Pennsylvania Ryan White Part B Case Management Standards

Medical and Non-Medical Case Management

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Introduction

Pennsylvania HIV Case Management Standards

This document was written to establish the minimum recommended standards for Ryan White Part B (RWB) funded HIV case management services across the Commonwealth of Pennsylvania. They are meant to serve as guidelines for best practice. The authors of this document recognize that standard case management practices may already be implemented by other regions in the state through other Ryan White funding streams. This document is not meant to conflict with what may already be in existence; rather, it is intended to serve as a helpful tool and supplement. It is the overall intent of the Pennsylvania Department of Health (DOH), Division of HIV Health to assist HIV case management service providers in understanding their case management responsibilities and to promote cooperation and coordination of case management efforts. To that end, a specific work group comprised of HIV service providers and recipients from across the state was convened in September 2021 by the DOH, Division of HIV Health to review and update the prior set of case management standards that existed. The state Medical Case Management workgroup met frequently and spent much time planning for a revised manual to reflect the changes in client needs that have coincided with advances in the treatment and prevention of HIV. What is found in the following pages represents thoughtful discussion, acknowledgement of the individuality of the HIV service regions along with their providers, and recognition of the common case management activities needed to end the HIV epidemic.

Case management standards are in place for several reasons. Having standards for providers is an important component of quality management and quality assurance. Through standards, case management and specific models can be clearly defined. In addition, standards allow for providers to know what is expected of them in terms of service delivery and required documentation. Standards provide clarity, consistency, and more efficient use of resources, and they promote quality of service. For the individual living with HIV, this means that wherever they choose to go for case management in the state, they will receive the same basic set of services.

RWB includes two models of case management services – Medical Case Management and Non-Medical Case Management. These two models were established to respond to varied levels of client need, client readiness for case management services, and agency resources. In the following pages, readers will find updated definitions and procedures for these approaches which are more in line with current trends in helping those with HIV experience better health outcomes. While there are subtle differences between the two models, their common goals are to ensure clients are engaged and retained in HIV medical care, that they have access to life-saving HIV medication, and that any barriers associated with accessing either of these are addressed.

A crucial aspect of HIV case management is continuity of care. Case managers play an important role in making sure that individuals become connected to care and that they remain in care during transition periods. These transitions can include, for example, times of unstable housing, discharge after incarceration, periods of active substance use, and/or severe mental illness, and the myriad of life losses. In addition, one of the biggest transitions is moving from one location to another, be it within one's home state or to another part of the country. Relocating to an area without having knowledge of HIV resources and planning for HIV care can negatively impact care continuity and potentially jeopardize gains made in health outcomes. Case managers should be prepared to aid individuals with HIV who are planning to move to another part of the state or out of state. In the section below, we review funding for RWB HIV Case Management and provide a table with information for case managers on how to access HIV services for individuals across the seven PA regions.

Funding

Funding for Part B HIV Case Management (both Medical and Non-Medical) comes from the federal Ryan White HIV/AIDS Program (RWHAP), which is administered through the U.S. Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB) and is distributed by the PA DOH, Bureau of Communicable Diseases, Division of HIV Health. The PA DOH is responsible for monitoring these funds, which are given to subrecipients across seven HIV regions in the state. These regions include three on the eastern side of PA, two in the central section, and two in the western part of the state. Regions can offer either or both models of case management. Each region also has its own process for referral of individuals into case management services – some use a central intake system, whereas in others, individuals in need of services can call directly to a provider agency and set up their initial visit. For a list of each subrecipient by region, their associated counties, and how to access case management services in that region, please see the table below.

Subrecipient Name	Website	How to Access MCM Services	Counties
Philadelphia Division of HIV Health (East)	HIV & STDs | Department of Public Health | City of Philadelphia	Central Intake Process Client Services Unit 215-985-2437	Philadelphia, Bucks, Montgomery, Chester, Delaware; (Burlington, Camden, Gloucester, Salem in NJ)
AIDSNET (East)	AIDSNET | Building Healthier Communities Together (aidsnetpa.org)	610-882-1119 Call funded providers directly Providers listed on website	Northampton, Lehigh, Berks, Monroe, Carbon, Schuylkill

United Way of Wyoming Valley - NEPA Regional HIV Services (East)	Home | Northeast PA Regional HIV Services (northeastpahiv.org)	No Central Intake Process Regional office will refer to MCM Provider if called (570) 829-6711 - UWWV (570) 270-9108 – NEPA Regional HIV Services	Pike, Wayne, Lackawanna, Luzerne, Wyoming, Susquehanna
Northcentral District Allied Connections (Central)	HOME | ncdac	No Central Intake Process NCDAC will refer to MCM Provider if called 570-726-8456 800-764-4545 TOLL FREE	Columbia, Northumberland, Snyder, Montour, Union, Sullivan, Lycoming, Clinton, Centre, Bradford, Tioga, Potter
Southcentral – Family Health Council of Central PA (Central)	HIV/AIDS Programs in Central PA | FHCCP	No Central Intake Process FHCCP website has place to request help finding provider FHCCP - 717-761-7380	Lancaster, York, Adams, Lebanon, Dauphin, Perry, Cumberland, Franklin, Juniata, Mifflin, Huntingdon, Fulton, Bedford, Blair
PA Thrive Partnership (formerly Northwest Alliance) (West)	PA Thrive – We're Here for You. (pa-thrive.com)	Central Intake Process 814-454-3811	Cameron, Clearfield, McKean, Elk, Jefferson, Warren, Forest, Clarion, Venango, Erie, Crawford, Mercer, Lawrence
Southwest – Jewish Healthcare Foundation (West)	Projects & Programs - JHF AIDS Free Pittsburgh HIV Treatment Finder (aidsfreepittsburgh.org)	No Central Intake Process Have website to help locate providers (HIV Treatment Finder)	Cambria, Somerset, Indiana, Westmoreland, Fayette, Greene, Armstrong, Allegheny, Washington, Butler, Beaver

This manual has been divided into two sections - Section A covers the standards for Medical Case Management and Section B includes those for Non-Medical Case Management. In addition to the standards themselves, we have provided indicators and examples of evidence related to each. A "**standard**" is a criterion required to be met by case management providers. An "**indicator**" is a more specific measure which is also required and shows that the related standard is being met. An "**example of evidence**" is not a requirement but is an example of how the appropriate party may visibly and objectively show that the related indicator and standard is being met. Although these standards set minimum requirements, the Division of HIV Health may establish additional requirements, modifying the standards to fit settings, objectives, target populations, and/or PA DOH initiatives.

