management. The Program is the payer of last resort.

The University of Utah, Division of Infectious Diseases Clinic 1A, located in Salt Lake County, is Utah's recipient for Ryan White Part C and D services. Services covered under this funding include HIV-related medical visits and care, HIV-related lab work, and HIV-specific pharmaceuticals for clients who are deemed ineligible for Ryan White Part B Program due to eligibility criteria.

Utilizing a holistic case management approach is the key component of the Care Continuum that allows case managers (CM) to address many of the barriers which may lead to clients becoming confused, frustrated, disengaged, and detached from service. The CM plays a valuable role in the Care Continuum by linking clients to applicable services to alleviate their barriers so they can concentrate on their medical care while ensuring their basic needs are being met.

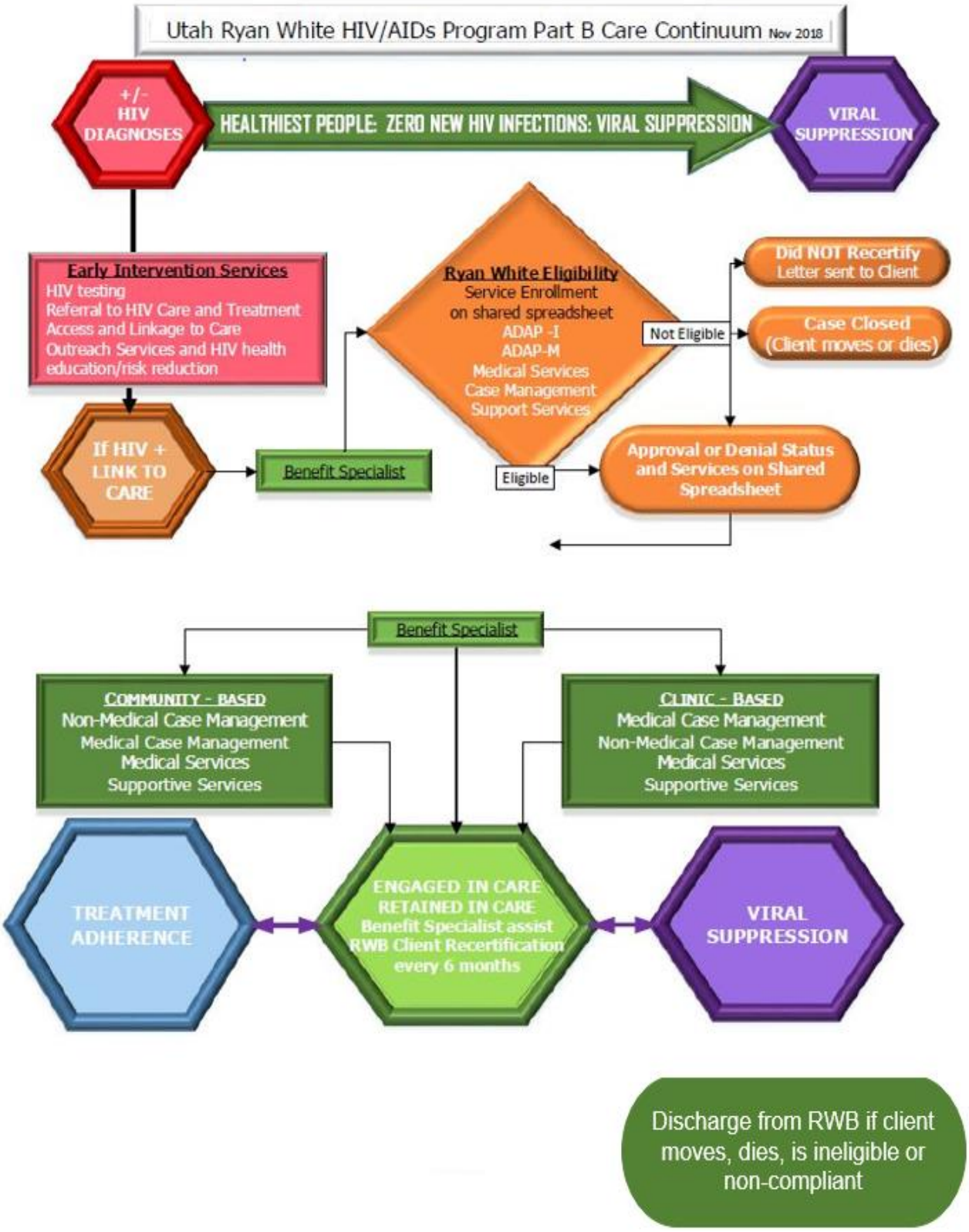

**HIV Care Continuum, Utah 2016**




*Estimated by applying Utah's HIV-prevalence estimate (89.4%) to the number of persons diagnosed with HIV infection through December 31, 2015 and alive as of December 31, 2016

**Data from multiple data systems were utilized to compile the above graph, including HIV Surveillance data from the enhanced HIV/AIDS Reporting System (eHARS) and the Utah-National Electronic Disease Surveillance System (UT-NEDSS).*

**Indicators measured in the above graph are directly adapted from CDC's guidance on HIV Care Continuum.*


Utah Ryan White HIV/AIDs Program Part B Care Continuum Nov 2018
+/- HIV DIAGNOSES
HEALTHIEST PEOPLE: ZERO NEW HIV INFECTIONS: VIRAL SUPPRESSION
VIRAL SUPPRESSION
Early Intervention Services
HIV testing
Referral to HIV Care and Treatment
Access and Linkage to Care
Outreach Services and HIV health education/risk reduction
If HIV + LINK TO CARE
Benefit Specialist
Ryan White Eligibility
Service Enrollment on shared spreadsheet
ADAP -I
ADAP-M
Medical Services
Case Management
Support Services
Not Eligible
Did NOT Recertify Letter sent to Client
Case Closed (Client moves or dies)
Eligible
Approval or Denial Status and Services on Shared Spreadsheet
Benefit Specialist
COMMUNITY - BASED
Non-Medical Case Management
Medical Case Management
Medical Services
Supportive Services
CLINIC - BASED
Medical Case Management
Non-Medical Case Management
Medical Services
Supportive Services
TREATMENT ADHERENCE
ENGAGED IN CARE
RETAINED IN CARE
Benefit Specialist assist RWB Client Recertification every 6 months
VIRAL SUPPRESSION
Discharge from RWB if client moves, dies, is ineligible or non-compliant

## SECTION 2.0 CASE MANAGEMENT OVERVIEW

| **Effective Date:** *June 2019* | **Revision:** |
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### 2.1 WHAT IS HOLISTIC CASE MANAGEMENT

Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's needs based on their circumstances. The goal of case management is to provide clients with a continuum of services by working with the client to identify appropriate resources that may assist in meeting their medical, socioeconomic, and psycho-social needs. CM's are social workers, social service providers, nurses or health providers, or anyone in a profession which works with clients to support them in developing effective and comprehensive systems of care and support to meet their needs and alleviate current or future barriers. CM core emphases consist of:

**Service:** CM applies her or his knowledge and skills to support the bio-psychosocial well-being of clients and to address challenges faced by clients. CM prioritizes services to clients beyond professional or personal self-interest.
**Social Justice:** CM pursues change to decrease poverty, discrimination, oppression, and other forms of social injustice experienced by individuals. CM provides services in a culturally and linguistically appropriate manner and acts on individual and systemic levels to ensure clients' access to needed information, services, and resources, and to facilitate clients' maximal participation in decision making.
**Human Dignity and Worth:** CM works with clients in a caring manner, respecting their self-determination, and valuing their strengths. CM strives to heighten clients' capacity to improve their situations and accomplish their goals.
**Integrity:** CM acts in accordance with the mission and values of their organization and practices ethical principles, ethical standards, and uses the power inherent in the professional role responsibly. CM embarks on all actions with respect for clients' goals, exercising judicious use of self, avoiding conflicts of interest, and applying professional judgment in presenting resource options and providing services to clients.
**Competence:** CM practices within her or his area of competence and persistently strives to develop knowledge and skills related to case management and the population served. CM recognizes that self-care is essential to being present for clients and attends to self-care accordingly.

| **Effective Date:** *June 2019* | **Revision:** |
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### 2.2 WHY IS CASE MANAGEMENT IMPORTANT FOR PEOPLE LIVING WITH HIV

According to Centers for Disease Control and Prevention (CDC) an estimated 1.1 million people were living with HIV in the United States at the end of 2015. Of those people, about 15% or 1 in 7, were unaware of their HIV status. The medical prognosis is immensely different today for those diagnosed with the disease than it was in the early days of the epidemic, when treatment was largely reassuring, and life expectancies following diagnosis were comparatively short. Today's treatments have altered HIV from what was once a perilous, terminal condition to what is today a chronic, manageable disease. Individuals with the virus have the potential to live long, productive, fulfilling lives, however; many people experience significant barriers which prevent them from accessing or receiving the benefits of available treatment options.

