

*New York State Department of Health
AIDS Institute*

COBRA Community Follow-up Program (CFP)

Program Standards

Introduction

The Community Follow-up Program (CFP) provides intensive, family-centered case management services, to HIV-infected and high risk persons, who are identified as having had difficulty accessing medical care and/or other services, and who require frequent personal contacts and/or home visitation to ensure their return for medical care and other needed services. Consistent with the intent of the model, the goals of the Community Follow-up Program are:

- Provide access to services which increase independence and self sufficient functioning;
- Provide access to services which prevent or delay institutionalization;
- Increase universal access to HIV information, counseling, testing and services;
- Monitor clients to ensure access to medical and social services in order to promote early medical intervention
- Assure continuity of care and follow-up of clients;
- Promote coordination among service providers and other support systems to eliminate duplication and foster resource development;
- Increase access to appropriate services for, and promote the functioning of the family unit, recognizing that the family constellation is a constant in the client's life.

Please note that the term "family" is used in its broadest sense to include family, collaterals, co-residents, and other significant supports in an individual's life.

Towards these goals, the CFP established standards of case management which help to ensure that services achieve a defined quality of care. Case management is a multi-step process which ensures coordination and expedient access to a range of appropriate medical and social services for the client and family. The multi-step process includes the following activities.

- A. Intake
- B. Assessment
- C. Initial Service Plan Development
- D. Initial Service Plan Implementation
- E. Reassessment
- F. Service Plan Update
- G. Service Plan Update Implementation
- H. Monitoring
- I. Crisis Intervention Activities
- J. Termination/Case Disposition Activities
- K. Client Advocacy, Interagency Coordination and Systems Development Activities
- L. Supervisory Review/Case Conferencing/Staff Support
- M. Client Rights

The following sections describe the specific functions in detail.

A. Brief Intake/Assessment and Brief Service Plan

The intake is the collection of identifying information concerning the client, family, caregivers and informal supports. It determines eligibility for enrollment in the program and provides the basis for beginning case management activities and a comprehensive assessment. Intake procedures should be completed within fifteen days of the individual's referral to the Community Follow-up Program provider. Intake procedures may be performed by the case manager or case management technician. Intake information must be documented on forms developed or approved by the State Department of Health, AIDS Institute.*

Information to be collected includes:

- the referral source and date of referral
- identifying and demographic information
- a list of family members and co-residents, including children not currently living at home, identification of the primary caregiver and legal guardian(s) of the children
- confidentiality concerns
- HIV diagnosis
- medical status, housing status, financial status and other issues requiring immediate attention for the client
- emergency contact
- health insurance
- languages spoken
- date completed

Immediate needs identified as a result of the Intake/Brief Assessment should be addressed by the case manager and services implemented promptly. A Brief Service Plan addressing the immediate or presenting problems is due at completion of the Intake/Brief Assessment.

The intake process also includes obtaining client consent to case management, home visitation, case conferencing, service acquisition and local department of social services (HRA) registration procedures. The consent form for CFP case management must include confirmation that the case management program has been fully explained to the client, including the client's right to choose care providers and that they have chosen to enroll in the agency CFP. A copy of "client rights" should be given to the client at intake. Intake costs for clients who do not consent to case management are not directly billable; however, costs for these services are fundable and built into the reimbursement rate.

* The State Department of Health, AIDS Institute Case Management Unit has developed specific case management documentation. These include the consent, intake, assessment, reassessment, service plan and exit summary forms. These formats identify the scope of information that must be collected.

B. Comprehensive Assessment

Assessment is the collection of information about the client's medical, physical and psychosocial condition, resources and needs. The purpose of an assessment is to identify the client's/family's problems and service needs, what service needs are being met and by whom, what services have not been accessed or are not adequately coordinated, as well as to evaluate the strengths/resources of the client and support system which can be utilized during service planning. Assessment activities should be finalized, no later than sixty (60) days from the date of the completed Brief Intake/Assessment. The assessment is the primary responsibility of the case manager, who may be assisted by the case management technician. Assessments must be documented on forms developed or approved by the AIDS Institute.

The assessment process should include a home visit to evaluate the client's needs, informal supports, and general living condition. Family members should be seen during the assessment process, if appropriate, as the assessment should include a description of the family functioning as a unit; notation of psychosocial, medical, financial and other problems affecting the family; and include information about preventing the transmission of HIV.

The initial assessment should focus on immediate health and social services needs and address the client's history of under-utilization of care, and the reasons for such under-utilization.