Medical Case Management

Medical Case Management (MCM), including Treatment Adherence Counseling, is the

provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. The coordination and follow-up of medical treatments is a component of MCM and requires collaboration and coordination between the medical provider and medical case manager. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. MCM includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV treatments.

MCM includes client-specific advocacy and/or review of utilization of services. This includes all types of encounters including face-to-face, phone contact, and any other forms of communication. It also includes assistance in obtaining medical, social, community, legal, financial, and other needed services. MCM is a proactive case management model intended to serve people living with HIV (PLWH) with multiple complex psychosocial and/or health related needs, their families and support systems. It is strongly recommended that newly diagnosed individuals be offered MCM as opposed to Non-Medical Case Management to ensure linkage, retention, and adherence to all aspects of HIV medical care.

Non-Medical Case Management

Non-Medical Case Management (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or 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, Children's Health Insurance Program, Medicare Part D, state pharmacy assistance programs, pharmaceutical manufacturer's patient assistance programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication).

Goals and Key Activities

The goals of medical and non-medical case management include the following:

(1) Early access to and maintenance of comprehensive medical care and social services.
(2) Retention in Care
(3) Prevention of disease transmission and delay of HIV progression.
(4) Promotion and support of client independence and self-sufficiency using a strength-based service approach.

Key activities include the following:

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

A. Medical Case Management Practice Standards

Standard A-1: Client Screening

Following a referral or request for case management services, each client is screened (see Glossary, Attachment D) within five working days to determine:

1. The client's HIV diagnosis.

   (***NOTE:*** In cases in which a clinical diagnosis is not available and may take longer than five days to acquire, the case manager should operate based on a client's statement about HIV status until the clinical diagnosis becomes available. A clinical diagnosis must be obtained within 30 days for services to be provided.)

   The client's engagement in HIV medical care must be documented by the date of the most recent CD4, viral load, or ART medications.

   (***NOTE:*** In cases of a new diagnosis, a client is not in care or is returning to care and a CD4 or viral load test has not been performed or medications have not been prescribed, tests or prescriptions must be obtained within 30 days for services to continue.)
2. Client needs, and given these needs, whether case management services are appropriate for the client.
3. The types of services for which the client is eligible.
4. Financial/income status and medical benefits/insurance status.
5. Proof of identification.
6. Proof of residency.
7. Payer of Last Resort (refer to Attachment A.)

Indicator A-1.1: In cases of crisis situations, screening is suspended, and the crisis is addressed immediately.

Example of evidence:

- A client file addresses ways that crisis situations were handled.

Indicator A-1.2: Screening is conducted within five working days of request/ referral.

Example of evidence:

- A client file contains dated documentation of referral/request for service and client screening.

Indicator A-1.3: An official, dated diagnosis statement is received by the case manager.

Example of evidence:

- An official, dated statement is in the client file.

Standard A-2: Overview of Case Management
As part of the assessment, each client is given an overview of case management services and the roles and responsibilities of the case manager and the client, including the agency's grievance procedures and case management agreement.

Indicator A-2.1: Case management services, grievance procedures, and rights/responsibilities are described to the client.

Example of evidence:
- A client contact file contains a signed form indicating that the client has received an overview of services, grievance procedures, and roles/responsibilities of case manager and client.

Standard A-3: Comprehensive Assessment
Each client who consents to receive case management services receives a comprehensive assessment (see Glossary, Attachment D) within 30 days of the client's initial screening to identify the client's strengths, resources, needs, and problems. This assessment is done under circumstances (e.g., time and location, telehealth appointment) agreeable to the client and case manager and includes the following areas:
- Identification of source if referred to services
- Date assigned to case manager
- Basic demographic information, including gender identity
- Assessment of past and present utilization of community resources
- Client's statement of need
- Client's strengths
- Phone/internet/wifi/data capabilities
- Pets
- Summary of physical health history and respective treatment (including, but not limited to, hospitalizations and most recent CD4 and viral load results)
- Summary of mental health history and treatment
- Summary of substance use history and respective treatment
- Assessment of risk behavior and risk reduction behavior (e.g., risk of transmitting HIV, sexual risk behavior, domestic violence, partner notification)
- Summary of medical benefits/insurance
- Legal history, including probation officer, if applicable
- Housing/living situation (type of housing/household composition)
- Debt and financial concerns and sources of income
- Employment assessment (current employment; ability to be employed, job training and retraining)
- Family history/social support
- Names and addresses of primary physician, dentist, and pharmacist
- All current prescribed and over-the-counter medications/dosage, including

nutritional supplements and other substances used in other therapies (e.g., homeopathic remedies)

- Assessment of health literacy and treatment adherence (all medical care and medications)
- Releases of Information
- Other formal and informal resources
- Any barriers to services (physical, social, emotional, trauma, financial, etc.)

Indicator A-3.1: A case manager has identified past sources of services/care and has obtained summaries of pertinent, existing client primary and behavioral health records and legal history, as well as phone numbers and addresses of key providers.

Example of evidence:

- Existing client records have been received.
- Sources of referral, past service/care providers, and providers' phone numbers and addresses are listed in the comprehensive assessment documentation.

Indicator A-3.2: The client is assessed in key areas listed in Standard A-3.

Example of evidence:

- Documentation exists in the client's file that assessment in each area was conducted.
- When case management is being provided in a medical setting, client health information may be omitted from the case management record if it is clearly documented elsewhere on site and easily accessible to the case manager. Case note should refer to location in which information can be accessed.