A high percentage of PLWH belong to populations historically underserved by traditional health care systems. Many PLWH struggle with homelessness, substance abuse/use, and mental health issues. Minority populations, including men who have sex with men (MSM), bisexual men, and people of color are disproportionately affected by HIV and often experience a number of barriers which may prevent them from accessing treatment and services.

Despite years of public awareness and education campaigns intended to dissipate misapprehensions about the disease, PLWH still experience a significant amount of stigma socially, within their communities and within health care systems which can depress them from seeking care. In addition, an HIV diagnosis may impact multiple areas of an individual's life, including biomedical, psycho-social, sexual, legal, social, and economic, and the impact in these areas may create additional barriers in accessing treatment and services. For those with access to long term treatment, HIV medications can be effective, but may be accompanied by substantial side effects that affect quality of life and add to the complexity of managing co-morbidities. Additionally, many people find it difficult to manage the cost of their HIV treatment, as co-payments can be quite costly, even with access to health insurance coverage.

PLWH often experience a variety of complex needs and barriers which can delay or disrupt treatment. Substantial evidence and research suggest that since the beginning of the HIV epidemic, case management services have been fundamental in linking individuals to programs and resources which seek to address a wide array of medical, socioeconomic, and psycho-social factors that may affect the function and well-being of PLWH and their families. The barriers and challenges present in the lives of many PLWH indicate that optimum care for PLWH requires a comprehensive approach in which CM services are of significant importance, as the CM offers support and links individuals to services, treatment, additional support, and monitors their delivery of care.

In order to provide effective case management to individuals, CM's can benefit from training in the following areas, regardless of their educational background:

- Case management process (Intake, Assessment, Service Plan development and implementation, Coordination of Services, Monitoring/Re-evaluation, and documentation)
- Interviewing
- Oral, written, and general communication skills
- Establishing rapport and maintaining relationships
- Knowledge of Ryan White Part B Program services
- Community organization/resources
- Basic working knowledge of HIV/AIDS
- Basic understanding of highly active antiretroviral therapy (HAART)
- Record keeping and documentation
- Knowledge regarding the current standards of HIV/AIDS care and case management processes

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## 2.3 CLIENT-CENTERED APPROACH TO HIV CASE MANAGEMENT

Carl Rogers is considered the founder of the client-centered approach, which he developed in the 1940s and 50s. Three elements are key to effectively practicing a client-centered approach: be unconditionally positive, be genuine, and practice empathetic understanding. The essential principle of the approach is that all people have an innate inclination to strive toward growth, self-actualization, and self-direction. Comprehending how the client identifies their needs, resources, and priorities for utilizing services to meet their needs is crucial if the CM relationship is truly going to be client-centered. One of the most difficult challenges for a CM is to see their client making a choice that will perhaps result in negative outcomes and which are in conflict with the CM's best guidance. In these situations, the CM must be

willing to let the client experience the consequences of their choices, while continuing to nurture and build the relationship between the CM and client, creating a safe space and place where the client can return for support without being judged.

It is the CM'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 decision.
- 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 withholding it would place the client or someone else at risk for harm.

| **Effective Date:** *June 2019* | **Revision:** |
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## 2.4 CHRONIC DISEASE MANAGEMENT

Chronic disease management utilizes an approach to health care that supports individuals in maintaining independence and optimum health through early detection and effective management of chronic conditions. This approach prevents deterioration, reduces risk of complications, prevents associated illnesses, and enables 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.

PLWH need support and information to become effective managers of their own health. Chronic conditions require not just medical interventions, but behavioral interventions as well. Clients with chronic conditions such as HIV 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 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 illnesses requires transforming a health care system that primarily responds when a person is sick and/or in crisis to one that is proactive and focused on providing a person with the information, services, and treatment they need to maintain ongoing good health. This requires not only determining what care is needed, but also clarifying roles and tasks in a structured, strategic way to ensure that everyone understands each person's role as part of the client's care team. It also requires making coordinated follow-up a part of standard procedures so clients are not left on their own once they leave the doctor's or CM's office. Clients with more complex needs require more intensive case management for a longer period to optimize clinical care, the effectiveness of their treatment regimen, and their self-management behavioral skills.

Effective self-management support does not entail telling clients what to do. Effective self-management support acknowledges the client's central role in their care, fostering a sense of responsibility for their own health. It includes the use of proven techniques and connection to resources that provide basic information, emotional support, and strategies for living with chronic illness. Self-management, however, cannot begin and end with a class. Using a collaborative approach, the CM and client work together to define problems, set priorities, establish goals, create service plans, and solve problems along the way. The key principles of chronic disease management and client self-management are:

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

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

| Steps | Actions |
|---|---|
| Step 1: Identify areas of need | • Impact of the illness<br>• Symptoms of the illness<br>• Medication side effects<br>• Lifestyle factors<br>• Strengths and barriers<br>• With the client, determine factors that will affect his or her capacity for self-management |
| Step 2: Planning (Service Plan) | • Determine stage of change<br>• Determine specific goals<br>• Prioritize goals<br>• Identify outcomes<br>• Determine realistic time frames<br>• Select interventions<br>• Document the service plan |
| Step 3: Management (Referral and follow-up) | • Achievement of goals<br>• Availability of resources<br>• Personal capacity |

**Stages of Change**

Prochaska and DiClemente developed the Stages of Change that consist of Pre-contemplation, Contemplation, Preparation, Action, and Maintenance. It is a trans-theoretical framework that allows social service providers (clinicians, case managers, social worker, or nurses) to meet clients where they are in relation to their readiness to change. Change should not be looked at as a linear process, but rather as a process that happens along a cyclical continuum. This is a valuable framework for the social service field, and can be applied to all clients no matter where they are in the process of change. The stages of change will allow the CM to identify where the client is in relation to readiness for change. It will encourage social service providers to focus on a strengths-based perspective when working with clients to select interventions that are compatible with the particular stage of change. This will empower clients to create autonomy by allowing clients to move toward positive change at their own pace. Below are goals and strategies associated with using Stages of Change with clients.

| Stages of Change | Goals | Strategies |
|---|---|---|
| *Pre-contemplation:* Not thinking of change | *Keep the door open for future discussions*<br>• Build rapport by joining with client<br>• Bring awareness to the surface<br>• Keep client engaged in the process | • Listen to concerns (reflective listing)<br>• Elicit information (past and current strengths)<br>• Communicate caring (empathy and non-judgement) |
| *Contemplation:* Think about change | *Keep the client thinking about change*<br>• Increase perceived benefits of change<br>• Boost awareness of options for change<br>• Keep client talking | • Develop discrepancy (reflect ambivalence)<br>• Role with resistance (step back if client become defensive)<br>• Past successes and optimism<br>• Explore extremes<br>• Measure commitment to change<br>• Support autonomy |
| *Preparation:* Preparing for change | *Help clients prepare for change* | • Clarify goals<br>• Negotiate change plan<br>• Encouragement and with permission, advice offering |
| *Action:* Changing behavior | *Decrease barriers to change*<br>• Increase confidence<br>• Help to problem-solve | • Coach on process of change<br>• Reduce barriers<br>• Restrain excessive change |
| *Maintenance:* Maintaining change and prevention relapse | *Sustain gain made*<br>• Help client stay focused<br>• Reduce chance of relapse<br>• Normalize relapse | • Predict ups and downs<br>• Enlist support<br>• Plan for relapse prevention<br>• When relapse occurs, reassess |

