

## ATTACHMENT G

### NON-MEDICAL/TARGETED HIV CASE MANAGEMENT SERVICES SCOPE OF SERVICES

Non-medical/targeted HIV case management is a formal and professional service that links persons living with HIV/AIDS (PLWHA) with multiple service needs to a formal continuum of health and social service systems. Non-medical/targeted HIV case management services strive to ensure that clients with complex needs receive timely coordinated services that enhance a client's ability to function independently as long as it is practical. Non-medical/targeted HIV case management assesses the needs of the client, the client's family, and the client's support system, and then arranges, coordinates, monitors, evaluates, and advocates for a package of services to meet the client's specific needs.

During the early years of the HIV epidemic, non-medical/targeted HIV case management was primarily concerned with coordinating support services for a terminally ill population. Non-medical/targeted case managers provided support to assist PLWHA and their families cope with a disease that ultimately would lead to death. While some levels of nursing and medical case management were available, the focus of case management was the coordination of psychosocial support services.

Changes in the HIV epidemic has required Rhode Island to examine how HIV services are delivered in its communities. Non-medical/targeted case management has expanded to incorporate the principles of chronic disease management. New treatments require a strong link between the provision of medical care and wrap around services. The demographics of infected populations are changing. Providers deal with multiculturalism, women's issues, children and youth, substance abuse, mental illness, homelessness, and persons in poverty.

Traditional activities of non-medical/targeted case management are intake, assessment, care plan development and implementation, referral, follow-up and monitoring, and discharge. Non-medical/targeted HIV case management services include the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. **Non-medical/targeted HIV case management does not involve coordination and follow-up of medical treatments.** Referral for health care/supportive services is the act of directing a client to a service in person or through telephone, written, or other type of communication. Non-medical/targeted HIV case managers must assure the client's privacy and confidentiality in all phases and activities of non-medical/targeted HIV case management.

In Rhode Island, non-medical/targeted HIV case management services includes assisting eligible clients to obtain access to other public and private programs for which they may be eligible (e.g. Medicaid, Medicare Part D, AIDS Drug Assistance Program (ADAP), Pharmaceutical Manufacturer's Patient Assistance Programs (PAPS), and other state and local health care and supportive services) and identifying clients who have dropped out of medical or ADAP care and assisting them to reconnect with care.

The following are the expectations associated with the processes of non-medical/targeted HIV case management services in Rhode Island.

**1. Brief Intake and Assessment:** The Brief Intake and Assessment is the initial meeting with the client during which the case manager gathers information to address the client's immediate needs to encourage his/her engagement and retention in services. The Brief Intake and Assessment may also be used to screen clients to determine if they need non-medical/targeted HIV case management services, and if so, to determine the model of case management most appropriate to meet a client's needs, and to assess the client's willingness and readiness to engage in case management services. The brief intake must be conducted within 3 business days of initial contact.

Key information, concerning the client, family, caregivers, and informal supports is collected and documented to determine client enrollment eligibility, need for ongoing case management services, and appropriate level of case management service. In the **Supportive Case Management** model, the Brief Intake and Assessment is the sole

mechanism for assessing client needs. Documentation from this assessment provides the basis for developing the Brief Service Plan and providing case management services. In **Supportive Case Management**, a Comprehensive Assessment is not required. In the **Comprehensive Case Management model** the Brief Intake/Assessment allows initiation of case management activities until a Comprehensive Assessment can be completed.

During the Brief Assessment & Intake, immediate needs are identified and addressed promptly. Brief Intake/Assessment documentation includes, at minimum:

**A. Basic Information**

- Presenting problem
- Contact and identifying information (name, address, phone, birth date, etc.)
- Language Spoken/Literacy Level
- Demographics
- Emergency Contact
- Confidentiality Concerns
- Household Members
- Documentation of Insurance Status
- Documentation of HIV Status
- Documentation of Gross Family Income
- Documentation of Residence
- Other Current Health care and Social Service Providers, including case management providers

**B. Brief Overview of Status and Needs Regarding:**

- Medication Access
- Food/clothing services
- Financial assistance
- Housing
- Transportation
- Legal services
- Substance use
- Mental health
- Domestic violence
- Support system
- Medical case management
- HIV disease, other medical concerns, access to and engagement in health care services
- Prevention of HIV/AIDS transmission
- Prevention of HIV disease progression
- Medical nutrition therapy
- Oral health services
- Outreach/psychosocial support services