The following information should be included in the assessment:

- health status which includes but is not limited to TB, OB/GYN, disease staging, medications, other known medical conditions
- nutrition
- employment/education
- financial resources, entitlements
- housing
- transportation
- support systems
- parenting/children's needs
- alcohol/drug use history
- mental health
- legal (e.g., health care proxy, guardianship arrangements)
- activities of daily living
- supervisor signature and date, signifying review and approval

Other service providers should also be contacted (with client approval) to complete a comprehensive assessment.

In order to discuss an individual's case with a provider, agencies must first secure the client's documented permission to release necessary information to that agency. The approved Department of Health release of information form should be dated and filled out completely. There can be no blank, signed forms maintained in the chart for future use. All agencies should be indicated and all unused boxes should be crossed out prior to a client signing the form.

Release forms should be dated to expire at the end of one year or when the client's case is closed, which ever comes first.

C. Comprehensive Service Plan Development

Development of the service plan is the translation of assessment information into specific goals and objectives, with defined activities, services, providers and time frames to reach each objective. It should be completed immediately following the comprehensive assessment within sixty (60) days of the date of brief intake/assessment. The Brief Service Plan developed at intake should be incorporated into this Comprehensive Service Plan. The case manager has primary responsibility for the development of the service plan, with assistance from team members and in conjunction with the client, family representatives and other providers. The plan should be documented on forms developed or approved by the AIDS Institute.

Assessment information should be used to guide the identification of short term and long term goals. These goals and resultant activities and services are determined with participation of the client and support persons. Ideally, professionals from relevant disciplines and agencies are also involved in the development of the service plan and will have agreed to assume specific functions/responsibilities. Actions to be taken by the client, case manager, and others, including family members should be clearly defined. Two important aspects of the plan are the client's personal and capacity-building goals.

The service plan will reflect services to be accessed on behalf of the client and family members and identify expected outcomes toward goal attainment. If services actually provided differ, a note explaining the difference should be made. Goals for family members/collaterals should be clearly identified as such. The client's participation in the development of the plan and agreement with the plan and/or declination of any part of the plan must be indicated by their (or family representative) signature. A copy of the plan should be given to the client.

The service plan should be organized to include:

- the goal
- activities (actions to be taken)
- the individual/agency who will perform the activity (e.g., case manager, client, family member, agency representative)
- anticipated time frame for completion
- expected outcomes
- supervisor signature and date, signifying review and approval

It is the intent of the NYS Department of Health AIDS Institute and NYS Department of Social Services that case management provided under the Community Follow-up Program represent a fully integrated case management approach. The case manager coordinates all necessary services along the continuum of care, institutional and community based, by directly arranging access to services or by establishing linkages with other service programs, including those under the jurisdiction of the local department of social services. The role of the case manager is to reduce service, agency and administrative barriers to ensure that clients obtain needed services.

Services accessed for the client should include institutional and non-institutional medical and non-medical services, social and other support services and linkages to existing community resources. In so doing, the case manager will coordinate services with other service providers/case managers who may also serve the client.

D. Service Plan Implementation

Service plan implementation is the ongoing responsibility of the case manager and should begin immediately after service needs are assessed. The case manager and other team members will assist the client and family or co-residents as needed, in contacting support persons and agency providers to negotiate the delivery of planned services. The service plan may be modified to accommodate the client, family members, co-residents, and service providers. Any changes from the original plan should be noted in the record.

Clients, consistent with the responsibilities identified in the service plan, should be encouraged to carry out the tasks they agreed to. Case management staff should take into consideration client strengths and encourage active client participation, to promote empowerment. Family members and collaterals, as identified in the service plan, also take part in service acquisition. It is, however, for all service needs identified in the service plan, the responsibility of the case management staff to ensure and/or perform the following activities:

1. contact providers, including support persons, by phone, in writing, or in person;
2. assist the client and family members or collaterals in identifying and applying for services and entitlements, including basic needs such as transportation, child care, food stamps, etc.;
3. confirm service delivery dates with providers, and supports;
4. schedule multiple visits by family members on the same day if such scheduling better accommodates the needs of the family and children;
5. document services that aren't available or cannot be accessed;
6. obtain assurance from other care providers that services will be initiated, and confirm the delivery of these services;
7. in conjunction with the client and other providers, determine and articulate the ongoing responsibilities of each provider;
8. give other service providers accurate and complete information about the service(s) they are expected to provide and the services provided by others; and
9. monitor and assist the client to maintain optimal physical health and well-being.

Coordination of service delivery involves frequent contact with providers and clients to ensure that services have been arranged and received.

