TABLE OF CONTENTS

Ryan White Program
Service Area Standards: Medical Case Management
September 2013

INTRODUCTION

These standards exist to ensure that people with HIV have access to consistent, adequate services and that the public funds which purchase these services and other HIV care are effective and cost-efficient. Additionally, MCM is time limited and need based, with clearly defined roles and expectations for both clients and case managers.

The MCM system is designed to allow many agencies to provide this service, in the belief that different types of agencies will be better able to meet the needs of diverse populations. Standards ensure that within that diverse system, no matter which agency he or she chooses, a person with HIV will be assured of getting the same basic set of services and those services will be at or above a certain minimum level of quality. Agencies will still differ from one another in that each will enhance services in ways unique to their program, but all agencies will provide the same basic services. Another reason for there being standards is, in part, as a protection for persons living with HIV who are usually in a very vulnerable position when they seek case management services.

Finally, MCM is not a "stand-alone" service, in that it functions as a gateway to many other services. One role of MCM is to facilitate the effective and efficient use of all the resources in the care system. MCM standards exist, in part, to ensure that case management services are indeed integrated with the rest of the services system and that "management" function of the service is not short-changed.

It is important to remember that standards always describe a minimum level of service. Grantees do hope that agencies work to exceed the minimum standards through grantees providing training and necessary supervision to HIV MCM case managers. As always, those agencies which fund MCM services acknowledge and congratulate those agencies and individuals who have provided excellent MCM services to Minnesotans with HIV. We look forward to our continuing partnership in creating and sustaining an outstanding system for providing high quality, compassionate, vital services that support persons with HIV as they continue to live productive lives with dignity and hope.

All subrecipients must meet universal standards requirements in addition to service area standards for which they are funded.

Background:
Medical Case Management (MCM) is the backbone of the HIV services delivery system and the primary way of ensuring that people with HIV access, receive, and stay in primary medical care. The HIV services system provides several types of coordination, referral, and follow-up services that eliminate barriers and help people with HIV get connected and stay in care. MCM is the piece of this system that assesses the primary and immediate needs of people with HIV, coordinates referrals, and follows-up with critical core medical and support services to ensure people with HIV remain in medical care.

In 2001, the first written standards for Case Management were produced by the Minnesota Department of Health, AIDS/STD Prevention Services Section, under the guidance of a task force of thirteen case managers from several agencies. In 2005 and 2010, the standards were updated by Minnesota Department of Human Services (DHS), Hennepin County Ryan White Program, and staff from medical case management programs. In 2010, the Minnesota HIV Services Planning Council's Community Voice Sub-committee was also engaged for input.

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

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

Program Guidance. Medical Case Management services have as their objective improving health care outcomes whereas Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services. Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence Services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visits.

HIV/AIDS MEDICAL CASE MANAGEMENT STANDARDS
SEPTEMBER 2013

SECTION ONE: ENROLLMENT AND INTAKE

Intake is a time to gather and provide basic information from the client with care and compassion. It is also a pivotal moment to establish trust, confidence, and rapport with client. If there is an indication that the client may be facing imminent loss of medication or other forms of medical crisis, the intake process should be expedited and appropriate intervention should take place prior to formal enrollment. Service providers will understand that persons living with HIV/AIDS who are not accessing or utilizing HIV primary medical care can still receive other supportive services if desired.

Introducing Client to MCM - The first steps of the intake process is to ensure the client understands what medical case management is and that the client is currently not receiving this service elsewhere. Explain the goals, objectives, and key activities of MCM outlined in the HRSA definition above. It is extremely important to provide mandated information and obtain required consents, releases, and disclosure – see below.

Standard	Intervention	Measure	Data Source
Introducing Client to Medical Case Management (MCM)			
1. Client understands what MCM is and his/her roles and responsibilities as well as the case manager's 2. Client is not currently receiving MCM with another provider	1. Case Manager (CM) describes medical case management including these 7 components: • Intake • Mini Acuity Assessment and Acuity Scale • Education Development of goals and objectives focusing on access and retention in care. • Activities that are need based and in conjunction with the development and coordination of an individual service plan (ISP) • Follow-up and monitoring of client progress, and • Time limited with planning for individuals graduating to Self Management Tier or discharge 2. Verify that the client is currently not receiving this service elsewhere (if appropriate offer the option of changing providers by dis-enrolling and enrolling) The burden of obtaining documentation for the client lies with the new provider and involves a signed consent for services form, a completed assessment and a ISP, and an assigned case manager.	1a. Client understands and wants MCM services as defined in the Consent to Receive MCM Services. 1b. Client wants and can receive MCM from the agency. 1c. Client goals are met and Acuity levels are improved 1d Clients with no further needs are discharged from MCM. 2. Client understand he/she may receive MCM services from one provider only.	1a. A "consent to receive MCM services" form is signed by the client and kept in the client's file. 1b. Client goals and Acuity scores are documented in the ISP. 1c. Changes in Acuity tiers are documented in Acuity Scale 1d. CAREWare reports, acuity scale, and client chart. 2. A written "intent to switch providers" signed by the client is kept in the client's file at both the old and the new provider.