A client's acute needs and/or crises are paramount. If the presenting problem requires immediate attention, the Brief Intake/Assessment may be postponed or abbreviated, but should be completed as soon as possible. Documentation includes appropriate releases, including Authorization for the Release of HIV Confidential Information in accordance with federal and state requirements, and other releases for information as required by applicable law. Client is assessed for program eligibility and meets eligibility criteria. The organization must have non-medical/targeted HIV case management policies and procedures containing guidelines for conducting the Brief Intake/Assessment including staff responsible for and supervisory oversight. The agency must have a written policies and protocols for determining client eligibility for services. Agencies must ensure access to

services for clients with limited English proficiency in one of the following ways (listed in order of preference): bi-lingual staff, face-to-face interpretation, telephone interpretation, and referral to programs with bilingual staff and/or interpretation services. Clients must be informed of their right to obtain no-cost interpreter services in the preferred language. Client must have access to linguistically appropriate signage and educational materials.

The agency must have a written grievance procedure in place. Clients must be made aware of the grievance procedure and how to use them. The agency must have written policies and procedures addressing client rights. The agency must provide each client a copy of the client rights policies and procedures, which must include the agency's confidentiality policy, the agency's expectations of the client as a consumer of services, the client's right to file a grievance, the client's right to receive no-cost interpreter services, and the reasons for which a client may be discharged from services, including a due process for involuntary discharge. The agency's fee structures must be made available for client viewing as applicable. Clients must be informed of the agency's hours of operation, the procedures for notifying clients of unscheduled closings, and the procedures for after-hour emergencies.

Staff with good interviewing skills that can put clients at ease, obtain key personal information, and recognize potentially urgent situations should perform the Brief Intake/Assessment process. Placement into the appropriate case management model and provision of initial case management services depend on utilizing capable, empathetic staff. Information obtained during the Brief Intake/Assessment should be shared, after client consent, with other providers to coordinate services and avoid duplication of efforts. To increase efficiency, information from an agency's program eligibility screening process may also be used in the Brief Intake/Assessment.

**2. Selection of Case Management Model and Placement:** The Supportive and Comprehensive models of case management provide different levels of service geared to the needs and readiness of the client. *Supportive case management* is designed for clients who need short term service, for those who require continued maintenance support following comprehensive case management, or for those not yet willing to participate in comprehensive case management. *Comprehensive case management* is intended for people with multiple, complex needs who require intensive, longer term service. For case management programs approved to provide both models of service, the ability of clients to shift from one model to another within the same program provides flexibility and enhances continuity of service as client needs evolve. Clients are enrolled in Supportive or Comprehensive case management services that provides a level of service that meets the needs identified in the Brief Intake & Assessment and in which the client is ready and willing to participate.

A. The case management model most appropriate for client needs is determined.

- Acuity of client needs is ascertained, through the use of a formal acuity scale.
- Case management services are explained.
- Readiness and interest in case management is assessed.
- Client is enrolled in model most suited to their needs regardless of agency enrollment needs.

B. Program capacity is evaluated.

- Program's service level and staff qualifications and/or expertise meet clients' needs.
- Program has caseload capacity.
- Program has capacity to meet clients' cultural and linguistic needs.

C. Clients are enrolled in Supportive or Comprehensive Case Management services within agency.

- Consent for case management services is obtained where required by initiative.
- All required forms authorizing the release of HIV confidential information and other protected information forms are signed by clients as required by applicable law.

Clients will be assigned to a case manager within 10 business days of contact. In some circumstances clients with extensive needs may be unwilling to accept or participate in Comprehensive Case Management but will agree to a supportive level of services. In these instances Supportive Case Management may be provided to meet immediate and crisis needs. With a continued cycle of crises, efforts should be made to encourage clients towards engagement in Comprehensive Case Management.

Agencies that coordinate with a variety of service providers and hold multiple reciprocal service agreements can best meet diverse client needs. The most effective agencies are culturally competent and employ staff that culturally and linguistically represent the community served. At a minimum, organizations must have policies and procedures that meet federally mandated CLAS standards. When clients are referred for services elsewhere, case notes include documentation of follow-up and level of client satisfaction with placement.