| **Effective Date:** *June 2019* | **Revision:** |
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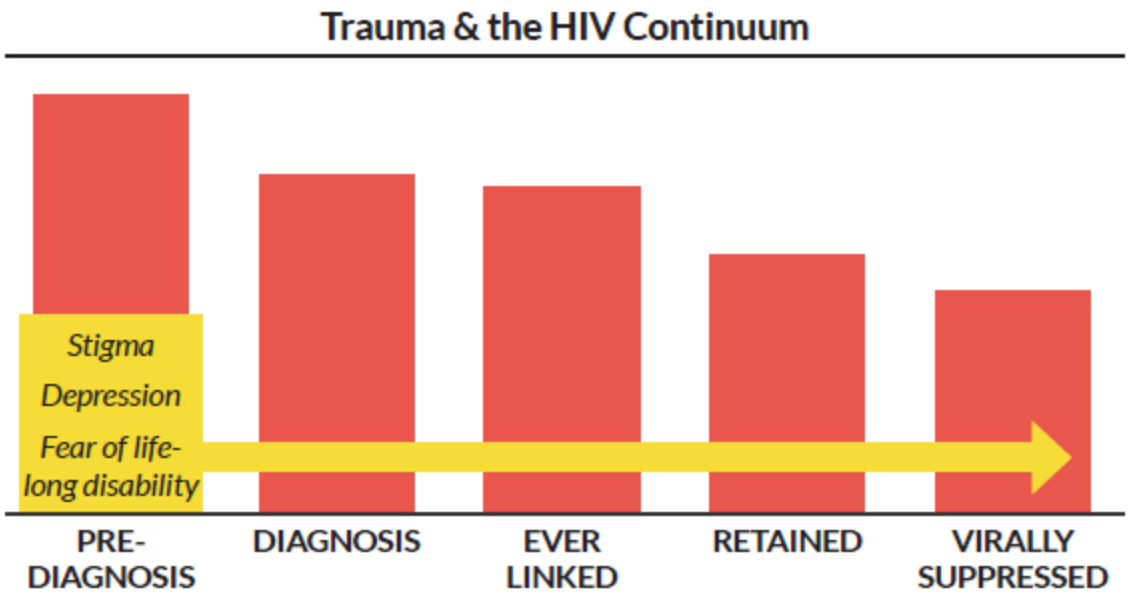
## 2.5 TRAUMA INFORMED

Based on the definition from NASTAD, "trauma is broadly defined as experiences that produce intense emotional pain, fear, or distress, often resulting in long-term physiological and psychological consequences. Experiences of trauma, especially in childhood, can change a person's brain structure, contributing to long-term physical and behavioral problems. Trauma can be a one-time event (e.g. natural disaster, loss of a loved one, or receipt of an HIV diagnosis), repeated events (e.g. abuse or neglect), or a vicarious event (e.g. witnessing trauma experienced by another). Trauma can be experienced by a single individual (e.g. domestic violence, sexual assault) or an entire population (e.g., slavery, intergenerational trauma). While some people fully recover from trauma, others experience lifelong physical and behavioral effects."

As identified in the NASTAD Trauma toolkit, it is important to recognize comorbidities such as substance use disorder and mental health issues as it can have an impact that contributes to trauma at every stage of the HIV continuum (Pre-Diagnosis, Diagnosis, Ever Linked, Retained, and Virally Suppressed).




*Data from NASTAD Trauma-Informed Approaches Toolkits*

**Vicarious Trauma**

Health care providers, case managers, benefit specialists, and any other individuals who works in a social service and health setting can develop trauma that they have experience or vicarious trauma. As stated in the NASTAD Trauma toolkit, "vicarious trauma results of bearing witness to the experience of trauma in others. This can be exposed through hearing about traumatic experiences or bearing witness to symptoms of trauma in their clients (e.g. aggression or anger). Vicarious trauma can lead to various levels of burnout and compassion fatigue, impacting high rates of turnover in many organizations that serve PLWH. Furthermore, many persons in helping professions are drawn to the work based on their own personal experiences, thus increasing the risk for vicarious trauma."

Below are the six principles of trauma-informed approaches SAMHSA outlined:

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| **1) Physical and Emotional Safety**<br>• Create a safe and welcoming environment<br>• Be consistent and predictable<br>• Non-shaming, non-blaming, non-violent<br>• Ensure privacy and confidentiality<br>• Provide clear expectations about what is happening and why | **2) Collaboration & Mutuality**<br>• Ensure respect, connection, and hope<br>• Recognize that healing occurs in the context of the interpersonal relationship<br>• Share in decision making (i.e. doing 'with' vs. 'to' or 'for')<br>• Level power differences between staff and clients by creating true partnering<br>• Everyone has a role to play in a trauma-informed approach from reception to direct medical care |
| **3) Trustworthiness and Transparency**<br>• Build and maintain trust among staff, clients, and family members of those served<br>• Maintain professional boundaries<br>• Transparent policies and processes<br>• Roles are clear<br>• An informed consent and grievance process are present | **4) Empowerment, Voice & Choice**<br>• Validate strengths and resilience<br>• Use strengths to build and enhance healthy coping skills<br>• Understand past coping mechanisms and the normalcy of the response to a not normal situation<br>• Apply strengths-base philosophy<br>• Value social roles |

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| | • Increase and ensure individual control and autonomy<br>• Frame experiences as survivorship, not victimization |
| **5) Peer Support**<br>Recognize that peer support and mutual staff-help are key vehicles for:<br>• Establishing safety and hope<br>• Building trust<br>• Enhancing collaboration<br>• Using stories and lived experience to promote recovery and healing | **6) Cultural, Historical and Gender Issues**<br>• Actively move past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, religion, gender geography, etc.)<br>• Provide gender-responsive services<br>• Leverage the healing value of traditional cultural connections<br>• Incorporate policies, protocols, and processes that are responsive to the racial, ethnic, and cultural needs of individuals serviced<br>• Recognize and address historical trauma |

To reduce and prevent primary or secondary trauma, an agency should implement Trauma-Informed approaches. This allows an organization to become trauma-informed and able to offer support to staff who may experience vicarious trauma. As stated by the NASTAD Trauma toolkit, "Becoming trauma-informed is not a fix that can be made quickly, rather, it is a slow-moving process in a system." Please go to https://www.nastad.org/sites/default/files/resources/docs/nastad_traumatoolkit_022219.pdf to read the full article on trauma-informed approaches.

| **Effective Date:** *June 2019* | **Revision:** |
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## 2.6 CASELOAD SIZE

The size of a CM's assigned caseload greatly impacts job performance and the CM's ability to meet the needs of the individuals they are responsible for supporting. Historically, case management programs have had a difficult time determining realistic standardized caseload size due to many complex factors across a diverse case management setting. An average caseload size expectation for MCM is between 25-50, and for NMCM is between 50-100, but the assigned number may vary depending on the setting and the acuity of clients, as well as the duties of the CM.

Caseload assignment is pivotal in managing caseloads, reporting agency activity, and determining who is currently responsible for managing an individual's case, as well as communicating to the client who their assigned CM and person of support is. Caseload assignment creates a channel of effective communication between clients and their CM, streamlines service provision, and significantly reduces confusion. Clients should be assigned to a CM's caseload within the first week after eligibility for services has been determined. Caseloads may be assigned or designated by caseload number, specialization of cases, client's level of acuity, the client's geographic location, or a different system which works for the agency. A CM's caseload size may vary as individuals are discharged from service and new individuals complete intake.

## SECTION 3.0 HRSA-HAB CASE MANAGEMENT STANDARDS OF CARE

https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

| **Effective Date:** *June 2019* | **Revision:** |
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### 3.1 HRSA-HAB MEDICAL CASE MANAGEMENT (MCM) AND NON-MEDICAL CASE MANAGEMENT (NMCM)

**MCM** is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. MCM is used by an interdisciplinary team that includes the client's provider and possibly other specialty care providers. MCM includes all types of case management encounters (e.g. face-to-face, phone contact, and any other form of communication).
Key activities include:

- Initial assessment of service needs.
- Development of comprehensive and individualized care plan or service plan.
- Timely and coordinated access to medically-appropriate levels of health and support services and continuity of care.
- Continuous client monitoring to assess the efficacy of the plan.
- Re-evaluation of the care plan or service plan at least every 6 months with adaptation as necessary.
- Ongoing assessment of the client's and other key family members' needs and personal support systems.
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments.
- Client-specific advocacy and/or review of service utilization.

In addition to providing the medically oriented services above, MCM may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g. Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

**NMCM** provides guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. NMCM services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by the Program recipient.

**Key activities include:**

- Initial assessment of service needs.
- Development of a comprehensive and individualized care plan or service plan.
- Continuous client monitoring to assess the efficacy of the care plan or service plan.
- Re-evaluation of the care plan or service plan at least every 6 months with adaptations as necessary.
- Ongoing assessment of the client's and other key family members' needs and personal support system.