Standard	Intervention	Measure	Data Source
Complete required enrollment forms			
Intake: 1. Current demographic data for each client. 2. The mini acuity assessment will be completed during intake to identify issues that require immediate attention and establish frequency and intensity of engagement.	1. Demographic information as defined in Form I of CAREWare is kept current and accurate. 2. Complete the mini acuity assessment to identify needs in these 10 areas that will place clients in intensive MCM: Homelessness Peri-incarceration Pregnancy without prenatal care CD4 count below 200 AND a viral load above 400 New diagnosis of HIV Untreated mental illness New to antiretroviral therapy Not in care/re-engaging in care Non-adherence to HIV medication Chemical health/substance use	1. Client demographic information is collected and reported. 2. MCM Intake should take place as soon as possible and within five business days of referral or initial client contact. If MCM intake is not completed within five business days, coordinate referral for client and notify contract manager. ISP will prioritize and address crises.	1. Form I of CAREWare 2. Intake is signed, dated, and in client file.

The Mini Acuity Assessment (see Appendix)

The Mini Acuity Assessment is administered with every client as part of the initial intake to identify and address crisis needs. It can be a companion document for the Acuity Scale and provides information for the development of the individual service plan (ISP). If client reports suicidal or homicidal thoughts/intents, an **IMMEDIATE REFERRAL** is required.

Conduct the MCM 2013 Acuity Scale (see Appendix)

The MCM 2013 Acuity Scale, developed as part of the HIV Medical Case Management Guidelines by the District of Columbia in 2010, is replacing the two tools (the Comprehensive Assessments and the Acuity Scale). There are 4 tiers in this Acuity Scale: Tier 3 Intensive Management; Tier 2 Moderate Management; Tier 1 Basic Management; and Tier SM (Self-Management).

The Acuity Scale is an objective tool used to establish the frequency and intensity of engagement a client requires when receiving MCM services. It should be a client centered process; one that focuses on the needs and interests of the client with consistent and continuous access to medical care being a top priority. It should also include support services needs of clients in areas such as housing, social network and psychosocial support, nutrition, mental health services, substance abuse, transportation, legal, and prevention. This is a continuing and evolving process rather than an activity that could be initiated and completed in a single session. Periodic reassessments occur as defined by the needs of the client and the new four Tiers model. Total points identify the Tier (Tier 3-SM) of service and the client needs for this case management period.

Standard	Intervention	Measure	Data Source
Conduct the Mini Acuity Assessment			
1. The Mini Acuity Assessment is used in conjunction with the Intake form and the 2013 Acuity Scale	1. Agencies use the Mini Acuity Assessment with incoming clients to identify and address any crisis needs	1. Use the Mini Acuity Assessment with every client on the first day 2. CM uses the Mini Acuity Assessment to guide provision of emergency services to clients	1. Mini Acuity Assessment Template is on file 2. Date of first contact will be noted in client record. Mini Acuity Assessment will be dated. 3. Dated Mini Acuity Assessment is documented in file or electronically
Conduct Acuity Scale			
1. The 2013 MCM Acuity Scale is a detailed assessment of client's basic needs 2. CM conduct Acuity Scale assessments with each new client 3. CM reassess Tier I, II, and III clients' needs every 6 months. Self-managed tier clients will be re-assessed annually.	1. Agencies use the 2013 Acuity Scale 2. CM conducts an the Acuity Scale with incoming clients to fully identify needs and provide goals for the Individual Service Plan (ISP). 3a. The Acuity Scale is used to place clients in Tiers 3b. The Acuity Scale is used to reassess Tier I, II, and III clients' needs every 6 months. Self-managed tier clients will be reassessed annually.	1. Tier I, II, and III clients require a face-to-face Acuity Scale assessment at least once every 6 months. Self-managed tier clients require a face-to-face Acuity Scale assessment annually. If there is a major change in Tier (such as the client presents a number of new and critical issues) a face-to-face assessment is required. 2. CM will start an Acuity Scale /assessment within 5 days of client intake and complete it within 30 days. 3. CM uses Acuity Scale to guide provision of services to clients	1. Acuity Scale Template is on file 2. Date of first contact will be noted in client record. Acuity Scale assessment will be dated. 3. Dated Acuity Scale is documented in file or electronically