Standard A-4: Service Coordination Plan

At the completion of the comprehensive assessment, each client and respective case manager develops an individual Service Coordination Plan (SCP) which:

- Includes realistic, measurable, and mutually acceptable goals which are based on information from the bio-psychosocial assessment.
- Identifies the action step(s) needed to achieve each goal, including target date(s) for accomplishment of stated goals.
- Specifies action steps for which the client and/or the designated representative and case manager are responsible.
- Indicates the anticipated result of each action step.
- Indicates referrals made to other providers/services in connection with the action steps.
- Includes a space for signatures by the client and case manager.

Indicator A-4.1: The SCP is completed at the end of the comprehensive assessment; both the client and the case manager sign the SCP; and a copy of the SCP is given to the client.

Example of evidence:

- A signed and dated SCP is in the client file, with an indication that the client received a copy.
- Letters of cooperation/collaboration among providers are on file.

Standard A-5: Referrals and Case Coordination

Each case manager refers to and coordinates services among community-based organizations, primary care providers, housing services, and other providers in managing the care of a client by advocating for the client and collaborating with these entities. 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 to ensure retention in care.

Indicator A-5.1: A case manager makes appropriate referrals to providers.

Example of evidence:

- Progress notes and the SCP show evidence of referrals to providers and advocacy for clients.
- Notes or other written materials give evidence that providers exchanged information, coordinated planning, etc.

Standard A-6: Documentation

Written or electronic documentation is kept for each client which includes:

- The client's name and/or unique identifier number.
- The case manager's name.
- The amount of time, date, place, and a description of each case management service.
- Indication of changes in client's situation.
- Information relating to the services provided which further reflects progress toward reaching goals identified in the SCP. Such documentation should be provided in a format, such as Data/Assessment/Plan (or DAP notes.)
- Referrals made to other services.
- Policies and procedures are in place for tracking, reporting, and billing for clients receiving medical case management services. (See CAREWare, Attachment C)

Indicator A-6.1: All documentation, both dated and signed by the case manager, is kept.

Example of evidence:

- Documentation is in the client file.

Indicator A-6:2: There is a policy and procedure in place for tracking, reporting, and billing of clients receiving medical case management services.

Example of evidence:

- A policy and procedure that is in place.
- Tracking, reporting, and billing reports are generated.

Standard A-7: Face-to-Face Contact

The client has face-to-face contact with the case manager a minimum of every 180 days or sooner based on client needs. As a result of this contact, the following is noted and recorded in the SCP and/or progress note:

- Assessment of progress toward goal achievement
- Effectiveness of the services and SCP
- Changes, additions, or deletions to current services, including the need for continued contact and for case management services

Indicator A-7.1: Progress notes are kept, and a review of the SCP is completed at least every 180 days.

Example of evidence:

- Progress notes and a revised SCP are in the client file.

Indicator A-7.2: Problems or critical issues which may hinder access to services are identified and action is taken to resolve them.

Example of evidence:

- Client records and SCP give evidence that problems/issues are identified, and action is taken.

Standard A-8: Retention in Care

If a client has not maintained contact with their case manager, there must be a mechanism in place to re-engage the client.

Indicator A-8.1: A policy and procedure is maintained by agencies to retain clients in case management and HIV medical care.

Example of evidence:

- The agency has a documented policy and procedure in place to re-engage clients that defines specific times frames and actions/methodologies to follow,
- Documentation that the procedure was followed is noted in the client's case file.

Standard A-9: Treatment Adherence

The client's adherence to HIV treatment must be assessed at least every 180 days or 6 months following the initial assessment.

Indicator A-9.1: Treatment adherence activities (including keeping medical appointments, taking prescribed medications, refilling prescriptions, etc.) are tracked for individual clients.

Example of evidence:

- Documentation is in the client records, and the SCP demonstrates that treatment adherence activities have been discussed and identified problems have been addressed.

Indicator A-9.2: Ongoing engagement in HIV medical care is documented at least every 180 days or six months.

Example of evidence:

- There is documentation in client records of the date of a CD4 count, viral load test, or prescribed ART medications within the past year.

Standard A-10: Reassessment

Clients will be reassessed on a yearly basis in the key areas cited in Standard A-3. A new service care plan must be completed based on the reassessment of the client.

Indicator A-10.1: The client is reassessed in required key areas as per Standard A-3.

Example of evidence:

- Documentation exists in the client's record that re-assessment in each key area was completed.

Standard A-11: Termination of Services

Case management services are terminated:

- When the client, in consultation with the case manager, indicates services are no longer needed or may be met better by another agency.
- When 12 months have lapsed since the client's last face-to-face contact or service

from the case manager. This time frame incorporates possible movement of a client to/from either case management model.

- For threatening verbal and/or physical behavior by clients toward case manager or agency staff, pursuant to individual agency policies.
- When the client moves to a new service area.
- When the client is incarcerated for more than 180 days.

Indicator A-11.1: Agencies must have procedures in place for attempting to contact clients who have been lost to follow-up before termination.

Example of evidence:

- Documentation that the procedure was followed is in the client file.

Standard A-12: Suspension of Services

Case management services may be suspended, but not terminated, when the client is institutionalized (i.e., hospitalized, placed in county jail or treatment facility) for 180 days or less. All efforts should be made to exchange information, as needed, for continuity of care.

Indicator A-12.1: The client is provided seamless case management services when entering or returning from the institution.

Example of evidence:

- The case manager acquires necessary information about case management received while the client was in the institution whenever possible.
- A policy is on file for suspending but not terminating cases so that seamless services can be offered on client's return to the case management provider.

Indicator A-12.2: The case manager obtains consent from the client or legal representative for transfer of appropriate records and information and ensures that the transfer of records/information is made to the respective institution for the sake of continuity of case management services.