Guidelines for contact include:

1. upon determination of service need, assist client with any necessary applications, or forms that need to be completed if appropriate;
2. confirm approval, of services to be provided and if possible set a date for service delivery;
3.
 - a. 24-48 hours to arranged service delivery date, confirm service delivery arrangements, or
 - b. continue contacts to attempt to confirm service delivery date;
4.
 - a. immediate contact and follow-up is required, for services targeted to children, and in certain cases adults, that are necessary to assure the immediate safety and health of that individual; and
 - b. for life-sustaining services that have been arranged through nursing or other home care referral, case management staff should coordinate with hospital or health center case managers to confirm receipt of services within 24 hours after agreed upon service delivery date.

E. Comprehensive Reassessment

Reassessment is a scheduled or event generated formal re-examination of the client's situation, functioning, clinical and psychosocial needs, to identify changes which have occurred since the initial or most recent assessment. A formal reassessment is due within one hundred eighty days (180) of the completion of the original assessment and every 180 days thereafter or when a change in the client's status occurs which significantly affects the service plan.

Significant changes in status include:

- Death, illness or hospitalization of a family member or care giver(s), or a condition or circumstance which impairs the client's ability to provide for the family's physical and/or emotional needs.
- Change in the client's clinical or functioning status.
- Loss of housing.

Reassessment is the primary responsibility of the case manager, with assistance from the case management technician. Reassessment information should be documented on forms developed or approved by the AIDS Institute.

During the reassessment the case manager conducts a formal review with the client and family of each area administered in the assessment. Reassessment, also includes information on stage of HIV disease, and the agencies involved with the client. A case conference should be held with these agencies, the client and family. The reassessment should measure progress toward the desired goals outlined in the service plan. This information is used to prepare a new or revised service plan or confirm that current services remain appropriate.

F. Service Plan Update

Updating the service plan means modification to or revision of the service plan based on the reassessment. Update of the service plan may also occur as a result of changes in clients' needs, or information from monitoring contacts when changes are not significant as to require a formal reassessment. Update of the service plan includes all activities of service plan development, described above in Section C, relative to new or changed needs and services. Another service plan should be completed at every reassessment or earlier, when a change in client status occurs which significantly affects the service plan. The service plan may be updated by the case manager with assistance from the members of the case management team.

G. Service Plan Update Implementation

Implementation of the updated service plan includes the same activities as described for service plan implementation noted in Section D, and may be the responsibility of the technician or community follow-up worker under the supervision of a case manager. Activities which foster client self-sufficiency should be promoted.

H. Monitoring

Monitoring is contact between the case manager or other team members and the client or representative, support persons and service providers. The purpose of these contacts is to assure that services are being delivered according to the service plan. Contacts may include encounters in the agency, home, hospital or outpatient department, and other community providers' office settings. Contacts may occur by phone, mail or in person. Any problems noted during monitoring contacts will be followed up immediately with the client, support person or provider, as needed, to address the problem. Case coordination with other service providers should be evident in the progress notes.

The case manager will assure that all clients in the Community Follow-up Program who are of unknown serostatus receive HIV counseling and are provided access to testing and an initial comprehensive HIV medical evaluation within six months. If high risk clients refuse testing within this time period, or if they test HIV negative, plans must be made to discharge clients and make referrals to another case management program or appropriate service providers. The case manager should assure the client's freedom of choice of providers by allowing the client to choose a provider from a list of qualified providers.

For all CFP clients, the case management staff in conjunction with a medical provider, are responsible for active monitoring of the client's overall medical status. This involves on-going case conferencing with medical providers and confirmation of a client's HIV status (AIDS, symptomatic, asymptomatic) especially as part of an assessment and reassessment process. This will assist in determining the appropriate stage to initiate active prophylactic and secondary treatment of infections, as well as identify the types of interventions that may need to occur as one progresses through the course of the illness. Initial assessment information gathered should include confirmation of HIV status, TB status, OB/GYN status, T-cell count, nutrition, medications, etc. and these areas should be regularly monitored. Appropriate referral resources

should be identified through these periodic assessments. When requested, or when high risk behavior is reported or suspected, periodic testing of other family members should also be encouraged and arranged by the case manager/case management team.

For clients receiving intensive case management, programs should comply with the following contact frequencies:

- A minimum of three (3) contacts per month.
- At least four (4) face to face contacts with the case manager every one hundred eighty (180) days.
- Home visits should occur at assessment/reassessment, and as needed based on the individualized needs of the client/family.