SECTION TWO: COORDINATION AND FOLLOW-UP

The Individual Service Plan (ISP) should reflect the client's needs identified in the acuity scale. **The priority is always to get clients into or maintain primary medical care.** It is critical that the ISP be developed in collaboration with client, taking into account his/her priorities and perception of needs. The approach should also be strength based. This means building on clients' strength and accomplishments rather than focusing on short comings or relapses. And finally, the ISP should be updated as needs or addresses and new goals are identified. Case managers have found this tool useful for tracking client's progress.

Standard	Intervention	Measure	Data Source
Develop the Individual Service Plan			
1. An Individual Service Plan (ISP) is developed which provides steps for client and CM to follow to address client needs 2. ISP is completed with clients within 30 days of the acuity scale. ISP will prioritize primary care access, retention, and treatment. 3. ISP will be reviewed and updated at least 30 within 30 days of an acuity scale reassessment.	1. Agencies have a standard form for an ISP and the ISP includes documentation of the following: • Identified needs(s) or issue(s) to address. • Process/steps to resolve the identified issues. Timeframe to accomplish the steps • Person(s) responsible for taking • action. Outcome of the actions taken. • the mechanism to check in on • progress 2. CM develops an ISP jointly with client—assist client with identifying and prioritizing needs. Outline steps to accomplish goals. 3. ISP will be updated as defined by the agreed upon timeframe. Revised or new ISPs will be written within 30 days of an acuity scale re-assessment.	1. A standard ISP form is used by all agency CMs 2. The ISP will be completed within 30 days of an acuity scale (exceptions will be documented). The CM and the client will indicate agreement to the plan by signing and dating the ISP. 3. The ISP will be reviewed and updated, as defined by the agreed upon timeframe or at minimum, every six months. ISP will be signed at least every six months.	1. A ISP Template is on file 2. A signed and dated ISP is in the client's record. 3. ISPs and review dates will be recorded on the written ISP.

Conduct Re-Assessments – the case manager needs to assess clients' medical, both HIV and non-HIV related, needs at minimum of every six months for Tier 3, 2, 1, and annually for SM clients (and more frequently as needed such as when a client presents a significant number of new and critical issues). This includes a reassessment of clients' understanding of health issues related to HIV, resources available to clients, and continuity/ regularity and access to medical and dental care as well as compliance with treatment. Service providers will ensure that persons living with HIV/AIDS and not accessing or utilizing HIV primary medical care could still receive other supportive services if desired. Access to other HIV supportive services is not conditional upon access to or utilization of HIV primary medical care.

Standard	Intervention	Measure	Data Source
Conduct reassessments			
1. At minimum every 6 months for Tiers III, II, and I clients and annually for Tier SM clients or whenever a client presents a significant number of new and critical issues.	1. At a minimum, reassessment should include • Confirmation of client's HIV care, medical provider's name, date of last clinic visit. • Updated income verification • Completed mini acuity assessment and acuity scale • Discussion and documentation of VL and CD4 counts.	1. All Tier III, II, and I clients should be reassessed every six months at minimum. All SM clients should be reassessed annually at minimum.	1. Dated reassessments are in client chart/file.

SUMMARY OF FREQUENCY OF CONTACT (All contacts will be noted in the client's file.)

	Frequency of Contact	**Frequency of Assessment**

	Phone contact	Face-to-face	Mini-Acuity Assessment	Complete Acuity Scale	ISP	Reassessment
Tier 3	Once a month	every 2 months	within 5 days of referral	within 30 Days of intake	within 45 days of intake	every six months
Tier 2	every 3 months	every 6 months	within 5 days of referral	within 30 Days of intake	within 45 days of intake	every six months
Tier 1	every 6 months	every 6 months	within 5 days of referral	within 30 Days of intake	within 45 days of intake	every six months
Tier SM	Every 6 months	annually	within 5 days of referral	within 30 Days of intake	within 45 days of intake	annually

Ensure Coordination and Follow-up – Medical case management is an ongoing "management" process, one that includes reassessments and follow-up. Coordination and follow-up are key components of medical case management**.** As appropriate, case managers will facilitate referrals by obtaining releases of information so they can provide information about client's needs to another service provider. The goal of the referral is to secure needed care and services and it is important that the case manager follow-up to make sure the client successfully accesses these.