Example of evidence:

- A provider has a policy on file regarding appropriate transfer of records.
- Client records indicate that a policy regarding transfer of records was maintained, and consent was given by the client.

B. Non-Medical Case Management Practice Standards

Standard B-1: Client Screening

Following a referral or request for case management services, each client is screened (see Glossary, Attachment D) within five working days to determine:

1. The client's HIV diagnosis.

   (***NOTE:*** In cases in which a clinical diagnosis is not available and may take longer than five days to acquire, the case manager should operate based on a client's statement about HIV status until the clinical diagnosis becomes available. A clinical diagnosis must be obtained within 30 days for services to be provided.)
2. The client's engagement in HIV medical care must be documented by the date of the most recent CD4, viral load, or ART medications.

   (***NOTE:*** In cases of a new diagnosis, a client is not in care or is returning to care and a CD4 or viral load test has not been performed or medications have not been prescribed, tests or prescriptions must be obtained within 30 days in order for services to continue.)
3. Client needs, and given these needs, whether case management services are appropriate for clients.
4. The types of services for which the client is eligible.
5. Financial/income status and medical benefits/insurance status.
6. Proof of identification.
7. Proof of residency.
8. Proof of primary care.
9. Payer of Last Resort (refer to Attachment A.)

Indicator B-1.1: In cases of crisis situations, screening is suspended, and the crisis is addressed immediately.

Example of evidence:

- A client file addresses ways that crisis situations were handled.

Indicator B-1.2: Screening conducted within five working days of request/ referral.

Example of evidence:

- A client file contains dated documentation of referral/request for service and client screening.

Indicator B-1.3: An official, dated diagnosis statement is received by the case manager.

Example of evidence:

- An official, dated statement is in the client file.

Standard B-2: Overview of Case Management
As part of the assessment, each client is given an overview of case management services and the roles and responsibilities of the case manager and the client, including the agency's grievance procedures and case management agreement.

Indicator B-2.1: Case management services, grievance procedures, and rights/responsibilities are described to client.

Example of evidence:
- A client file contains a signed form indicating that the client has received an overview of services, grievance procedures, and roles/responsibilities of case manager and client.

Standard B-3: Comprehensive Assessment
Each client who consents to receive case management services receives a comprehensive assessment (see Glossary, Attachment D) within 30 days of the client's initial screening to identify the client's strengths, resources, needs, and problems. This assessment is done under circumstances (e.g., time and location, telehealth appointment) agreeable to the client and case manager and includes the following areas:
- Identification of source if referred to services
- Date assigned to case manager
- Basic demographic information, including gender identity
- Assessment of previous or current case management services
- Client's statement of need
- Client's strengths
- Phone/internet/wifi/data capabilities
- Pets
- Summary of physical health history and respective treatment (including, but not limited to, hospitalizations and most recent CD4 and viral load results)
- Summary of mental health history and respective treatment
- Summary of substance use history and respective treatment
- Assessment of risk behavior and risk reduction behavior (e.g., risk of transmitting HIV, sexual risk behavior, domestic violence, partner notification)
- Summary of medical benefits/insurance
- Legal history, including probation officer, if applicable
- Housing/living situation (type of housing/household composition;)
- Debt and money management issues
- Employment issues (current employment; ability to be employed, job training and retraining)
- Family history/social support
- Names and addresses of primary physician, dentist, and pharmacist
- All current prescribed and over-the-counter medications/dosage, including nutritional supplements and other substances used in other therapies (e.g., homeopathic remedies)

- Assessment of health literacy and treatment adherence (all medical care and medications)
- Other formal and informal resources
- Releases of information
- Any barriers to services (physical, social, emotional, trauma, financial, etc.)

Indicator B-3.1: A case manager has identified past sources of services/care and has obtained summaries of pertinent, existing client primary and behavioral health records and legal history, as well as phone numbers and addresses of key providers.

Example of evidence:
- Existing client records have been received.
- Sources of referral, past service/care providers, and providers' phone numbers and addresses are listed in the comprehensive assessment documentation.

Indicator B-3.2: The client is assessed in key areas listed above.

Example of evidence:
- Documentation exists in the client's file that assessment in each area was conducted.
- When case management is being provided in a medical setting, client health information may be omitted from the case management record if it is clearly documented elsewhere on site and easily accessible to the case manager. Case note should refer to location in which information can be accessed.

Standard B-4: Service Coordination Plan

At the completion of the comprehensive assessment, each client and respective case manager develops an individual Service Coordination Plan (SCP) which:
- Includes realistic, measurable, and mutually acceptable goals which are based on information from the bio-psychosocial assessment.
- Identifies the action step(s) needed to achieve each goal, including target date(s) for accomplishment of stated goals.
- Specifies action steps for which the client and/or the designated representative and case manager are responsible.
- Indicates the anticipated result of each action step.
- Indicates referrals made to other providers/services in connection with the action steps.
- Includes a space for signatures by the client and case manager.

Indicator B-4.1: The SCP is completed at the end of the comprehensive assessment; both the client and the case manager sign the SCP; and a copy of the SCP is given to the client.

Example of evidence:

- A signed and dated SCP is in the client file with an indication that the client received a copy.

Standard B-5: Referrals and Case Coordination

Each case manager refers to and coordinates services among community-based organizations, housing services, and other providers in managing the care of a client by advocating for the client and collaborating with these entities. Case managers may also refer clients to HIV and/or primary care providers, as necessary, with minimal follow-up, but coordination of care is not required. 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 to ensure retention in care.

Indicator B-5.1: A case manager makes appropriate referrals to providers.

Example of evidence:

- Progress notes and the SCP show evidence of referrals to providers and advocacy for clients.
- Meeting notes and other written materials give evidence that providers have met to exchange information, coordinated planning, etc.