3. **Brief Service Plan:** In the **Supportive Case Management** model, the Brief Service Plan is completed in conjunction with the Brief Intake/Assessment and guides all case management activities until it is updated following a reassessment or a change in client circumstances. In the **Comprehensive Case Management** model, the Brief Service Plan is an interim guide for case management, enabling clients to secure services to meet immediate needs while more extensive information is being collected for the Initial Comprehensive Case Management Assessment. Needs identified in the Brief Intake/Assessment are prioritized and translated into a Brief Service Plan.

A. A Brief Service Plan is developed and includes:

- Goal(s)
- Activities (work plan, action to be taken, follow up tasks)
- Individuals responsible for the activity (case manager or team member, client, family member, agency representative)
- Anticipated time frame for each activity
- Client signature and date, signifying agreement
- Supervisor's signature and date, indicating review and approval

Documentation includes:

- Service plan format developed by the program including the above information
- Progress notes recording activities on behalf of the clients to implement the service plan
- Actual outcomes of case management goals and activities.

Agency must have an ongoing monitoring process to assess the client's ability and motivation to complete service plan activities and to address any other barriers to achieving goals. (For example if client is unable to perform specific activities alternative approaches to meet goal are explored such as skills development or staging of activities.)

If the Brief Intake/Assessment process determines the client has no presenting issues to be addressed, no service plan is required. In **Supportive Case Management** services, supervisory review and signoff on the Brief Service Plan can provide proactive monitoring for quality and ensure identified needs are prioritized and activities well planned. In **Comprehensive Case Management**, where an Initial Comprehensive Assessment and Comprehensive

Service Plan are performed, supervisory review and signoff on the Brief Service Plan may not be necessary. Organizations will have policies and procedures describing individual program practices.

Service plans developed during face-to-face meetings and negotiated between client and case manager encourage a client's active participation and empowerment. A copy of the service plan offered to the client emphasizes the partnership necessary in the case management process. Measurable goals and activities, taking into consideration cognitive and physical abilities, available resources, support networks, and client interest, result in a more realistic, client-specific plan. Although client signature denotes acceptance of a plan, a client may decline all or any portion of a service plan. Documentation of changes or updates to a service plan as well as actual outcomes ensures a simple method of tracking client progress. Family members and collaterals may assist in ensuring a client receives needed service. They can be included in the service plan to carry out activities.

**4. Initial Comprehensive Assessment:** The Initial Comprehensive Assessment is required for the **Comprehensive Case Management Model** only. It expands the information gathered in the Brief Intake and Assessment to provide the broader base of knowledge needed to address complex, longer-standing psychosocial or health care needs. **Comprehensive Case Management** services serve the client in the context of their family and support system. An Initial Comprehensive Assessment describes in detail the client's medical, physical and psychosocial condition and needs. It identifies service needs being addressed and by whom; services that have not been provided; barriers to service access; and services not adequately coordinated. The assessment also evaluates the client's resources and strengths, including family and other close supports, which can be utilized during service planning. Due to the extent of the Initial Comprehensive Assessment, supervisory oversight is required. Supervisory sign-off signifies review of the content and approval of the quality of the assessment conducted by the case manager. The needs assessment will be completed within 45 days from case manager assignment.

The initial Comprehensive Assessment includes at minimum:

A. Client health history, health status, and health-related needs, including but not limited to:

- HIV disease progression
- Tuberculosis
- Hepatitis
- Sexually transmitted diseases
- Other medical conditions
- OB/GYN, including current pregnancy status
- Medications and adherence
- Allergies to medications
- Dental care
- Vision care
- Home care
- Current health care providers; engagement in and barriers to care
- Clinical trials
- Complementary therapy.