Greater frequency of contacts in all categories should be arranged on an as needed basis. In certain difficult cases, contacts may need to be on a daily basis especially during times of crisis. The schedules of team members should be flexible enough to allow for intense intervention when it is needed. Clients with whom a case management relationship has been established and who experience periods of stability, or for clients who are non-compliant with their service plan, and/or are lost to follow-up, may receive less intensive case management. However, a minimum of one client contact per month is required under Comprehensive Medicaid Case Management regulations and 180 day reassessments must continue with at least one home visit during that time and a minimum of three (3) face to face contacts every 180 days.

The contact frequencies may be met by any combination of contacts from the case management team members, i.e., the case manager, case management technician or community follow-up worker. However, the case manager must personally have two contacts with the primary client every ninety days. Case conferences should be held for clients/families with multi-agency service plans including agencies such as community health centers, local departments of social service, local child welfare or community based organizations whenever possible.

The client's and support person's progress in obtaining services will be noted, as applicable in the record. Documents needed by service providers in order to initiate services are completed and forwarded, and a copy placed in the record. Copies of service schedules for all services provided to the client and/or co-residents shall be given to the client or co-resident.

I. Crisis Intervention

The purpose of crisis services is to provide assessment and referral for acute medical, social, physical or emotional distress. Crisis intervention should be made available to all Community Follow-up Program clients on an emergency 24 hour basis through formal agreements with other (internal or external) programs or service providers, subcontract with a 24 hour crisis agency, crisis hotline, mobile crisis team, other subcontract, or via direct provision by the CFP staff.

Crisis services may be needed for a variety of reasons, such as an emergency medical need, drug use, loss of housing, domestic violence or child abuse. Irrespective of the nature of the crisis, it is the responsibility of the case manager or provider agency to assist the client, family, co-

resident or collateral in obtaining the appropriate response to the situation, keeping in mind the need to maintain the client's dignity and rights to privacy and confidentiality. In addition, the crisis intervention should be designed to decrease inappropriate utilization of emergency rooms by targeting the response more appropriately to the identified crisis.

Crisis intervention planning should be a part of each service plan. The client record should reflect consideration of specific responses for each type of intervention that may be necessary in the particular case. The plan should contain instructions for clients on how and when to identify the appropriate crisis response for a given emergency need. These responses should be discussed with the family and informal caregivers as well. The agency should take steps to assure that crisis services are utilized only when necessary but that crisis services are available and usable on a 24 hour basis. In addition, the provider agency should have a crisis plan or crisis manual under which emergency responses are outlined.

All incidents requiring crisis intervention shall be documented in the client record and reported to the case manager. The case manager, in turn, should review the service plan to determine what revisions, if any, are necessary to assist the client. Crisis intervention may be a joint responsibility of the case manager and members of the case management team. Staff support and supervision should be available to case managers and the case management team involved in crisis intervention.

J. Exit Planning/Case Discontinuation

Exit planning procedures are initiated when the client:

- expires
- is no longer CFP eligible due to loss of Medicaid or programmatic eligibility
- declines the case management services of CFP
- desires to be referred to a different CFP provider agency or other case management program that would meet their/family case management needs and/or is desired by a client
- will be institutionalized for greater than 180 days and discharge to community based care is not anticipated
- the client relocates out of the CFP provider's service area
- the client cannot be located or does not become engaged in service planning within six months

Exit planning is the responsibility of the case manager with assistance from the members of the case management team. A case closure summary on forms developed or approved by the New York State Department of Health, AIDS Institute noting case disposition and measures of progress toward identified goals should be prepared and placed in the final record.

In all cases, except where the client expires, the provider must complete a referral process designed to link the client with appropriate ongoing case management and other vital services necessary to meet their care needs. With the client's consent, a case summary should be prepared for referral to the new provider. The local Department of Social Services should be

notified of the dis-enrollment and case disposition, and may be able to assist in referral of the client to alternate case management providers.

K. Client Advocacy, Interagency Coordination and Systems Development

The function of the case manager is to be an advocate for services for the client with particular emphasis on self-sufficiency in the community and avoidance of premature or unnecessary institutionalization. As such, a percentage of time spent by the case manager can be expected to be related to non-client specific activities such as interagency coordination for the purpose of development of needed, nonexistent resources in the community, reorganization of access to existing services, and development of referral agreements and relationships between existing agencies as specified in the section on Case Management Standards. Case managers may also serve a useful purpose in the development of the continuum of care and in community efforts to bring attention to the problems associated with the lack of services. These activities may be performed on an ongoing basis and may be part of the allowable administrative costs of the agency.