Standard	Intervention	Measure	Data Source
Referral and Follow-up			
1. Standards are the same for all Tiers	1. A referral will be made if a client has not accessed or utilized HIV primary medical care within the past 6 months. Within three months of the referral, the case manager will follow up with the client, or provider to which they were referred either in person, by telephone or in writing. Service providers will have in place a procedure for verifying a client's health insurance status.	1. Ensure that the client is accessing or has accessed medical care in the previous 6-month period. If it is determined that a client does not have access to health insurance, an appropriate referral must be made and documented in the client's file.	1. Referrals made and the outcome of those referrals will be noted in client's file. The determination of health insurance status forms part of the client's permanent record and is to be retained in a secure location for at least six years.

SECTION THREE: HEALTH EDUCATION AND RISK REDUCTION (HE/RR)

Standard	Intervention	Measure	Data Source
Education			
Standards are the same for all tiers.	For new clients and/or clients with identified HE/RR needs through assessments and/or ISP , HIV and health care education may include the following: signs and symptoms of HIV disease • HIV progression • meaning and use of routine medical • tests (ie. viral load HIV test, CD4) medication adherence • managing medication side effects •	The provision of information, including dissemination about medical and behavioral health or preparation/distribution of materials in the context of medical and behavioral health.	HIV Education will be documented in the client's file as indicated by the client's presenting needs Document in the client's file any dissemination of information about methods to reduce spread of HIV
Risk Reduction			
	1. Client and CM identifies a need for prevention education or supplies 2. When identified as a need, and agreed	1. CM identifies need through assessment 2. Prevention	1. Need is documented in files

Standard	Intervention	Measure	Data Source
	upon by client, risk reduction education, prevention supplies (condoms, sharps box, needle exchange), partner testing and referral will be provided to the client and documented.	education and supplies are provided to the client as needed is identified	2. Document response in ISP or case notes

SECTION FOUR: TERMINATION, DISCHARGE PLANNING, INCARCERATION

Termination of Medical Case Management Services/Discharge Planning is an important component of medical case management. There are legitimate reasons for terminating medical case management services with a client, but keep in mind that termination should never be assumed. For example, clients may be very difficult to locate because they are recently homeless or in transition. Remember to close the client in the data collection system within thirty days of case termination.

Standard	Intervention	Measure	Data Source
Termination, Discharge or Graduation to Self-Management			
Termination or Discharge should occur to manage resources and ensure coordination of care for active clients	1. A client's case will be closed within 2 weeks receiving notification of the following situations: • Client wishes to terminate services • Death of client • Client refuses services Client • has been deported • Client has met the goals in the ISP • and no other relevant needs can be identified • Client moves out of state for > 3 months • Client has been physically threatening or verbally abusive • Client no longer meets program eligibility requirements • Client does not participate in client responsibilities of case management (i.e. signing release forms, participating in planning, etc.) • Client is incarcerated for greater than 6 month or client is lost to the provider for greater than six months * Standard is the same for all tiers	1. For cases being closed due to client request, clients need to provide a signed request to stop services 2. For cases being closed by the agency (not due to client request), client will receive a written notice of closing two weeks prior to the closing to allow time for client to challenge the decision to close.	1. A notification to close or copies of closure letters (originals in original envelope in the case of returned mail) will be included in the client's file. 2. The appropriate criteria will be noted in the client file client's file or closing summary. A brief closing summary stating the reason for closing, the final status of ISP and any other relevant information will be included in the client file.
Transfer Ensure coordination and continuity of care for clients	When client transfers to another provider ensure that the transition is smooth and client does not experience any lapse in medical services. The agency has a system in place to assist a client with changing providers and/or case manager	1. Agency understands current protocol for clients accessing MCM services from one provider only	1. Adopt and sign policy on one service provider per client 2. A dated and

Standard	Intervention	Measure	Data Source
		2. CM uses standard protocol to transfer or enroll clients to other providers	signed MCM provider transfer form
Incarceration Coordinate with correctional facilities to ensure continuity of care for clients	These individuals need intense medical case management immediately after release from incarceration to assess if their meds are running out, link them with a primary provider.	1. Client in Federal, State, and County Facilities may be enrolled and in MCM six months prior to release, unless additional time is needed to assist client with securing stable housing upon release.	Client's needs are clearly documented in client files including time needed to secure stable housing upon release.