B. Client's status and needs related to:

- Nutrition
- Financial resources and entitlements
- Housing (including results of home visit to assess living situation)
- Transportation
- Support systems
- Identification of children and separate assessment of children's needs

- Identification of collaterals
- Determination of collaterals needing case management assessment and services
- Parenting needs
- Partner notification needs
- HIV disclosure status/issues
- Alcohol/drug use/smoking history and current status
- Mental health
- Domestic violence
- Legal needs (e.g. health care proxy, living will, guardianship arrangements, parole/probation status, landlord/tenant disputes)
- Activities of daily living
- Knowledge, attitudes, and beliefs about HIV disease; current risk behaviors; and prevention of transmission
- Employment/education.
- Client strengths and resources
- Other agencies serving client and collaterals

Case managers should collaborate with the client's physician to complete the health-related aspects of the comprehensive needs assessment. The Comprehensive Assessment should contain a brief narrative summary, the name of person completing assessment and date of completion, and the supervisor signature and date, signifying review and approval. The case manager has primary responsibility for the Initial Comprehensive Assessment and meets face-to-face with the client at least once during the assessment process. The Initial Comprehensive Assessment is documented in the case record on forms developed by the organization. In the **Supportive Case Management Model**, the Initial Comprehensive Assessment is not required. Case management services are provided based on information gathered for the Brief Intake/Assessment and Brief Service Plan and updated throughout service provision and reassessment. A comprehensive assessment performed over time rather than in one sitting is often more complete and less intrusive and tiring for a client. Information is gathered from client self report and (with client release) a variety of sources, including providers serving the client and the client's collaterals.

**5. Initial Comprehensive Service Plan Development:** Service planning is a critical component of the **Comprehensive Case Management Model** and guides the client and case manager with a proactive, concrete, step-by-step approach to addressing client needs. The Comprehensive Service Plan can serve additional functions, including: focusing a client and case manager on priorities and broader goals, especially after crisis periods; teaching clients how to negotiate the service delivery system and break objectives into attainable steps; and serving as a review tool at reassessment to evaluate accomplishments, barriers, and re-direct future work. Goals, objectives, and activities of the service plan are determined with the participation of the client and, if appropriate, family, close support persons and other providers. Client needs identified at Initial Comprehensive Assessment are prioritized and translated into an Initial Comprehensive Service Plan, which defines specific goals, objectives, and activities to meet those needs. The comprehensive service plan will be completed within 45 days of case manager assignment.

The initial Comprehensive Service Plan includes at the minimum:

- Goal(s)
- Activities (work plan, action to be taken, follow up tasks)
- Individuals responsible for the activity (case manager or team member, client, family member, agency representative)
- Anticipated time frame for each activity
- Client signature and date, signifying agreement
- Supervisor's signature and date, indicating review and approval.

The case manager has primary responsibility for development of the service plan. The Initial Comprehensive Service Plan is included in the case record and completed on forms developed by the organization. The Initial Comprehensive Service Plan is updated with outcomes and revised or amended in response to changes in client life circumstances or goals.

The Initial Comprehensive Service Plan is not required in the **Supportive Case Management** model, which uses the Brief Service Plan developed at the Brief Intake/Assessment. In specified **Comprehensive Case Management** program initiatives, when assessment of the children and collaterals is not required, addressing their needs is optional within the client's Initial Comprehensive Service Plan.

Service plans developed during face-to-face meetings and negotiated between client and case manager encourage client active participation and empowerment. A copy of the service plan offered to the client reinforces client ownership and involvement in the case management process. Measurable goals and activities, taking into consideration the client's cognitive and physical abilities, available resources, support networks and motivation, result in a more realistic, client-specific plan.

Although client signature denotes acceptance of a plan, a client may decline all or any portion of a service plan. Documenting changes or updates to a service plan as well as actual outcomes provides a simple method of tracking client progress. Family members and collaterals may assist in ensuring a client receives needed service. They can be included in the service plan to carry out activities.

Clients with HIV infection should have adequate mental health and substance abuse screening, with adequate communication, including the provision of advice and assistance, with a medical care provider, each year. Support service referrals will be coordinated with the client's primary care provider (physician). Eligible clients with oral health needs should be referred to dental care to receive an oral exam at least once each year.

Case managers will submit a completed application to the ADAP program on behalf of eligible clients within two weeks of the point of identified need or expressed client interest in medications. Case managers will ensure that clients are recertified for ADAP every six months. Case managers will ensure that ADAP applications are complete and accurate. It is the responsibility of the case managers to notify the ADAP Program of any changes in a client's eligibility status for ADAP medications.