Standard B-6: Documentation

Written or electronic documentation is kept for each client that includes:

- The client's name and/or unique identifier number.
- The case manager's name.
- The amount of time, date, place, and a description of each case management service.
- Indication of changes in client's situation.
- Information relating to the services provided which further reflects progress toward reaching goals identified in the SCP. Such documentation should be provided in a format, such as Data/Assessment/Plan (or DAP notes.)
- Referrals made to other services.
- Policies and procedures are in place for tracking, reporting, and billing for clients receiving non- medical case management services. (See CAREWare, Attachment C)

Indicator B-6.1: All documentation, both dated and signed by the case manager, is kept.

Example of evidence:

- Documentation is in the client file.

Indicator B-6:2: There is a policy and procedure in place for tracking, reporting and billing of clients receiving medical case management services.

Example of evidence:

- A policy and procedure that is in place.
- Tracking, reporting, and billing reports are generated.

Standard B-7: Face-to-Face Contact

The client has face-to-face contact with the case manager at least every 180 days, consistent with client needs. As a result of this contact, the following is noted and recorded in the SCP and/or progress note:

- Assessment of progress toward goal achievement
- Effectiveness of the services and SCP
- Changes, additions, or deletions to current services, including the need for continued contact and for case management services

Indicator B-7.1: Progress notes are kept, and a review of the SCP is completed at least every 180 days.

Example of evidence:

- Progress notes and a revised SCP are in the client file.

Indicator B-7.2: Problems or critical issues which may hinder access to services are identified and action is taken to resolve them.

Example of evidence:

- Client records and the SCP give evidence that problems/issues are identified, and action is taken.

Standard B-8: Retention in Care

If a client has not maintained contact with their case manager, there must be a mechanism in place to re-engage the client.

Indicator B-8.1: A policy and procedure is maintained by agencies to retain clients in case management and HIV medical care.

Example of evidence:

- The agency has a documented policy and procedure in place to re-engage clients that defines specific times frames and actions/methodologies to follow.

- Documentation that the procedure was followed is noted in the client's case file.

Standard B-9: Reassessment
Clients will be reassessed on a yearly basis in the key areas cited in Standard B-3. A new service care plan must be completed based on the reassessment of the client.

Indicator B-9.1: The client is assessed in required key areas as per Standard B-3.

Example of evidence:
- Documentation exists in a client's record that reassessment in each key area was completed.

Indicator B-9.2: Ongoing engagement in HIV medical care is documented every at least every 12 months.

Example of evidence:
- There is documentation in a client's record of the date of a CD4 test, viral load test, or prescribed ART medications.

Standard B-10: Termination of Services
Case management services are terminated:
- When the client, in consultation with the case manager, indicates services are no longer needed or may be met better by another agency.
- When 12 months have lapsed since the client's last face-to-face contact or service from the case manager. This time frame incorporates possible movement of a client to/from either case management models.
- For threatening verbal and/or physical behavior by clients toward case manager or agency staff, pursuant to individual agency policies.
- When the client moves to a new service area.
- When the client is incarcerated for more than 180 days.

Indicator B-10.1: Agencies must have procedures in place for attempting to contact clients who have been lost to follow-up before termination.

Example of evidence:
- Documentation that the procedure was followed is in the client's file.

Standard B-11: Suspension of Services
Case management services may be suspended, but not terminated, when the client is institutionalized (i.e., hospitalized, placed in county jail or treatment facility) for 180 days or less. All efforts should be made to exchange information, as needed, for continuity of care.

Indicator B-11.1: The client is provided seamless case management services when entering or returning from the institution.

Example of evidence:

- A case manager acquires necessary information about case management received while the client was in the institution whenever possible.
- A policy is on file for suspending but not terminating cases so that seamless services can be offered on a client's return to the case management provider.

Indicator B-11.2: The case manager obtains consent from the client or legal representative for transfer of appropriate records and information and ensures that the transfer of records/information is made to the respective institution for the sake of continuity of case management services.

Example of evidence:

- A provider has a policy on file regarding appropriate transfer of records.
- Client records indicate that the policy regarding transfer of records was maintained, and consent was given by the client.

C. Case Manager Supervision, Education and Training Standards

Standard C-1: Minimum Qualifications

Case managers meet minimum qualification requirements (see Attachment B for a list of requirements.)

Indicator C-1.1: A personnel file for each case manager indicates that all qualifications are met by each case manager.

Example of evidence:

- A resume indicates the appropriate degrees/professional experience.
- A certification of HIV training is in the personnel record.
- Other diplomas and certification are noted in the personnel record.

Standard C-2: Professional Norms

Each case manager abides by professional norms (see Attachment B for a list of professional norms.)

Indicator C-2.1: The personnel file indicates that all professional norms are evident in each case manager's job performance.

Example of evidence:

- Annual performance reviews give evidence that a case manager understands and abides by professional norms.
- Client satisfaction surveys indicate a case manager has used professional norms as guidance in client interaction.
- Other documentation indicates that professional norms are understood and incorporated.

Standard C-3. Ongoing Education

Each case manager meets necessary ongoing educational requirements (see Attachment B for a list of these requirements.)

Indicator C-3.1: A file of written materials kept by the agency regarding each case manager indicates that each one of the above ongoing requirements is met or being met by the case manager.

Example of evidence:

- Annual performance reviews give evidence that a case manager meets or is meeting each ongoing requirement.
- Documentation is kept by individual case managers such as certificates of training completion.

Standard C-4: Case Loads
Each agency providing case management services may determine the maximum number of active cases that can be maintained by each case manager. Careful consideration needs to be exercised when assigning clients based on current caseload, acuity of clients and the proportion of medical compared to non-medical case managed clients.

Indicator C-4.1: An internal system exists to determine maximum case load and what actions are taken when a case load exceeds this maximum number.

Example of evidence:

- A written policy is on file at the agency.

Standard C-5: Clinical Supervision
Each case manager receives appropriate clinical supervision and oversight.

Indicator C-5.1: Each agency providing case management services establishes qualifications for supervisors of case managers.

Example of evidence:

- Qualifications are in writing and on file.

Indicator C-5.2: A process exists by which each case manager is assigned to, and receives clinical supervision from, a qualified supervisor.