## SECTION 4.0 UTAH HIV CASE MANAGEMENT

| **Effective Date:** *June 2019* | **Revision:** |
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### 4.1 EDUCATION REQUIREMENTS

| Role | Minimum Requirements | Minimum Requirements for Supervision | Training Requirement | Documentation Requirement |
|---|---|---|---|---|
| Medical Case Manager (MCM) | • Medical Assistant<br>• Registered Nurse (RN)<br>• Physician Assistant (PA)<br>• Nurse Practitioner (NP)<br>• Any other medically-trained staff<br>• License Clinical Social Work (LCSW)<br>• Certified Social Work (CSW)<br>• Master of Social Work (MSW) | • License Clinical Social Work (LCSW)<br>• Bachelor of Science in Nursing (BSN) | • All MCM required to attend the Utah Case Management Standards of Care training annually facilitated by UDOH Case Management Coordinator.<br>• All MCM required to attend other training set by UDOH.<br>• All MCM required to participate in annual HIV prevention and care related training set by the Case Management agency.<br>• All MCM required to participate in 4 hours of continuing education that focus on case management. | • A copy of diploma/ credentials<br>• Training certificates/ records |
| Non-Medical Case Manager (NMCM) | • Bachelor of Social Work (BSW)<br>• Social Service Worker (SSW)<br>• Other related health or human services degree from accredited College or University<br>• Two years of full-time work experience working with | • License Clinical Social Work (LCSW) | • All NMCM required to attend the Utah Case Management Standards of Care training annually facilitated by UDOH Case Management Coordinator.<br>• All NMCM required to attend other training set by UDOH.<br>• All NMCM required to participate in an | • A copy of diploma/<br>• Credentials or<br>• Documentation of 2 years of related direct client service experience.<br>• Training certificates/ records. |

| | | | | |
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| | people living with HIV<br>• Adult Case Management Certification | | annual HIV prevention and care related training set by the Case Management agency.<br>• All NMCM required to participate in 4 hours of continuing education that focus on case management. | |
| Benefit Specialist (BS) | • High School Diploma<br>• Other related health or human services degree or certificate<br>• Two years of full-time work experience working within a related health/social service field | • Bachelor degree-level professional (Social Work or Public Health) | • All Benefit Specialists required to attend an annual Eligibility training facilitated by UDOH Eligibility staff.<br>• All BS required to attend other training set by UDOH. | • A copy of diploma/ credentials or<br>• Documentation of 2 years of related direct client service experience.<br>• Training certificates/ records. |

| **Effective Date:** *June 2019* | **Revision:** |
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## 4.2 AGENCY POLICY AND PROCEDURES

**Confidentiality and Release of Information:**
Case Management agency staff, who are involved in the client's case, ensure client health information is protected including, but not limited to: a client's HIV status, behavioral risk factors, or use of services and is only retrieved as a means to perform service responsibilities. Client information can only be released to third party entities upon client consent using an Authorization Release of Information. This allows communication regarding a client's case with Ryan White Part B Program or other associated parties that are a part of the client's case.

The benefit specialist and/or case manager informs clients of confidentiality guidelines, and has clients sign all requisite confidentiality forms and releases at intake and annually thereafter, or when appropriate. Contracted agencies must take the required steps to ensure that their practice conforms to these Standards of Care.

**Client's Rights and Responsibilities:**
Case management agency staff who are involved in the client's case must inform clients of their rights and responsibilities related to their participation in the Program and case management agency. This ensures the client has a clear understanding of what is expected of them during participation and outlines what they can expect from the Program and case management agency.

**Grievance:**
Grievance guidelines and procedures are required by the case management agency. The case management agency staff who are involved in the client's case must inform and educate the client of the grievance procedures and guidelines. This ensures the client is familiar with the process of filing or reporting a grievance through the case management agency. If the client has a concern related to the services that they are receiving, it is important that they understand the process for properly addressing that concern and working towards a resolution.

**Linguistic Service:**
Linguistic services serve a vital purpose for social service and healthcare organization as they work with vast cultures and a diverse population. It is recommended that a friend or family member should not act as translator as it can create bias, lack of identifying terminology terms, and conflict of interest between the proposed interpreter and the parties. A professional service is preferred when a language barrier is presented between the individual and the case management agency staff. Case management agency staff who are involved in the client's case must have a process to determine if the client requires professional language interpretation or sign-language services or visits.

| **Effective Date:** *June 2019* | **Revision:** |
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## 4.3 ELIGIBILITY AND ONGOING SERVICES

**Benefit Specialist (BS)** works in cooperation with MCM and NMCM to ensure Program clients receive and/or maintain service eligibility. BS also informs and assists clients in accessing benefits such as direct purchase health insurance (DPI), or employer-based health insurance coverage. BS works directly with clients to increase knowledge of the Program and health insurance coverage, including how to access services and maximize their benefits. It is a primary function of BS to educate enrolled clients on health insurance usage and benefits. Services provided by BS reduce barriers for clients to maintain eligibility and may be over the phone, in a clinic or office setting, or in the field, such as in a client's home or other public space.

### 4.3.1 Summary of Functional Role

- Initial enrollment intake for new applicants
- Re-certification for enrolled clients
- Insurance enrollment
- Provide education on Program services
- Collaboration between BS and MCM and/or NMCM in regard to client eligibility needs or barriers
- Education and outreach

### 4.3.2 Process of each Functional Role

***Initial Enrollment***
**Purpose:**
The initial enrollments serve as the primary foundation for demographic and eligibility information collection to ensure client approval for the Program, and referral of client to case management. The BS is the first contact for new applicants and plays an important role in informing the applicant about Ryan White Part B Program to determine appropriate service(s). The process also consists of several forms and documentation that must be provided to and/or signed by the client during the initial intake for the client to maintain eligibility and to avoid a gap in service. (*APPENDIX A Ryan White Part B Program Application Form*)

| Expectations | Requirements | Responsible Role |
|---|---|---|
| *New Applicant:*<br>• BS will verify the time and date of the appointment set for the client.<br>• BS will contact potential client to provide information/ documents the client will needs to bring to the initial application as well as verify the appointment time with client.<br>• BS will determine eligibility for Ryan White Part B services.<br>• BS will educate client to the Ryan White Part B Program Services. | • Email a complete initial application to Utah Department of Health (UDOH) Eligibility Specialist (rwp@utah.gov) or fax to 801-536-0978.<br>• BS utilizes the re-cert log to identify client's current eligibility status.<br>• Any interaction regarding a client will need to be documented in client's chart/file.<br><br>***Once ClientTrack is available:***<br>• BS will complete the initial application with client and document any communication made with the client, or any other parties related to the client's case, by utilizing ClientTrack. | Benefit Specialist |

***Re-certification***

**Purpose:**

Re-certification is required every 6 months to re-assess an individual's eligibility for Program services. An individual is required to submit current information during each re-certification period. The BS offers support and assistance to individuals with the re-certification process. The BS will work with an individual to ensure they are aware of their re-certification deadline, coordinate a time to meet with them, if applicable, and assist them in completing and submitting all necessary forms and documents to maintain program coverage and avoid gaps in service. (*APPENDIX B and C Ryan White Part B Program Re-certification and Self-Attestation Forms*)

| Expectations | Requirements | Responsible Role(s) |
|---|---|---|
| *Enrolled Client:*<br>• BS contacts client to set an appointment for re-certification.<br>• BS contacts client prior to the re-certification to provide a list of information/ documentations the client needs to bring to the appointment and verify the appointment time.<br>• BS determine eligibility for Ryan White Part B services. | • BS assists clients with re-certification every 6 months.<br>• Email complete re-certification to Utah Department of Health (UDOH) Eligibility Specialist (rwp@utah.gov) or fax to<br>• 801-536-0978.<br>• BS utilizes the re-cert log to identify client's current eligibility status.<br>• Any interaction regarding a client will need to be documented in client's chart/file. | Benefit Specialist |

| | | |
|---|---|---|
| • BS educate client to the Ryan White Part B services. | ***Once ClientTrack is available:***<br>• BS will complete the re-certification application with client and document any communication made with the client, or any other parties related to the client's case, by utilizing ClientTrack. | |

***Insurance Enrollment***

**Purpose:**

To assist clients who do not have sufficient health care coverage or financial resources for coping with HIV disease. The Program fills gaps in care not covered by others sources. The BS will work with the individual to determine and identify coverage and plan options available for the individual, and to support the individual through the enrollment process.

| Expectations | Requirements | Responsible Role(s) |
|---|---|---|
| *New applicant/enrolled clients:*<br>• BS will assess potential eligibility for DPI services during client initial application or re-certification.<br>• BS will assist client that might qualify for DPI during open enrollment.<br>• BS will complete all of the necessary forms and submit to either Select Health or Regence. | • BS will assess clients every 6 months or as needed for enrollment eligibility.<br>• BS utilizes the re-cert log to identify client's current eligibility status.<br>• Any interaction regarding a client will need to be documented in client's chart/file.<br><br>***Once ClientTrack is available:***<br>• BS documents in ClientTrack any communication made with client or other parties related to the client's case (face-to-face, phone, and email). | Benefit Specialist |