L. Supervisory Review/Case Conferencing/Staff Support

An important component of the required quality assurance process for each CFP provider is supervisory review of case management documentation, service plans and other products as well as peer review or case conferencing with other case managers.

Supervisory review of each client assessment and service plan by the designated supervisor must be conducted initially at the time of the development of the original assessment/service plan and after each reassessment and service plan revision. It is recommended that supervisory reviews occur within two weeks, particularly for the first comprehensive assessment. Supervisory reviews are required within a month.

Reviews ensure that documentation is in compliance with AIDS Institute standards and CMCM regulations and that case management services are relevant to the identified and emergent needs of the client. These reviews also evaluate the effectiveness of case management interventions and identify barriers case managers face in meeting client goals. Procedures should be implemented to ensure that corrective actions take place in a timely fashion. In addition, each agency participating as a CFP provider will establish a peer review process wherein all case managers will present and discuss client specific case management plans with other case managers in the agency at least once quarterly.

Case conferencing is an integral mechanism for coordinating service provision, identifying needs, and accessing care. Case conferences with other agencies are required at the initial assessment and development of service plan and at subsequent reassessments (every 180 days), taking into consideration the client's need for confidentiality, privacy, and consent. This would include contacts with discharge planners, medical providers and case manager's from other agencies, etc. Case conferencing and case specific supervision, are billable in the Community Follow-Up Program. Agency conferences and supervisory sessions that are not client specific

are not billable, however, are part of the administrative indirect costs built into the reimbursement rate.

The agency shall also provide staff support for its case managers. Case managers can easily become overwhelmed by the complexity of the physical and emotional problems of persons with HIV/AIDS, and thus may be faced with exploring their own fears of vulnerability, mortality, and loss. Many case managers in an intensive setting may need to be involved with clients and families on a daily basis. The agency supervisor needs to be aware of staff's need for respite and informal peer support. Monthly supervision, and staff support sessions allow time for adequate supervision of and assistance with case management issues and may be more often if needed. The standardized reimbursement rate includes time for such staff support activities and adequate on-call coverage which helps prevent staff burnout and unnecessary staff turnover. Staff development activities such as training in bereavement, death and dying and dealing with stress are also important for case management staff and may be helpful in addressing the stressful situations with which case managers deal on a daily basis.

M. Client Rights

In the context of the aforementioned case management activities, clients rights must always be taken into consideration and every effort made to safeguard the individual's rights. Case management staff shall ensure that client rights are protected in all aspects of the program.

The following are standards which must be adhered to by CFP providers.

1. All case management staff shall be trained on the rights of clients and on confidentiality.
2. The case management agency shall have written policies and procedures regarding the rights of clients, including grievance procedures for clients.
3. Case management staff must exhibit sensitivity toward the "family" unit; recognizing that the family is a constant in the client's life, while service systems and personnel fluctuate.
4. Each client or authorized representative shall be informed of his or her rights in writing, at the time of admission into the program through the execution of a signed client consent form. This includes the right to freely accept or decline case management services with the agency or any other provider, or to accept or decline home visitation or other elements of the service plan, and:
 - a) to participate in the development and revision of the comprehensive services plan and of the exit plan; be informed of all services to be provided, and when/how services will be provided;
 - b) to be given the name, agency address, agency telephone number, and function of any person or affiliated agencies providing care or services to the client;
 - c) to decline any portion of the plan after being fully informed of and understanding the consequences of not receiving such services;

- d) to recommend changes in policies and services to program staff, local agency staff and state agency staff;
- e) to voice complaints and to seek protection from mental, physical and financial abuse, mistreatment and neglect;
- f) to be informed both verbally and in writing of available grievance procedures;
- g) be informed of the conditions under which he or she may be discharged;
- h) to be treated with respect, consideration and full recognition of his or her dignity and individuality;
- i) to be shown proper and current identification by any person providing services in the home and to have his or her wishes regarding the home and environment, furnishings and possessions respected;
- j) to have his or her case records treated confidentially; and
- k) to receive services without regard to age, race, creed, color, gender, sexual orientation, marital status, political affiliation or disability status.

Please note: Time frames for the AIDS Institute Community Follow-up Program Standards documentation requirements differ from the minimum standards set by the State Department of Social Services CMCM regulations. Community Follow-up Program Standards have been modified to allow more time for a thorough assessment to include a home visit, and the collection of information from family, significant supports and other service providers to ensure the development of a comprehensive service plan. Compliance reviews will monitor against AIDS Institute Community Follow-up Program Standards.