SECTION FIVE: AGENCY STANDARDS

Standard	Intervention	Measure	Data Source
Medical Case Manager Competencies & Qualifications			
1. Medial Case Managers will be qualified for the positions	1. Professional CM will have current state licensure and • an undergraduate or graduate degree in social work, nursing, or public heath, human services *or* • at least two years experience providing social services responsible for a case load *or* • at least one year experience providing HIV services in a position that included providing the direct service skills listed above. (DHS will offer variance to case managers. Requests for variance are subject to the discretion of DHS). 2. Case Managers will have knowledge of • Signs and symptoms of HIV disease and HIV progression • Meaning and use of routine medical tests (i.e. viral load testing) • Medication adherence • Managing medication side effects HIV • transmission and transmission	1. The competencies for every case manager will be retained by each agency from the time of hire until at least one year after a case manager leaves the position. Professional staff possess current state licensure 2. Case managers will complete the HIV Medical Case Management certification training provided by the state as well as all required trainings by DHS and Hennepin County Ryan White program.	1. Program file contains documentation of all current direct service CM including education, work experience, skills assessment, and relevant certification or licensure where applicable and background check. 2. Program file contains documentation of training completion and ongoing education.

Standard	Intervention	Measure	Data Source
	prevention • HIV Risk Assessment and Risk Reduction 3. Case Managers will have competencies in the following areas: • psycho-social assessment of clients • interdisciplinary care coordination • monitoring of health/social service delivery to maximize efficiency/cost effectiveness • knowledge of the resources available to target populations • development and utilization of client-centered ISPs • data privacy and confidentiality • cultural and social indicators • impacting disease management for unique client populations 4. All new case managers will complete the annual MCM training provided by DHS.	Within 3 months of employment, a case manager will be knowledgeable on HIV/AIDS as listed. 3. Programs are staffed with personnel with knowledge of HIV and experience to provide medical case management.	3. Program file contains documentation of competencies requirements and how these are met by case manager.
Routine Supervision			
1. Routine Supervisor will be qualified for the position.	1. Program Supervisors will have an undergraduate or graduate degree in social work, nursing, or psychology *and* at least three years experience providing social services responsible for a case load *or* at least two years experience providing HIV services in a position that included providing the direct service skills listed above. 2. Formal supervision of program staff should occur at least monthly. DHS will offer variance to supervisors upon request from agency.	1. Program Supervision is provided by a qualified person 2. Supervision is provided on a regular, formal basis	1. Program file contains documentation of program supervisor qualifications including education, work experience, and relevant certification or licensure where applicable. 2. Records on formal supervision sessions are maintained for two years.

Standard	Intervention	Measure	Data Source
Clinical Consultant Services			
1. A licensed clinical consultant will provide guidance to MCM staff.	1. Program maintains a service agreement with a qualified clinical consultant to provide clinical supervision either in a group supervision setting at least once a month or in a one-to-one setting at least quarterly. 2. Clinical Consultant services include: Discuss CM observations of challenges experienced by clients and/or CM at meeting agreed upon goals and objectives. Consult with clinical consultant regarding possible mental health services referrals.	1. Qualifications for a clinical consultant: a licensed mental health professional with a graduate degree in one of the behavioral sciences or related fields 2. Documentation of staffing of individual clients. .	Program file contains copies of current licensure of clinical consultant. 2a. Provider record has dated and signed documentation of staffing with clinical consultant. 2b. Hours of clinical consultation documented in program quarterly reports to grantee.
New Employee Orientation			
1. New employees will be trained on Ryan White services, client eligibility requirements, and MCM standards.	1. Service providers will have an orientation program for new employees/volunteers who will be working with Ryan White eligible clients. The orientation program will include at minimum, a discussion of Ryan White funding eligibility, confidentiality and the universal standards. Orientation will be provided on topics relevant to HIV/AIDS and service specific standards.	1. Documentation of new employees' participation in orientation and content of training.	1. Documentation of new employee orientation content and attendance will be reviewed during annual site visits and/or audits.
Ongoing Training and Continuing Education			
1. On-going Training/ Continuing Education	1. Case managers will complete the core HIV case management training provided by the state, as well as all required trainings by DHS and Hennepin County Ryan White Program. 2. Case managers who have already completed the core training will complete 12 hours of continuing education annually. Continuing education sessions will be provided by grantees. Any grantees-sponsored training sessions, annually, will meet the continuing education standards. 3. A case manager may use other professionally accredited (nursing or social work) continuing education hours	1-3. Certificate of attendance or equivalent documentation.	1-3. Continuing education sessions will be reported in quarterly reports and documentation will be reviewed during annual site visits and/or audits.