***Education and Outreach***

**Purpose:**

The BS provides beneficial information on Program services and Health Insurance enrollment to PLWH to alleviate any misperceptions about services offered to enrolled clients, and to reengage clients who have not re-certified and have possibly been lost to care. The BS regularly engages in outreach efforts which are focused on re-engaging individuals into care. The BS provides clients with updated information and support to empower the client to make decisions on current or future services offered through the Program.

| Expectations | Requirements | Responsible Role(s) |
|---|---|---|
| • BS interact with each individual at least every 6 months (face to face, phone conversation, email, and/or home visit) to inform clients about Program services currently available based on the client's needs.<br>• BS ensures current and accurate information is communicated to the client in a timely manner.<br>• BS conducts outreach activities (phone, email, and/or home visit) to re-engage clients into care (be mindful of what interaction options might be appropriate when reaching out to clients). | • BS utilizes the re-cert log to identify client's current eligibility status.<br>• Any interaction regarding a client will need to be documented in client's chart/file.<br><br>***Once ClientTrack is available:***<br>• BS uses ClientTrack to document interaction related to education and outreach, or any communication made with client or other parties related to the client's case (face-to-face, phone, and email). | Benefit Specialist |

***Interaction between Benefit Specialist and Case Manager***

**Purpose:**

A collaborative team approach is most effective in successfully meeting the needs of the individuals. Communication is key in successful collaboration, allowing the BS and the CM to determine together how they can best approach even the most difficult of client situations and achieve the most successful outcomes. The expectation is that the BS and the CM will practice transparent communication, which allows them to collaborate with each other while working to meet client needs and prevent uncertainties that may cause the client to become ineligible and result in a gap in service.

| Expectations | Requirements | Responsible Role(s) |
|---|---|---|
| BS and CM will:<br>• Communicate on a regular basis in regards to client's case.<br>• Maintain regular and ongoing communication related to their mutual clients.<br>• Work together to ensure the client's needs are met and enrollment in the Ryan White Part B Program remains uninterrupted. | • Any interaction regarding a client will need to be documented in client's chart/file.<br><br>***Once ClientTrack is available:***<br>• BS documents in ClientTrack any communication made with client or other parties related to the client's case (face-to-face, phone, and email). | • Benefit Specialist<br>• Case Manager |

| Effective Date: *June 2019* | Revision: |
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## 4.4 CASE MANAGEMENT FOR INCARCERATED AND JUSTICE INVOLVED INDIVIDUALS

https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/PCN-18-02-people-who-are-incarcerated.pdf

As stated from HRSA Policy Clarification Notice (PCN) 18-02, "The purpose of this PCN is to provide guidance to HRSA Ryan White HIV/AIDS Program (RWHAP) recipients and sub-recipients on the use of program funds to provide HRSA RWHAP core medical services and support services on: 1) transitional basis to PLWH who are incarcerated in Federal and State prison systems; and 2) short-term and/or transitional basis to PLWH who are incarcerated in other correctional systems (e.g. local prisons and jails) or under community supervision (e.g. parole or home detention)." Refer to the Program Policy and Procedure Manual for more information (APPENDIX M).

| Effective Date: *June 2019* | Revision: |
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## 4.5 MEDICAL CASE MANAGEMENT AND NON-MEDICAL CASE MANAGEMENT

***Medical Case Management (MCM)*** provides proactive, holistic, client-centered case management services to support PLWH in meeting various needs. MCM services are intended to support enrolled clients who are medically non-adherent, or who struggle to achieve or maintain viral suppression. MCM focuses on treatment adherence by managing client's complex medical needs and improving their health outcomes. MCM does this by supporting client's health/medication treatment plans, offering psycho-social services and support, and providing referrals/follow up based on an individual's identified barriers and needs for ongoing support. The focus of MCM services is to provide medical intervention and improve health outcomes. The providers of this service are required to possess a medical background, who work with other medically-trained staff to be part of the client's medical multidisciplinary care team (this team may be comprised of physicians, pharmacists, psychiatrists, social workers, etc.). MCM will work with individuals most at-risk for falling out of medical care, those who have fallen out of medical care, and/or those with detectible viral loads.

**Non-Medical Case Management (NMCM)** provides proactive, holistic, client-centered services in an effort to support PLWH in meeting various needs. NMCM services are intended to support PLWH who are self-sufficient and have one-time/short-term needs to improve their health outcome. The services focus on adherence-related needs, providing psycho-social services, and providing referral/follow up based on the individual's unique barriers and their needs for ongoing support.

MCM and NMCM will follow the standards of service to ensure applicable and coordinated access to medically-appropriate levels of health and supportive services. The service will take place either in a community based or clinic setting geared towards providing linkage and assistance in obtaining medical and social components, based on the client's situation. It also promotes continuity of care through ongoing assessment of the client's needs, and by practicing culturally and linguistically appropriate service provision for the individuals accessing support. The interaction between the NMCM/MCM and clients will be face to face (in an office and or clinic setting or in the field such as in a client's home or other public space), via telephone, or using other forms of communication tailored to the client's circumstances.

### 4.5.1 Summary of Functional Roles

| MCM | NMCM |
|---|---|
| • Conduct an initial Psycho-Social Assessment (PSA) (reassess, at minimum, annually or as needed)<br>• Conduct an initial Utah Acuity Scale Assessment (UASA) (reassess minimum six months or as needed)<br>• Conduct an initial Service Plan (SP) within 15 days of the initial PSA. (Reassess minimum every six months or as needed)<br>• Service Plan Monitoring<br>• Treatment Adherence<br>• Follow up with medical provider to review client's medical care (minimum of every six months)<br>• Review current CD4, viral load lab, and medications (minimum of every six months or as needed) with the client<br>• Monitor adherence to medication<br>• Monitor adherence to medical appointments<br>• HIV prevention counseling<br>• Provide access to supportive services (housing, dental, transportation, food voucher, linguistic etc.) on an as-needed basis<br>• Referrals and follow up<br>• Assist client in gaining and maintaining access to the Program and other assistance services<br>• Transition or Discharge<br>• Re-engagement<br>• Documentation | • Conduct an initial Psycho-Social Assessment (PSA) (reassess minimum annually or as needed)<br>• Conduct an initial Utah Acuity Scale Assessment (UASA) (reassess every minimum six months or as needed)<br>• Conduct an initial Service Plan (SP) within 15 days of the initial PSA (reassess minimum every six months or as needed)<br>• Service Plan Monitoring<br>• Linkage to adherence counselor<br>• Monitor adherence to medications<br>• Monitor adherence to medical appointments<br>• HIV prevention and counseling<br>• Provide access supportive services (housing, dental, transportation, food voucher, etc.) on an as-needed basis<br>• Referrals and follow up<br>• Assist client in gaining and maintaining access to the Program and other assistance services<br>• Transition or Discharge<br>• Re-engagement<br>• Documentation |

### 4.5.2 Process of each Functional Role

***Initial/Update Psycho-Social Assessment (PSA)***

**Purpose:**

The PSA is a tool used to conduct a thorough and comprehensive evaluation of a client's physical, mental, and emotional health, and assess their ability to function within the community. The form provides the framework to promote a dialogue between the CM and client, in which the CM's focus is to identify and understand the client's situation in order to provide appropriate interventions and referrals. The PSA allows the CM to collect the information needed to complete an accurate Utah Acuity Scale Assessment (UASA) and create a Service Plan (SP) with the individual. The PSA needs to be completed within 30 days of the initial application intake. Re-assessment should occur when there are significant changes in a client's status, or at minimum once per year. The purpose of reassessment is to ensure the CM has an updated and thorough understanding of a client's current situation and needs for support. (*APPENDIX F PSA Form*)

| Expectations | Requirements | Responsible Role(s) |
|---|---|---|
| • New applicant that participates in case management service will take part in at least one initial PSA.<br>• Enrolled client that participates in case management service will take part in an annual PSA. | • PSA must be completed no later than 30 days of the initial intake.<br>• PSA must be updated annually or as needed based on client's immediate life changes.<br>• CM will utilize the PSA form to complete the initial and updated PSA, and placed it in the client's chart/file.<br>• Any interaction regarding a client is documented in client's chart/file.<br><br>***Once ClientTrack is available:***<br>• CM will complete the PSA with client and document any communication made with the client or any other parties related to the client's case by utilizing ClientTrack. | Case Manager |