Example of evidence:

- The agency files indicate that qualified supervisors exist (in-agency supervisors or those who travel from other agencies to provide supervisory tasks.)
- Personnel files indicate that qualified supervisors provide guidance and conduct case manager performance reviews.

Indicator C-5.3: A process exists by which a supervisor or administrator knowledgeable about appropriate client file contents signs off on these files.

Example of evidence:

- Client files contain appropriate sign-off signatures.

Attachment A – Payer of Last Resort

Policies and Procedures for Verification that Ryan White Part B is the Payer of Last Resort

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Policy:

All persons seeking services must provide the following documentation to be eligible for services:

- HIV diagnosis[1]
- Verification of identity
- Verification of residency
- Verification of income

Procedures:

1. Duration of eligibility: Documentation accepted during eligibility verification must be current – no greater than one year. The client's eligibility for services will lapse after one year from the date the client's eligibility was established or updated by the agency. Proof of HIV diagnosis does not have an expiration date and does not have to be updated.

Ryan White Part B is the payer of last resort for those services that are reimbursable by Medicare, Medicaid, commercial insurance, or other third-party resources. Agencies must verify a client's eligibility for Medicare, Medicaid, commercial insurance, or other resources prior to services being rendered. Agencies shall employ a traceable mechanism that assures that verification of eligibility occurred. This information must be maintained in the client's files.

2. HIV Diagnosis (Required by all agencies)

Acceptable documentation:

- A computer-generated lab test obtained directly from the test site
- Documentation submitted by a healthcare provider who ordered the testing

If the above documentation cannot be obtained, the client shall be referred for repeat testing.

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[1]For services available to persons not living with HIV, documentation of the relationship to an PLWH shall be maintained in the client's file.

3. Identity

Acceptable documentation:
- Pennsylvania driver's license
- Pennsylvania issued badge or card with photo ID
- United States Passport
- Social Security card
- Medicare/Medicaid/insurance card
- Voter registration card
- Birth certificate
- Any other document that has personal identifying information relating to the individual

Acceptable documentation for clients experiencing unstable housing::
- A letter with contact information on company letterhead from a case manager, social worker, counselor, or a professional from another agency who has personally provided services to the client

4. Pennsylvania residency

Acceptable documentation:
- Current lease listing client as occupant
- Current property tax documents
- Current utility/phone/other bills in the client's name
- Current pay stub
- Any other business correspondence with client's name and address, i.e., current bank statement, food stamp letter, Medicare/Medicaid/insurance letter
- A letter from a family member or friend certifying that the client is being provided a room and other assistance if applicable. The name, address, relationship to the client, and phone number shall be referenced in this letter
- Ryan White Part B funds cannot be used for individuals who do not reside in the Commonwealth of Pennsylvania
- If a client is a resident of Pennsylvania and presents for services outside of the region he or she resides in, documentation shall remain in the client's file that communication between regional grantees and/or providers has occurred. This will ensure that services are not being duplicated.

Acceptable documentation for clients experiencing unstable housing:
- A letter with contact information on company letterhead from a case manager, social worker, counselor, or a professional from another agency who has personally provided services to the client.

5. Income:

Prior to the provision of services, all clients shall be screened for financial eligibility for Ryan White Part B funded services.

Acceptable income documentation:
- Payroll stub/copy of payroll check/bank statement
- Stocks, bonds, and any other investments that generate income
- Unemployment benefits letter/copy of check
- IRS 1040 form/W2 form/1099 form
- Social security award letter
- Medicaid letter
- Any other letter referencing financial amount(s) awarded to a client
- Private disability/pension letter on company letterhead
- Child support
- TANF letter
- If a client reports zero income, the client shall submit a letter to the case manager stating why their income is zero. If a client receiving zero income, a case manager should ask how they are surviving and if they are receiving any under the table income. Clients with zero income are encouraged to apply for Pennsylvania Medical Assistance and SNAP benefits

6. Insurance and other third-party resources

All services covered or compensable under Medicare/Medicaid/Commercial insurance or other third-party resources shall be billed to those organizations prior to accessing Ryan White Part B grant monies. Payment(s) received from other resources for those services rendered, shall be payment in full. Rejected claims for compensable services due to provider billing errors or timeliness of submission of those claims to an insurance carrier, may not be submitted to Ryan White Part B for payment.

Funded Providers shall:
- Have a diversified funding base to support program activities.
- Enroll in Medicare/Medicaid/Commercial insurance and access other third-party resources for compensable services. (This will depend upon what type of services an agency provides)
- Verify a client's eligibility for insurance and other third-party resources prior to services being rendered to ascertain if services are covered or compensable under those plans before accessing Ryan White Part B grant monies. Verification of eligibility shall remain in the client's file.
- Ensure that there are not "unknowns" in the category of Medical Insurance in CAREWare. (See CAREWare, Attachment C)

Fiscal Agents shall:

- Review each funded provider's policies and procedures for the service(s) funded with Ryan White Part B grant monies.
- Require that charts and file notes be arranged in an orderly manner.
- Verify via a random chart audit, that there are traceable mechanisms in the chart that identify eligibility, HIV diagnosis, identity, residency, income, and potential sources of third-party revenues for each client. Fiscal Agents shall also ensure that providers have a system in place to bill and collect revenue(s) from appropriate third-party payers.
- Ensure that funded providers do not submit "unknowns" in the category of Medical Insurance in CAREWare. (See CAREWare, Attachment C)

Attachment B – Case Manager/Supervisor Minimum Qualification Requirements, Professional Norms, And Ongoing Requirements

Minimum Qualification Requirements for Case Managers (See Case Management Standards - Standard C-1):

Each case manager must:

- Have a Bachelor's degree in social work, psychology, sociology, or other related field or bachelor's degree in a non-similar field; or any combination of relevant education and experience.
- Have a working knowledge of HIV or be given education on HIV once hired.
- Possess interpersonal skills which allow effective interaction with clients and multiple providers in private households, residential care facilities, institutions, and medical settings.