**6. Service Plan Implementation, Client Contact, Monitoring, And Follow-Up:** The bulk of case management work occurs in the implementation of the service plan. For Brief and Comprehensive Service Plans, implementation involves carrying out of tasks listed in the plan, including the following activities:

- Provider contact in person, by phone, or in writing
- Assistance to client and collaterals in applications for services or entitlements
- Assistance in arranging services, making appointments, confirming service delivery dates
- Encouragement to client/collaterals to carry out tasks they agreed to
- Direct education to the client/collaterals as needed
- Support to enable client/collaterals to overcome barriers and access services
- Negotiation and advocacy as needed
- Other case management activities as needed by client, and as expected and permissible by program initiative.

In general the type and frequency of contact should be based on client needs. At a minimum, case managers will maintain contact with all clients receiving case management services at least once every 3 months. Reassessment of

client needs and service plan revisions will be conducted, based on acuity of needs, in consultation with the client's physician not less than once every six months. In the **Comprehensive Case Management Model**, client contact and monitoring are expected to be frequent and proactive in order to anticipate problems, stabilize the client's status, prevent crises, and support the client in achieving service goals. Expectations include face-to-face contacts, home visits, and accompaniment of clients to providers where necessary to ensure service acquisition. In the **Supportive Case Management Model**, at a minimum, client contact and monitoring is required to follow up on referrals, determine the status of service acquisition, and to assess whether the client has further needs requiring additional case management services.

Provision of case management services outlined in the Brief or Comprehensive Service Plan proceeds immediately after its completion. Clients are contacted based on their level of need. Client status is monitored. Case management staff follows up to determine receipt of service. Oversight of service plan implementation is the responsibility of the case manager.

- A. Progress notes in the case management record detail the advancement of the case management effort for client and collaterals and record actual outcomes of activities.
- B. Evidence is documented in the client's chart that the case manager and/or team members contact the client and/or providers by a means and frequency appropriate to the client's needs.
- C. Documentation indicates contact with client and/or providers occurs after arranging services to determine if services are:
  - Delivered as expected
  - Utilized by the client
  - Satisfactory to the client
  - Continue to be appropriate to the client's need
  - Result in positive outcomes
- D. Case management provider follows up on problems with service delivery.
- E. Status of the client/collaterals is monitored on a regular basis.

The client's right to privacy and confidentiality in contact with other providers and individuals is assured. The client's consent to consult with other service providers is obtained. The provider complies with federal and state requirements regarding confidentiality of HIV-related information. Confidential HIV and client level documentation is secured against unauthorized access.

7. **Reassessment:** Reassessment provides an opportunity to review a client's progress, consider successes and barriers, and evaluate the previous period of case management activities. In conjunction with updating the Service Plan, Reassessment is a useful time to determine if the current level of service and model of case management is appropriate, or if the client should be offered a change. A reassessment is performed which re-evaluates client functioning, health and psychosocial status; identifies changes since the initial or most recent assessment; and determines new or ongoing needs. In **Comprehensive Case Management** programs:

- A. Each Comprehensive Reassessment must include:
  - a. Updated personal information
    - Current contact and identifying information
    - Emergency contact

- Confidentiality concerns
- Household members
- Insurance status
- Other health and social service providers, including other case management providers.

b. Updated client health history, health status, and health-related needs outlined in **Initial Comprehensive Assessment**, including but not limited to:

- HIV disease progression
- Tuberculosis
- Hepatitis
- Sexually transmitted diseases
- Other medical conditions
- OB/GYN, including current pregnancy status
- Medications and adherence
- Allergies to medications
- Dental care
- Vision care
- Home care
- Current health care providers, engagement in and barriers to care
- Clinical trials
- Complementary therapy.

c. Updated client status and needs related to:

- Nutrition
- Financial resources and entitlements
- Housing (including home visit to assess living situation)
- Transportation
- Support systems
- Identification of children and separate assessment of children's needs
- Identification of collaterals
- Determination of collaterals needing case management assessment and services
- Parenting needs
- Partner notification needs
- HIV disclosure status/issues
- Alcohol use/drug use/smoking
- Mental health
- Domestic violence
- Legal needs (e.g., health care proxy, living will, guardianship arrangements, parole/probation status, landlord/tenant disputes)
- Activities of daily living
- Knowledge, attitudes, and beliefs about HIV disease; current risk behaviors; and prevention of transmission
- Employment/education.
- Other agencies serving client and collaterals