***Utah Acuity Scale Assessment (UASA)***

**Purpose:**

This tool will assist CM in planning and coordinating services for PLWH. The assessment is designed to guide a CM through determining the appropriate level of support needed to provide adequate service to the individual. The structure of the UASA promotes consistent service provision by providing an objective assessment and minimizing innate subjective bias. The UASA includes 13 areas of medical and psycho-social functioning and individuals are assigned a level of support need intensity in each area. Utilizing the completed assessment, CM will be able to identify an individual's overall level of functioning, as well as the intensity of their needs for support. The UASA is also designed to support the CM in identifying the areas of most crucial need so as to prioritize those needs when assisting the individual in creating a Service Plan, if applicable. (*APPENDIX G UASA Form*)

| Expectations | Requirements | Responsible Role(s) |
|---|---|---|
| • The UASA is conducted at intake and reassessed at least every six months or as needed.<br>• If CM decides to alter the tier level, supportive reasoning and evidence is identified and documented.<br>• Client may not be appropriate for case management service if they are determined as a level 1 in the UASA. | • UASA is completed no later than 30 days of the initial intake application.<br>• UASA is updated every six months or as needed.<br>• If client is at a level 1, CM will assess client's overall needs and communicate with the client if case management service is appropriate.<br>• CM uses the UASA form to complete the initial and | Case Manager |

| | | |
|---|---|---|
| | updated UASA and places it in the client's chart/file.<br>• Any interaction regarding a client will need to be documented in client's chart/file.<br><br>***Once ClientTrack is available:***<br>• CM will complete the UASA with client and document any communication made with the client, or any other parties related to the client's case, by utilizing ClientTrack. | |

| **UASA Instruction** |
|---|
| **Client Status:**<br>• This area helps CM determine client status automatically.<br>• The indicators are a representation of the client who might be at risk or vulnerable and requires immediate attention.<br>• Status is assigned as "Moderate" or "Intensive" need if one or more check box is marked.<br>• CM will reassess the client within 60 days to gauge any progress or digression. |
| **Area of Functioning:**<br>• The UASA covers 13 areas of functioning (Basic needs, transportation, housing status, Health insurance/Medical Home, Oral Health, Health Literacy, Treatment Adherence, Support System, Legal Status, Mental Health, Substance use, Risk Reduction, and Nutrition).<br>• CM designates a numerical value between 1 (Self-Management), 2 (Basic Need), 3 (Moderate Need), and 4 (Intensive Need) based on each description. There are multiple descriptions in each tier level and CM can mark more than one description.<br>• To determine the correct point value, CM will look at the highest tier level that was marked (not the tier level with the most descriptions marked; if several descriptions are marked under tier level 2, but 1 description is marked under tier level 3, then the individual is considered a level 3 in that area of functioning). |
| **Scoring:**<br>• The scale ranges from 0-52 points and is categorized into four levels as mentioned above.<br>• Once all of the necessary check boxes are marked, add each check box numerical value together to get the total points.<br>• The total points of all areas of functioning added together indicates the overall tier level of the individual.<br>• Each tier level will have a description of the service requirements and minimum level of interaction expected between the CM and the client. |
| **Case Manager Note/Exceptions:**<br>• The CM may change the client's acuity either up or down by giving a brief explanation of the reasoning or discrepancies within the score and the overall collateral information. |
| **Rule of Thumb:**<br>• Utilize the PSA and other collateral information as a guide to define the appropriate tier level.<br>• If a client is at a lower tier level, it does not mean the client does not have a crisis, which may indicate a need of frequent assistance from the CM. The client does not need to move to a higher tier level, unless the crisis is long term and there are multiple areas on the UASA that are affecting the client. |

***Initial, Update, and Monitoring Service Plan (SP)***

**Purpose:**

The SP offers direction in service provision. The CM and the individual they are supporting work collaboratively to prioritize the needs identified in the PSA and the UASA tool. The CM guides the individual in determining which needs to address first and then assists in creating goals and action steps that are SMART (specific, measurable, attainable, realistic and time-bound). The process supports the individual's self-determination and empowers them to actively participate in the planning and delivery of services. Creating a SP ensures the services and referrals offered are consistent with the goals outlined in the SP.

After a SP is created with, the CM regularly monitors the progress toward achieving the goals identified. Monitoring requires continual data gathering and frequent observation, which is dependent on the individual's acuity level. The CM provides support and assistance and assures engagement through close monitoring, progress reassessment at recommended intervals, and plan modification until goals are met and the client's health and/or situation improves. (*APPENDIX H Service Plan Form)*

| Expectations | Requirements | Responsible Role(s) |
|---|---|---|
| • The initial SP is developed after PSA and UASA processes are completed.<br>• Client participation is encouraged in prioritizing goals and action steps based on the UASA and PSA.<br>• The SP includes goal, action steps, responsible person, target date, and outcome.<br>• The goal ties back to the area of functioning on the UASA or PSA.<br>• Focus on achieving one or two goals at a time and recognizing action steps to be accomplished helps the client and the CM avoid feeling overwhelmed.<br>• Regular monitoring of current SP.<br>• Revise any goals or action steps on an as-needed basis.<br>• A SP may not be applicable if client's UASA is a level 1. | • Initial SP is completed within 15 days of the initial PSA.<br>• Update summary of SP is completed at least every six months or as needed.<br>• If client's UASA is at a level 1, CM will determine if SP would be applicable or assess if discharge from case management service is appropriate.<br>• CM will utilize the SP form to complete the initial and updated SP and placed it in the client's chart/file.<br>• Any interaction with regards to a client is documented in client's chart/file.<br><br>***Once ClientTrack is available:*** CM will complete the initial/update SP with client and document any communication made with the client, or any other parties related to the client's case, by utilizing ClientTrack. | Case Manager |
| **Rule of Thumb:** Include the following<br>• Plans for communication with the client's primary medical team and identify mechanism of feedback to ensure adherence (if applicable).<br>• Strategies to optimize adherence (e.g. medication management, medical appointments, CD4, and viral suppression) if applicable.<br>• Client's education on relevant topics (e.g. medication, side effects, general health literacy, and risk reduction)<br>• Linkages to other community services. | | |

***Treatment Adherence***

**Purpose:**

Treatment Adherence consists of assisting clients to manage their treatment by providing education on CD4, viral load, medical appointments, medications, and hands-on support. This can include, but is not limited to: customized medication plans to fit client's lifestyle, medical appointments reminders, scheduling appointments with providers, providing information on side effects, and other medical necessities as needed.

The causes of poor adherence in HIV treatment are extremely varied and may include, but are not limited to: client's challenges related to new diagnosis, trauma, age, health education, psycho-social, neurocognitive issues, mental health, and substance use. Clients may have difficulty keeping up with the demands of treatment adherence. In client-centered treatment adherence, the MCM determines client readiness of each client to ensure that the client is prepared for the intervention. This activity is critical to support a culture of transparent communication, and ensures the individual is empowered to make appropriate decisions about their care.

| Expectations | Requirements | Responsible Role(s) |
|---|---|---|
| • Assess client needs identified in the SP and determine readiness for treatment adherence.<br>• MCM discusses health education, including HIV disease and the purpose of medications, with client.<br>• MCM regularly monitors client adherence to medication and implements interventions to alleviate barriers.<br>• MCM coordinates with HIV care provider to discuss concerns regarding client's CD4, viral loads, and medications.<br>• Discusses with client any concern regarding CD4 and viral loads.<br>• Discusses medication side effects the client is experiencing.<br>• MCM assists clients in scheduling a routine or needed appointment(s) with HIV and Non-HIV care Providers. | • If applicable, treatment adherence goal and follow up is addressed in the SP.<br>• If applicable, MCM discusses with client one or more times as needed during service period.<br>• If medication adherence is applicable, the MCM monitors monthly at a minimum.<br>• If treatment adherence is applicable, MCM and HIV provider meet to discuss monthly at a minimum.<br>• MCM discusses with client CD4 and viral loads at a minimum of every six months.<br>• If applicable, MCM assists client in scheduling a routine medical visit as needed.<br>• Any client interactions are documented in client's chart/file.<br><br>***Once ClientTrack is available:***<br>• MCM documents in ClientTrack interactions related to treatment adherence, or any communication made with client or other parties related to the client's case (face-to-face, phone, and email). | • Medical Case Management |

***Linkage to Treatment Adherence***

**Purpose:**

If NMCM does not have the capacity to provide treatment adherence service, the NMCM is responsible for linking clients to the appropriate agency to receive treatment adherence services, if it is determined the individual will benefit from this service.