Case Manager Professional Norms (See Case Management Standards - Standard C-2):

Each case manager must:

- Have a working knowledge of respective client's HIV health based on medical assessments.
- Ensure that clients are involved in all phases of case management practice to the greatest extent possible.
- Ensure that each client receives appropriate assistance through accurate and complete information about the extent and nature of available services.
- Help the client decide which services best meet his/her needs.
- Employ every measure to assure that client information is treated in strict confidence, in compliance with Act 148, including prescribed uses and limitations of releases of information.
- Intervene at the client level to provide and/or coordinate the delivery of direct services to clients and their families, including:
  - Outreach, referral, client identification, and engagement.
  - A comprehensive assessment of the client (assessment of the client's needs and personal support systems.)
  - The development of a comprehensive, individualized service plan.
  - Coordination of the services required to implement the plan.
  - Following clients over time to assess the efficacy of the plan.
  - Advocacy on behalf of the client, including creating, obtaining, or brokering needed client resources.
  - Reassessment of the client's status.
  - Periodic re-evaluation and adaptation of the plan as necessary over the life of the client (or termination of the case when services are no longer warranted.)
- Keep clear, concise, and complete records.
- Carry out his/her duties in a culturally sensitive manner.

- Abide by professional ethics.
- Be proactive/preventive/wellness-oriented.
- Use a strengths-based approach.
- Utilize a trauma-informed lens.
- Use person first language.
- Be committed to ongoing professional development and learning.

Ongoing Requirements for Medical Case Managers (See Case Management Standards - Standard C-3):

Each case manager should:

- Have knowledge of, and contact with, health care entities, social service agencies, and public entitlement programs in immediate and surrounding communities; have knowledge of service costs and budgetary parameters; and be fiscally responsible in carrying out all case management functions and activities.
- Identify resources and/or weaknesses in the local service system and develop a resource file.
- Coordinate with other agencies providing similar case management services to prevent duplication.
- Follow any ongoing training requirements put in place by the PA Department of Health and the Medical Case Management Training Project facilitated by the University of Pittsburgh and the MidAtlantic AIDS Education and Training Center (MAAETC).
- Maintain active licenses, if applicable.

Minimum Qualification Requirements for Case Management Supervisors (See Case Management Standards - Standard C-1):

In addition to the above standards for case managers, each case management supervisor is recommended to have a bachelor's degree (master's preferred) along with two years of experience performing social work and/or MCM activities.

Attachment C – CAREWare

All Ryan White Part B funded HIV case management providers are required to use HRSA's free software database program for collecting, tracking, monitoring, and reporting client level data. The current version is CAREWare 6 which is a web-based application. As of the writing of this manual, PA is in the process of centralizing CAREWare as opposed to each provider having their own standalone version of the database. Provider agencies can contact RA-DHCAREWARE@pa.gov for assistance with this process. Once users have been set up with centralization, they must complete a user agreement form and return it to the Department of Health. After this form is received, providers may request additional CAREWare users for the system and set up permissions for the database.

CAREWare operates as an electronic version of the client record and because of that, the information it contains must be treated with the utmost degree of respect, privacy, confidentiality, and security. Some examples of protected health information in CAREWare include the client's name, date of birth, address, phone number, and their social security number. CAREWare also creates a unique record number (URN) for each client using an algorithm as well as an encrypted URN. It is important to keep in mind that alone some of these items may not be enough to identify an individual but taken together would be enough to allow for breach of identity.

CAREWare also contains highly sensitive medical information including the individual's HIV status and lab data among other things. As with a paper chart, every effort must be taken to protect this information and keep it secure. The database should only be accessed from a private, secure location and never out in a public space. Users should not leave their computer screen unattended with the database open - instead they should log off the system if they need to step away for a period of time.

Encounters documented in CAREWare should be accompanied by a case note written in DAP (Data – Assessment – Plan) format. Each region may have specific requirements regarding additional areas within CAREWare that need to be completed by case managers. Attention to detail is important when working with the system to reduce data errors. Case managers should do their best to ensure CAREWare client records are accurate and contain up-to-date information. In some regions, other staff, such as data administrators, may assist with CAREWare data entry.

Additional information on CAREWare 6 including helpful manuals and training webinars can be found at CAREWare | TargetHIV.

Attachment D – Glossary

ACT 148 (Confidentiality of HIV-Related Information) – In 1988 the Pennsylvania legislature passed the act, to prevent unauthorized HIV testing or disclosure of a person's HIV status without consent. The Act was amended in July 2011.
Act of Jul. 7, 2011,P.L. 274, No. 59 Cl. 35 - CONFIDENTIALITY OF HIV- RELATED INFORMATION ACT - LEGISLATIVE INTENT, CONSENT TO HIV - RELATED TESTS AND COUNSELING (state.pa.us)

ART (Antiretroviral Therapy) – The daily use of a combination of HIV medicines (called an HIV regimen) to treat HIV infection.

CARE Act (Ryan White Comprehensive AIDS Resources Emergency Act) – Federal legislation enacted in 1990 to improve the quality and availability of care for low-income, uninsured and underinsured individuals and families affected by HIV disease. The CARE Act, which is administered by the HIV/AIDS Bureau of the Health Resources and Services Administration, was re-authorized in 1996 and 2000. In 2006, it was reauthorized again as the Ryan White HIV/AIDS Treatment Modernization Act of 2006.

Case Coordination – Includes communication, information sharing, and collaboration. 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 to ensure retention in medical care.

Case Management Model – The process through which a case manager and client determines the model of case management the client needs and is willing to accept. This process is completed after the assessment.

CD4 Cell Count – The number of T-helper lymphocytes per cubic millimeter of blood. The CD4 count is a predictor of immunity. As CD4 cell count declines, the risk of developing opportunistic infections increases. The normal adult range for CD4 cell counts is 500 to 1500 per cubic millimeter of blood. (The normal range for infants is considerably higher and slowly declines to adult values by age six years.) A CD4 count of 200 or less is an AIDS-defining condition. CD4 counts should be rechecked at least every six to 12 months if CD4 counts are greater than 500/mm3. If the counts are lower, testing every three months is advised. (In children living with HIV, CD4 values should be checked every three months.)