The Comprehensive Reassessment should contain a brief narrative summary, the name of person completing assessment and date of completion, and the supervisor signature and date, signifying review and approval. The case manager has primary responsibility for the Comprehensive Reassessment and meets face-to-face with the client at least once during the reassessment process. The Comprehensive Reassessment is documented in the case record on forms developed or approved by the organization. Documentation includes appropriate releases, including Authorization for the Release of HIV Confidential Information in accordance federal and state requirements, and

other releases for information as required by applicable law. The organization must have policies and procedures that include guidelines for conducting the Comprehensive Reassessment, staff responsible for performing it, and supervisory oversight of the reassessment process.

**B. Each Brief Reassessment must include:**

- a. Client's presenting needs.
- b. Updated client information in the following areas:
  - Contact and identifying information
  - Emergency contact
  - Confidentiality concerns
  - Household members
  - Insurance status
  - Other health and social service providers, including other case managers.
  - A re-evaluation of the client's status and needs regarding:
    1. Food/clothing
    2. Financial/benefits
    3. Housing
    4. Transportation
    5. Legal
    6. Substance use
    7. Mental health
    8. Domestic violence
    9. HIV diseases and other medical concerns
    10. Prevention of transmission and secondary prevention support system.

The case manager has primary responsibility for the Brief Reassessment. The Brief Reassessment is performed in person or by phone. In **Supportive Case Management**, the Brief Reassessment is documented in the chart. A new or clearly updated Brief Intake/Assessment form, a form developed for the purpose, or a detailed progress note covering the areas of information listed above may be used as documentation of a Brief Reassessment. Documentation includes appropriate releases, including Authorization for the Release of HIV Confidential Information in accordance with federal and state requirements, and other releases for information as required by applicable law. Organizations must have policies and procedures including guidelines for conducting the Brief Reassessment, staff responsible for performing it, and supervisory oversight.

**8. Service Plan Update:** A Reassessment is always accompanied by a revision of the Service Plan. However a Service Plan may be updated between reassessments to reflect changes in direction of client goals and case management activities. A new or updated Service Plan is required at completion of each Reassessment, or sooner if client circumstances necessitate a change in goals, objectives, or case management activities. In **Comprehensive Case Management** programs, a Comprehensive Service Plan accompanies each Comprehensive Reassessment. In **Supportive Case Management** programs, a Brief Service Plan accompanies each Brief Reassessment.

**9. Case coordination & Case Conferencing:** Case coordination includes communication, information sharing, and collaboration, and occurs regularly with case management and other staff serving the client within and between agencies in the community. Coordination activities may include directly arranging access; reducing barriers to obtaining services; establishing linkages; and other activities recorded in progress notes. The agency has a written referral policies and procedures explaining how referrals to other providers are made. **Case Conferencing** differs from routine coordination. Case conferencing is a more formal, planned, and structured event separate from regular contacts. The goal of case conferencing is to provide holistic, coordinated, and integrated services across providers,

and to reduce duplication. Case conferences are usually interdisciplinary, and include one or multiple internal and external providers and, if possible and appropriate, the client and family members/close supports.

Case conferences can be used to identify or clarify issues regarding a client or collateral's status, needs, and goals; to review activities including progress and barriers towards goals; to map roles and responsibilities; to resolve conflicts or strategize solutions; and to adjust current service plans. Case conferences may be face-to-face or by phone/videoconference, held at routine intervals or during significant change. Case conferences are documented in the client's record. Supportive and/or Comprehensive Case Management services routinely coordinate all necessary services along the continuum of care, including institutional and community-based, medical and non-medical, social and support services. Case conferencing is utilized as a specific mechanism to enhance case coordination.

Coordination activities include frequent contacts with other service providers and case managers and are documented in the progress notes. Evidence of timely case conferencing with key providers must be found in the client's records. The client's right to privacy and confidentiality in contacts with other providers must be maintained. The client's consent to consult with other service providers is obtained. The providers comply with federal and state requirements regarding confidentiality of HIV-related information.