In client-centered treatment adherence, the NMCM determines client readiness to ensure the client is prepared for the intervention. This activity is critical to support a culture of transparent communication, and ensures the individual is empowered to make appropriate decisions about their care. NMCM is encouraged to support client adherence to medical appointments and medications. This can include, but is not limited to: customized medication plans to fit client's lifestyle, medical appointments reminders, and schedule appointments with providers.

| Expectations | Requirements | Responsible Role(s) |
|---|---|---|
| • Assess client needs identified in the SP and determine readiness for treatment adherence.<br>• NMCM regularly monitors client adherence to medication and implements interventions to alleviate barriers.<br>• NMCM assists the client to schedule routine or other needed appointment(s) with HIV and Non-HIV care providers. | • If applicable, a treatment adherence goal and follow up is addressed in the SP.<br>• If applicable, the NMCM monitors medication adherence monthly at minimum.<br>• If applicable, NMCM assists client in scheduling a routine medical visit as needed.<br>• Any client interaction documented in client's chart/file.<br><br>***Once ClientTrack is available:*** NMCM documents in ClientTrack interactions related to treatment adherence, or any communication made with client or other parties related to the client's case (face-to-face, phone, and email). | • Non-Medical Case Management |

***HIV Prevention and Counseling***

**Purpose:**

HIV Prevention and Counseling aims to empower individuals to better manage and maintain their health by creating dialogues regarding HIV transmission, disease management, risk and harm reduction, as well as safer sex practices. By increasing knowledge and understanding of HIV prevention and management, the individual is empowered and recognizes they are able to influence their own health outcomes.

| Expectations | Requirements | Responsible Role(s) |
|---|---|---|
| • Assess client to determine the need and readiness for HIV Prevention and Counseling and identify in SP.<br>• If client is ready, the CM discusses risk factor(s) related to their needs. | • If Prevention and Counseling is applicable, a related goal and follow up is documented in the SP.<br>• Any client interaction documented in client's chart/file.<br><br>***Once ClientTrack is available:***<br>• CM documents in ClientTrack interactions related to Prevention and Counseling, or any communication made with client or other parties related to the client's case (face-to-face, phone, and email). | • Case Manager |

***Supportive Services***

**Purpose:**

Connecting individuals to appropriate supportive services helps to alleviate barriers that may prevent the individual from focusing on health outcomes. Familiarity and understanding of internal and external resources available in the community to assist individuals in meeting their needs is a valuable component to providing case management services. CM is familiar with available resources, knowledgeable about the process for accessing services, and is competent in connecting individuals to supportive services such as housing, dental, transportation, food voucher, utility services, etc.

| Expectations | Requirements | Responsible Role(s) |
|---|---|---|
| • CM assesses client to determine needs and barriers for supportive services. | • If needs and barriers are identified that the client needs assistance with, CM refers the client to the appropriate resources.<br>• Any client interaction documented in client's chart/file.<br><br>***Once ClientTrack is available:***<br>CM documents in ClientTrack interactions related to Supportive Services, or any communication made with client or other parties related to the client's case (face-to-face, phone, and email). | • Case Manager |

***Referral and Follow Up***

**Purpose:**

The CM offers a referral to the individual to meet specific needs and identified barriers, or provides interventions or resources to eliminate the specific need or identified barrier. CM maintains a current and comprehensive list of internal and external providers that can assist with HIV and non-HIV related services. Referrals are appropriate and specific to the individual's identified needs.

After a referral is offered, it is imperative that the CM follow up to ensure the individual was able to access the referral. Follow up with the individual informs the CM if the needs or barriers were resolved, or if another referral is needed. Follow up documented on every referral. (*APPENDIX I Referral/Follow Up Form*)

| Expectations | Requirements | Responsible Role(s) |
|---|---|---|
| • CM assesses client to determine needs and barriers and provide the appropriate referral.<br>• CM will follow up on the referral. | • CM will document any referral given to client in client's chart/file.<br>• CM to follow up on the referral within no more than 15 days.<br>• Any client interaction documented in client's chart/file.<br><br>***Once ClientTrack is available:***<br>• If a referral was given, CM will enter the referral in ClientTrack.<br>  ○ CM provides client with printed referral information.<br>• CM will follow up on the referral within no more than 15 days, documented in ClientTrack.<br>• CM documents in ClientTrack interactions related to referral/follow up, or any communication made with client or other parties related to the client's case (face-to-face, phone, and email). | • Case Manager |

***Assist in gaining and maintaining access to services***

**Purpose:**

In many cases, the guidance and the support of the CM is essential in assisting individuals in gaining and maintaining appropriate services designed to support them in meeting their needs, addressing any barriers that may exist for them, as well as achieving their goals and managing their health outcomes. CM can provide guidance through the initial application process to obtain relevant services and referrals, and support an individual in maintaining those services by establishing a regular follow up process. Reminders for re-certification and collaborative care coordination minimizes potential gaps in service. A mutual understanding between the individual,

the CM, and the agency providing services is key to gain, maintain, and coordinate Ryan White Program services, including: ADAP-I, ADAP-M, Case Management Services, Supportive Services, etc., as well as external program services including housing, utility assistance, patient assistance programs, food assistance programs, etc.

| Expectations | Requirements | Responsible Role(s) |
|---|---|---|
| • CM contacts current client to schedule a re-certification appointment with the BS.<br>• CM follows up with client and BS to ensure re-certification is completed in a timely manner.<br>• CM offers support and/or information to answer any questions or concerns that pertain to re-certification, supportive services, and health insurance. | • CM guides or assists client in scheduling a re-certification appointment with BS.<br>• CM to follow up with client and BS regarding completion of re-certification.<br>• Any client interaction documented in client's chart/file.<br><br>***Once ClientTrack is available:***<br>• CM documents in ClientTrack interactions related to gaining and maintaining access to services, or any communication made with client or other parties related to the client's case (face-to-face, phone, and email). | Case Manager |

| **Effective Date:** *June 2019* | **Revision:** |
|---|---|

## C4.6 TRANSITION/DISCHARGE

**Purpose:**
CM may identify the need for client transfer or discharge. The goal is to transition without service interruption. The CM is not permitted to arbitrarily transfer, discharge, close, or terminate a client without cause or client consent. The client can request a transfer between case management agencies based on a reasonable need for the transfer. The agency will first attempt to transfer a client internally, exhausting all transfer possibilities, before transferring the client to an external agency. Any transfer needs to be appropriate, reasonable, and agreed upon by the case management agencies and the client, as well as agreed upon by all parties.

Client can request to close or terminate their case at any time during the service. Reasonable cause for discharging a client may include, but is not limited to: achieved self-sufficiency, voluntary request, relocation outside of Utah, failure to meet eligibility requirements, lost to follow up, and/or inappropriate behaviors affecting self or others. (*APPENDIX J Transition/Discharge Form*)

***Transfer of Clients***

| Expectations | Requirements | Responsible Role(s) |
|---|---|---|
| • Client or CM may request a transfer from one case management agency to another or within the agency.<br>• All parties work collaboratively to ensure that it is a smooth transition. | • Case management agencies collaborate to establish guidelines and process for the transfer.<br>• Once the process and guidelines are established between case management agencies, document the transfer process in the client's chart/file.<br>• Once the client is transferred, the current CM contacts the UDOH – Eligibility Specialist via email rwp@utah.gov to inform of the transfer.<br>• Any client interaction is documented in client's chart/file.<br><br>***Once ClientTrack is available:***<br>• CM utilizes ClientTrack to document the transfer process.<br>• CM documents in ClientTrack interactions related to the transfer, or any communication made with client or other parties related to the client's case (face-to-face, phone, and email). | • Case Manager |

***Transfer to Case Management Specialist (CMS)***

| Expectations | Requirements | Responsible Role(s) |
|---|---|---|
| Client is transferred to case management specialist if:<br>• CM has exhausted existing resources to engage client in care and/or meet client's needs.<br>• CM is unable to contact client for three or more months.<br>• Refer to case management guidelines for more information. | • CM must complete Case Management Referral Form (*APPENDIX K*) and email to Case Management Coordinator and CMS.<br>• Once the case has been transferred, CMS will contact Eligibility Specialist at UDOH via email rwp@utah.gov to inform of the transfer.<br>• Any client interaction is documented in client's chart/file.<br><br>***Once ClientTrack is available:***<br>• CM documents in ClientTrack any communication made with client or other parties related to the client's case (face-to-face, phone, and email). | • Case Manager |

***Conditional Discharge***

| Expectations | Requirements | Responsible Role(s) |
|---|---|---|
| Conditional discharge of client includes:<br>• The client moves out of Utah.<br>• The client is deceased.<br>• The client no longer wants/has a need for case management services. | • CM documents attempted contacts with client.<br>• CM sends a letter of notification to the client's last known address in regards to the discharge (if applicable).<br>• CM documents the discharge process in the client's chart/file.<br>• Once the client is discharged, the current CM contacts the UDOH – Eligibility Specialist via email rwp@utah.gov to inform of the discharge.<br>• Any client interaction is documented in client's chart/file.<br><br>***Once ClientTrack is available:***<br>• CM utilizes ClientTrack to document the discharge process.<br>• CM documents in ClientTrack interactions related to the discharge, or any communication made with client or other parties related to the client's case (face-to-face, phone, and email). | • Case Manager |