Client – An individual (and his/her defined support network), receiving case management services.

Code of Ethics – The Code of Ethics sets forth values, principles, and standards to guide decision-making and conduct when ethical issues arise. This code is relevant to all social workers, regardless of their professional functions, the settings in which

they work and the populations they serve. This code is to be adopted/followed by all case managers regardless of educational major and/or license.

Comprehensive Assessment – A comprehensive and interactive process between a client and case manager during which the case manager collects, analyzes, synthesizes, and prioritizes information to identify client's needs and strengths as well as resources for the purpose of developing a service coordination plan. Secondary data is frequently gathered from health and human service professionals to supplement gathered information.

Grievance – A verbal or written complaint regarding a practice or policy of an individual or organization per the organization's policy.

Health Education/Risk Reduction – The provision of services that educate clients with HIV about HIV transmission/reinfection and how to reduce the risk of HIV transmission/reinfection. It includes the provision of information about medical and psychosocial support services and counseling to help clients with HIV improve their health status.

HIPAA (Health Insurance Portability and Accountability Act) – In 1996 Congress passed the Health Insurance Portability and Accountability Act. This Act is the first comprehensive federal protection of patient privacy. It also sets national standards to protect personal health information, standardizes the way the health information is used, and makes health insurance more portable for clients.
HIPAA Home | HHS.gov

HIV Diagnosis – A copy of the documentation that verifies an individual is living with HIV. This proof of status must be obtained within 30 days from the date of intake to continue the provision of services.

Non-Medical Case Management – Non-Medical Case Management Services (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services.

Medical Case Management – Medical case management, including Treatment Adherence, is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. The coordination and follow-up of medical treatments is a component of medical case management, and requires collaboration and coordination between the medical provider and medical case manager.

Payer of Last Resort – Ryan White Part B is the payer of last resort for services that are reimbursable by Medicare, Medicaid, commercial insurance, or other third-party resources. Agencies must verify a client's eligibility for Medicare, Medicaid,

commercial insurance, or other resources prior to services being rendered. Agencies shall employ a traceable mechanism that assures that verification of eligibility occurred. This information must be maintained in the clients' files.

Performance Indicator – A performance measurement used as a guide to monitor, evaluate and improve the quality of case management or care. Indicators can relate to case management processes (key steps) and results (outcomes).

Progress Notes – Documentation relating to the services provided to a client, which further reflects progress toward reaching goals identified in the Service Coordination Plan (SCP). Such documentation should be provided in a format, such as Data/Assessment/Plan (or DAP notes). Each progress note is dated and signed by the case manager.

Screening – Initial process by which it is determined whether a potential client meets general eligibility for services, needs crisis assistance, and/or could benefit from a referral to other services. (See also assessment).

Service Coordination Plan (SCP) – The service coordination plan, also known as the care plan, is a case management work plan that identifies client needs based on the information exchanged during intake and comprehensive assessment. The purpose of the SCP is to facilitate client access to services and to enhance coordination of care to help maintain client health and independence. The purpose of the SCP is to facilitate client access to services and to enhance coordination of care to help maintain client health and independence. This plan must include realistic, measurable, and mutually acceptable goals, the action steps of the client and actual or potential providers necessary to reach those goals, a target date for accomplishment of each goal and action step, notation as to which party to the agreement is responsible for each step and the intended result or anticipated outcome of each action step. Progress notes in the client chart are expected to reflect the progress of this plan. Plans are updated as new goals and action steps are identified and as goals and action steps are completed.

Suspension of Services – Case management services may be suspended when a client is institutionalized (i.e., hospitalized, placed in a county jail or treatment facility).

Termination of Services – Case management services may be terminated when services are no longer needed, when twelve months have lapsed since the last face-to-face contact or service, when a client exhibits threatening verbal and/or physical behavior towards his/her case manager or agency staff and/or when a client moves to a new service area.

Treatment Adherence (HIV Treatment Regimen) – Adherence is following the recommended course of treatment by taking all prescribed medications for the entire course of treatment, keeping medical appointments, and obtaining lab tests when ordered.

Unmet Need – To determine the needs of individuals with HIV disease who know their HIV status and are not receiving HIV-related services and develop strategies to identify and bring into care individuals with HIV disease who are not in care and may be unknown to any health or social support system.

Viral Load – In relation to HIV, viral load is the quantity of HIV RNA in the blood. Viral load is used as a predictor of disease progression. Viral load test results are expressed as the number of copies per milliliter of blood plasma.

Additional Resources

- Pennsylvania Department of Health HIV/AIDS Information: HIV (pa.gov)
- Pennsylvania Ryan White Part B Continuous Quality Improvement Reference Guide (January 2024)
- Special Pharmaceutical Benefits Program (SPBP): Special Pharmaceutical Benefits (pa.gov)
- HIV/AIDS Bureau (HAB): https://ryanwhite.hrsa.gov/
- Ryan White Part B Manual: Ryan White HIV/AIDS Program -Part B Manual (hrsa.gov)
- CAREWare 6: CAREWare 6 | Ryan White HIV/AIDS Program (hrsa.gov)
- Ryan White HIV/AIDS Legislation: https://ryanwhite.hrsa.gov/about/legislation
- TargetHIV: Homepage | TargetHIV
- Health Resources and Services Administration (HRSA) HAB Policy Notices: https://ryanwhite.hrsa.gov/grants/policy-notices
- StopHIV: StopHIV.com
- Pennsylvania Medicaid Information: Medical Assistance (pa.gov)
- Social Security Disability Information: How To Apply For Social Security Disability Benefits (ssa.gov)
- Medicare: Welcome to Medicare | Medicare
- National Association of Social Workers Practice Standards: NASW Practice Standards & Guidelines (socialworkers.org)