A case conference form can help document the participants, topics discussed, and follow up needed as a result of a case conference. When distributed immediately to attendees, the form reminds each participant of the roles and activities they've agreed to perform. Although more difficult to arrange, a face-to-face case conference can clarify issues or resolve conflicts more directly than conferring with parties separately or by phone. Involving clients in face-to-face case conferences with providers encourages participation and recognizes their role in the process.

**10. Crisis Intervention:** A clear crisis intervention policy and staff training on crisis intervention help ensure quick resolution of emergencies to minimize any damaging consequences (i.e., acute medical, social, physical or emotional distress). The organization has a policy for client crisis intervention services that ensures all onsite emergencies are addressed immediately and effectively. Clients must be provided resources to address a crisis after hours.

All clients must be provided with emergency contact information that includes resources and guidance to secure assistance outside of agency business hours. The need for a crisis plan is determined for each client. Individual crisis plans must include at minimum information on service providers who are accessible 24 hours a day and able to handle emergency situations. Program staff must be trained on agency crisis policy and how to respond to crisis situations. The organization must have policies and procedures to address crisis intervention protocol for incidents that occur on site.

A crisis plan is specific to an individual client's needs. Plans should be developed to ensure a client is able to navigate services during crisis and has specific instructions and provider contact information. Co-occurring disabilities or life circumstances affect the nature and extent of the plan, i.e. people with mental illness or at risk of domestic violence need to have their special needs addressed in advance to minimize the impact of emergencies. Case managers must discuss with clients what constitutes a crisis. The case management agency must assess crisis intervention service providers to ensure quality and appropriateness of their services and care. Programs must develop a mechanism to assess a pattern of individual use of crisis intervention services (i.e., frequency, repeat types of situations, resolutions) in order to minimize situations leading to crisis.

**11. Case Closure:** Clients who are no longer engaged in active case management services should have their cases closed based on the criteria and protocol outlined in a program's Policies and Procedures. A closure summary usually outlines the progress toward meeting identified goals and case disposition.

Common reasons for case closure include:

- Client lost to care or does not engage in service.
- Client chooses to terminate service.
- Client relocates outside of service area.
- Agency terminates as described in Policies and Procedures.
- Mutual agreement.
- Client is no longer in need of service.
- Client completed case management goals.
- Client no longer eligible.
- Client is referred to a program that provides comparable case management services.

Upon termination of active case management services, a client case is closed and contains a closure summary documenting the case disposition. Client must be discharged from non-medical case management services through a systemic process, including notification to the provider of medical case management services. Closed cases must include documentation stating the reason for closure and a closure summary. The Supervisor must sign off on the closure summary indicating approval. The organization must have policies and procedures outlining the criteria and protocol for case closures.

Case managers must attempt to reconnect clients lost to care back to services. These attempts may include home visits, written/electronic correspondence, and/or telephone calls and may require contact with a client's known medical and human service providers (with prior written consent). When services are terminated, an exit interview must be conducted if appropriate. Case managers must attempt to secure releases that will enable them to share pertinent information with a new provider. A management review must be completed in situations where an agency intends to terminate services related to a client who threatens, harasses or harms staff.

**12. Qualified and Trained Personnel:** Case managers must have the minimum qualifications expected for their job position. The agency must promote a diversity program that recruits, trains, and retains staff that respect the cultural and linguistic diversity of the community while meeting federal CLAS standards. All staff must receive on-going training and education to build cultural and linguistic competence and/or to deliver culturally and linguistically appropriate services. The agency will train staff for compliance with all applicable state and federal HIPAA confidentiality statutes. Case managers must demonstrate continued professional development by earning a minimum of 10 hours of HIV training each year.

**13. Supervision of Direct Service Staff by Qualified Agency Supervisory Personnel:** Non-licensed staff interacting directly with clients must be supervised by appropriately licensed or certified professionals. Qualified agency supervisory staff should be a Master's level clinician, who can provide on-going supervision to assure quality of care. This clinician may hold a Master's level counseling or social work degree. This clinician needs to have considerable experience in a responsible position of providing services to clients with multiple issues. This clinician will be responsible for:

- Weekly supervision sessions with case managers
- Quality review of client files
- Informing case managers when information, forms, and notes are missing from client files