***Agency Discharge***

| Expectations | Requirements | Responsible Role(s) |
|---|---|---|
| • In serious circumstances, clients may be automatically terminated from case management services. Termination may be temporary or permanent. Reason for termination may include:<br>  ○ Clients demonstrates a pattern of abuse of agency staff, property and services.<br>  ○ Illegal substance use/abuse on the agency premises. | • CM must evaluate each situation with supervisor to determine if a discharge action plan with client is appropriate.<br>• CM documents the discharge process in the client's chart/file.<br>• If the client is discharged and the case has been closed, the CM must contact Eligibility Specialist at UDOH via email rwp@utah.gov to inform of the discharge.<br>• Any client interaction is documented in client's chart/file. | • Case Manager |

| | | |
|---|---|---|
| ○ Activities violating confidentiality of other client's at the agency.<br>○ Proven fraudulence and/or fabrication of documents. | ***Once ClientTrack is available:***<br>• CM utilizes ClientTrack to document the discharge process.<br>• CM documents in ClientTrack interactions related to the discharge, or any communication made with client or other parties related to the client's case (face-to-face, phone, and email). | |

| **Effective Date:** *June 2019* | **Revision:** |
|---|---|

## 4.7 RE-ENGAGEMENT

**Purpose:**
Clients are able to re-engage back to care if they previously did not have a permanent discharge from the Case Management Agency, as long as they are eligible for the Program. If client previously had an agency discharge, each agency will review the case with staff to determine the appropriate intervention.

| Expectations | Requirements | Responsible Role(s) |
|---|---|---|
| • Client was discharged from case management services and is now re-engaged back to care. | • If client has been discharged less than one year, the CM will:<br>○ Complete an update to the PSA.<br>○ Complete a new UASA.<br>○ Complete a new Service Plan.<br>• If client has been discharged for more than one year, the CM must complete:<br>○ Initial PSA.<br>○ A new UASA.<br>○ A new Service Plan.<br>• If client has a previous agency discharge, the agency determines an intervention that best fits the situation.<br>• Any interaction or documentations regard to a client will need to be noted in client's chart/file.<br><br>***Once ClientTrack is available:***<br>• CM will complete and document in ClientTrack any necessary assessments, and any communication made with client or other parties related to the client's case (face-to-face, phone, and email). | • Case Manager |

| **Effective Date:** *June 2019* | **Revision:** |
|---|---|

## 4.8 DOCUMENTATION

**Purpose:**
Documentation is an essential component of case management best practice. As defined from the Social Work Definition, documentation entails "the process of putting in writing and keeping on file relevant information about the client, the problem, the prognosis, the intervention plan, the progress of treatment, the social, economic, and health factors that contribute to the situation, and the procedures of termination or referral."

The purpose of documentation is to:

- Assist in planning client care and in evaluating the client's ongoing treatment.
- Record communication between the responsible practitioner and other professionals contributing to the client's care.
- Assist in protecting the legal interest of the client, the agency, and responsible practitioners.
- Educate others on the services provided, the range of skills utilized, and the impact of the services on the client, family, and the team.
- Invite the client to be empowered in their treatment by using the documentation process as a summarization when working with the client.

When recording any client interaction, such as face to face, emails, phone conversation, or collateral information, factual, accurate, objective, necessary, clear, concise, and specific documentation is to be used. Case notes are complete so anyone reading the notes can understand who the client is, what brought them to the office, what goals and plan were established, interventions utilized, and what referral/follow up was completed or planned. Remember, if it's not documented, it never happened.

| Expectations | Requirements | Responsible Role(s) |
|---|---|---|
| • Any interaction, either with a client, providers, or different agencies that pertain to the client via face- to-face, emails, or phone conversation, is always documented.<br>• Case notes should be documented within 24 hours after an interaction with the client or about the client's case. | • BS/CM use client's chart/file to document any interaction regarding client's service.<br><br>***Once ClientTrack is available:***<br>• BS/CM documents in ClientTrack any communication made with client or other parties related to the client's case (face-to-face, phone, and email). | • Benefit Specialist<br>• Case Manager |

## SECTION 5.0 ADDITIONAL INFORMATION

| **Effective Date:** *June 2019* | **Revision:** |
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### 5.1 HIV RYAN WHITE PART B PROVIDER INFORMATION

***University of Utah Hospital Infectious Disease Clinic (Clinic 1A)*** **Overview**

University of Utah Hospital Infectious Disease Clinic at Clinic 1A has been treating HIV/AIDS patients since 1988. The Infectious Diseases Division receives grant funding from the Ryan White Part B and C programs to provide primary care for HIV patients.

The primary care services provided for PLWH include the following:

- Mental Health Counseling
- Antiretroviral Medications
- Case Management
- Home Health Care
- Nutritional Services (supplement program)
- Substance Abuse Treatment
- Health insurance continuation

Clinic 1A case management program consists of onsite medical and non-medical case management to assess a patient's psycho-social needs and coordinate care with the HIV treatment team. Additionally, the team also provides outreach case management services, and case managers educate and link patients to community resources which promote health and self-sufficiency.

**Contact Information**
University of Utah Hospital, Clinic 1A
50 N. Medical drive
SLC, UT 84132
ID/HIV/AIDS Services: 801-585-2031
Case Management Services: 801-585-2670
Pharmacist Services: 801-587-35

***Utah AIDS Foundation (UAF) Overview***

In 1985, the Utah Department of Health reported a total of 17 persons living with AIDS in Utah. At that time, the state and most citizens were unprepared to address the HIV/AIDS issue. The need for public information and for assistance for persons living with HIV/AIDS forced a community-based response, which ultimately become the Utah AIDS Foundation (UAF).

UAF helps provide expertise to anyone struggling with the complex issues that surround HIV because UAF believes that no one should have to confront this disease alone. As we work side by side with community members, for as long as we are needed, we are committed to forming partnerships that mend health, promote compassion, and extend companionship to everyone who has been affected by HIV.

UAF offers case management services, free of charge, to anyone living with HIV/AIDS including children, adolescents, and their families. If you, or members of your family are living with HIV and need help planning, coordinating, or accessing any of the services available to you throughout the state of Utah, a UAF case manager can help. Understanding all the different programs and types of assistance can be confusing and difficult. Our case managers are here to help you sort through it all and get the services that will help you manage an HIV infection.

This means a UAF case manager can help you with:

- Accessing HIV Care
- Transportation
- Housing
- Mental Health Services
- Support Groups
- Food and Meal Services
- Benefits Advocacy
- Financial Assistance
- And many more…

**Contact Information**
1408 South 1100 East
SLC, UT 84105
Case Management, HIV/STI Testing, PrEP, Food Bank and other Resources: 801-487-2323

## SECTION 6.0 FORMS AND SERVICE STANDARDS

| **Effective Date:** *June 2019* | **Revision:** *7/31/19* |
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## Eligibility

Contact Policy and Eligibility Manager for all of the updated forms.

- ***Ryan White Part B Program Application Form***
- ***Ryan White Part B Program Re-Certification Form***
- ***Ryan White Part B Program Self-Attestation Form***
- ***Ryan White Part B Program Employment Verification & Insurance Form***
- ***Ryan White Part B Program Residency Verification Form***

## Case Management

Contact Case Management Coordinator for all of the updated forms.

- ***Initial/Update Psychosocial Assessment***
- ***Utah Acuity Scale Assessment***
- ***Service Plan***
- ***Case Management Referral/Follow up Form***
- ***Case Management Transition/Discharge Form***
- ***Case Management Specialist Referral Form***
- ***Case Management Guidelines***

## Service Standards

Contact Policy and Eligibility Manager for an updated documentation.

- ***Utah Ryan White Part B Program Manual***

Contact Client Services Manager for all updated documentations.

- ***Universal Service Standards Policy***
- ***AIDS Drug Assistance Program (ADAP)***
- ***Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals***

Contact Client Service Coordinator for all updated documentations.

- ***Oral Health***
- ***Emergency Financial Assistance***
- ***Food Bank/Home-Delivered Meals***
- ***Medical Transportation***

Contact Clinical Quality Coordinator for an updated documentation.

- ***Outpatient Ambulatory Medical Care***

Contact Case Management Coordinator for all of an updated documentation.

- ***Medical/Non-Medical Case Management***

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