Standard	Intervention	Measure	Data Source
	to meet the standard (with grantees' approval).		
Case Loads			
1. Case Load is on average, agency wide 50 cases per funded FTE. 2. Ensure a client is not waitlisted.	1. The contracted case load is 50 cases per funded FTE at any one time (per contract period) on average *agency wide*, unless a lower number is negotiated with the Grantee. Negotiated changes from this standard will be based on demonstrating that a significant portion of the program clients served require more time than a typical Tier III client. 2. Providers are expected to coordinate appropriate referrals to other MCM providers when they've reached their funded capacity and notify their contract manager.	1. Program tracks average FTE case load. 2. Referrals are coordinated if the next available appointment is longer than 5 business days.	1. Document case loads in quarterly reports, central database, and reviewed during site visits and audits 2. Quarterly reports and communications with contract manager
Monitoring and Documentation Systems			
1. Client information is stored and protected. 2. Internal chart reviews are conducted at minimum annually to ensure compliance with MCM Standards.	1a. Records of services to clients must be stored in a secure filing system. 1b. Computerized records must be password protected and backed up at least weekly. Backed up records will be kept in a safe and secure (off-site) location. Service providers must document when and by whom files are removed from a secure filing system. 2. Supervisor and peers will conduct internal chart audits for standards compliance.	1. Agency Procedures and demonstration of Client Data protection systems in place 2. Demonstration of compliance.	1a. For each client, a separate file must be maintained, or there is rationale as to why this did not occur. 1b. Systems verified during annual site visits and/or audits. Document in client record and report on centralized database 2. Documentation of internal chart reviews.

APPENDIX A DEFINITIONS

Acuity Scale—The MCM Acuity Scale is used to determine a client's MCM related needs. It is an objective tool used to establish the frequency and intensity of engagement a client requires when receiving MCM services.

Assessment— Process by which a case manager collects, analyzes, and prioritizes information which identifies client needs, resources, and strengths for purposes of developing a service plan.

Client File — A collection of printed and/or computerized information regarding a client using services currently or in the recent past.

Confidentiality — The process of keeping private information private. Information given by a client to a service provider will be protected and will not be released to a third party without the explicit written permission of the client or his/her representative.

Coordination with medical care — Health care services related to the treatment of HIV/AIDS infection and HIV/AIDS associated complications, as well as the maintenance of health status. Coordination includes referrals and follow-ups to ensure client access services and/or barriers are addressed.

Criteria —Definition of specific, measurable outcomes expected from a Standard.

Culturally Appropriate Care — The ability of service providers and others to accommodate language, values, beliefs and behaviors of individuals and groups they serve.

Demographic Information — Descriptive information about a client--including, but not limited to, age, race/ethnicity and gender. This information provides a profile of people receiving services from a specific agency.

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

Health Education/Risk Reduction — Activities which include information dissemination about methods to reduce the spread of HIV; HIV disease progression; and the benefits of medical and psychosocial support services. This activity does not include medication or treatment information, which is part of Adherence activities.

Individual Service Plan (ISP) — Created by identifying client needs based on information collected during assessment/reassessment; a written plan that directs the activities of the client and the case manager. The ISP delineates the medical case management goals and objectives that support the client's access to and retention in primary care and the continuum of health and support services required to manage their disease.

Reassessment — Conducted to determine the client's case management status and the need for revisions in the care plan. Acuity scale may be used in lieu of 6 month reassessment for Tier III clients. Comprehensive re-assessment required for all three tiers.

Referrals — The act of directing a client to a service in-person or through telephone, written or other type of communication.

Quality Assurance/Improvement —A method of program/service evaluation, which is designed to assure that the highest quality of services are provided to the client.

Standard — Authoritative statements by which a profession describes the responsibilities of its practitioners.

Unit of Service— 15 minutes of activities performed on behalf of a unique client = 1 unit of service