

Foundational Overview – Case Management Assessment

Denver Office of HIV Resources

Denver Department of Environmental Health

MEDICAL CASE MANAGEMENT

Purpose and Role of Case Managers

The American Case Management Association (AMCA) and others have helped define the general scope of case management services over a wide realm of service functions. For the purposes of this report, these functions have been grouped into seven main areas:

1. **Biopsychosocial Assessment.** Through the utilization of early biopsychosocial assessment tools, the case manager ensures that services are generated in a timely and cost-effective manner.
2. **Access to Care and Services.** By facilitating and coordinating timely and appropriate health services, the case manager assists the participant in achieving an optimal level of wellness and functioning.
3. **Self-Management.** Through health literacy and disease management education, individualized goal setting and self advocacy support the case manager assists the participant to become a full and active participant in their own health care.
4. **Adherence.** Through adherence assessments and screening, coordination of services, psychosocial support, crisis management and education, case managers assist all providers to communicate a consistent adherence message to the participant and assist the participant to adhere to their medical and service treatment plans.
5. **Coordination of Care and Services.** Through facilitation of the organizations providing services and assistance in the sequencing of appropriate health care services in the most cost-effective manner, case managers improve the quality of care in order to promote optimal outcomes for all parties involved. Additionally, they provide quality health care along a continuum, decrease fragmentation of care across many settings, enhance the participant's quality of life, and help contain costs.
6. **Transition Planning.** Through regular assessment and psychosocial support, case managers ensure that the participant is functioning in society at the most appropriate level, they assist in returning the participant to work (or other meaningful activities, depending on their condition), and they also determine when services, including case management, are no longer needed.
7. **Quality of Care.** Through continual assessment of the participant's situation and care, case managers ensure they are connected to and adhere to the proper treatment needed, and that the treatment is implemented in an efficient way and avoids duplication of other services the participant is already receiving (Powell & Tahan, 2008).

Working off the above purpose and the premises that —Case managers are required to professionally and legally provide state of the art and ethical services,|| (Powell & Tahan, 2008, p. 164) the research identifies nine key roles for case managers:

1. **Educator.** Given the complexities of our health, medical, and long-term care systems, case managers are able to assess the educational needs of their participants and their family members and educate them in the areas identified. This may include medications, types of treatment, healthy lifestyles (nutrition, fitness, stress management, substance use reduction, etc.), and illness risk-reduction strategies.
2. **Coordinator.** Through multidisciplinary collaboration efforts, case managers are able to organize service providers so that they meet the needs of their participants and their families.
3. **Communicator.** Case managers articulate and clearly communicate the needs of their participants to family members, health/medical clinicians, and other service providers so those participants can obtain the needed services and reach their highest level of functioning.
4. **Collaborator.** Case managers collaborate with numerous health, medical, and social service providers about the needs of their participants.
5. **Counselor.** Case managers provide psychosocial support and stability to participants while they go through difficult life events and medical situations.
6. **Utilization manager.** Case managers ensure cost-effective care delivery and use of services. They focus on the continuum of care and the transition of participants from one level of care to another.
7. **Transition planner.** Case managers plan transitions by examining the participant's condition, the necessary treatment options, and where the relevant services are available. They then develop a plan of care that includes a discharge or transition plan.
8. **Quality manager.** Case managers are responsible for improving the quality of care provided by supplying both qualitative and quantitative data on their services and outcomes from other services.
9. **Advocate.** Case managers ensure that the needs of participants and their families are met by treating them as a priority (Powell & Tahan, 2008; Rizzo & Abrams, 2008; Livneh & Antonak, 2005).

HRSA's defines both kinds of case managers as follows:

- Medical case management includes a range of client-centered services that link clients with health care, psychosocial, and other services. Coordination and follow-up of medical treatments are components of medical case management.

- Services ensure timely, coordinated access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of clients' and key family members' needs and personal support systems.

Medical case management includes treatment adherence counseling to ensure readiness for and adherence to complex HIV/AIDS regimens. Key activities include:

- (1) initial assessment of service needs;
- (2) development of a comprehensive, individualized service plan;
- (3) coordination of services required to implement the plan;
- (4) client monitoring to assess the efficacy of the plan; and
- (5) periodic reevaluation and adaptation of the plan as necessary over the life of the client. It includes all types of case management, including face-to-face meetings, phone contact, and any other forms of communication.

- Nonmedical case management includes advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Nonmedical case management does not involve coordination and follow-up of medical treatments, as medical case management does. (U.S. Department of Health and Human Services, 2008, p. 2)

HIV Case Management Process

Managing both the crisis and maintenance stages of HIV case management starts with a complete understanding of the medical, psychological and social state of the participant's life. Only after this happens can the case management services strategically work with the participant to develop goals and action steps to improving their conditions. Most importantly, it is critical for the case management system to adequately assess acuity in order to develop system interventions that meet the specific level of needs facing the participants they serve (Chernesky & Grube, 2000).

Biopsychosocial Assessment:

With complex needs, the case management process must have a strong biopsychosocial assessment at the beginning of the working relationship. A strong assessment has three key components:

- Multiple sources of data
- A comprehensive scope, and a determination of
- Appropriateness for service based on the level of service needed (acuity).
(Powell & Tahan, 2008).

While an interview with the participant is a key part of the case management assessment, a complete biopsychosocial assessment solicits information from all the key aspects of the

participant's life. In addition to an interview with the participant, a strong assessment includes:

- Input from the primary care provider
- Providers of other services (including criminal justice professionals) that the participant is receiving medical and other treatment records and in situations where employment is a key need, an employer.
- The 2008 site visits collected data on whether biopsychosocial assessments are completed on time and in compliance with the Denver Standards of Care. In medical case management, the biopsychosocial assessments were in compliance in 93% of files. Nonmedical case management files were in compliance only 39% of the time.

Acuity:

- Acuity, determined through the biopsychosocial evaluation process, ensures that the program is focusing on individuals who are most in need of case management services.

The AMCA has identified key indicators that determine if case management is necessary for a participant's overall care. While not an HIV specific list, it does put forth key risk factors that often require a higher level of case supervision and management (Powell & Tahan, 2008). An individual may need case management services if they have:

- Complex medical issues or comorbidities:
 - Are over 65
 - Have a readmission, or readmission within 15 days
 - Have Alzheimer/dementia
 - Show evidence of noncompliance
 - Have repeated admissions to acute care
 - Have frequent visits to the ER, family physician, or clinic
- Needs for complex and costly services/resources
 - Have been admitted to an extended care facility or sheltered living arrangement
 - Shows need for transitional care or sheltered living environment
 - Is a single or first-time parent
 - Is dependent in activities of daily living; inability to shop for groceries, drive, or cook for self
- Complex psychosocial issues:
 - Have a history of drug overdoses
 - Have a history of chemical dependency
 - Have an eating disorder
 - Have a chronic mental illness
 - Are uncooperative, manipulative, or aggressive behavior
 - Have coexisting behavioral and physical conditions
 - Lives alone or with someone with a disability
 - Is a victim of violent crime

- Have no known social or family support system
- Have a disruptive or obstructive family members or significant other
- Risks for untoward events including legal/ethical concerns :
 - Is suspected of child or elder abuse and neglect
 - Is an undocumented immigrants
- Compromised financial situations or absence of health insurance:
 - Have a history of or is currently homeless
 - Is existing in a poor or unsafe living environment
 - Have limited or no financial resources
 - Has no or inadequate health insurance (Powell & Tahan, 2008)

During recent years, several TGAs, EMAs and Part B Programs have moved toward a case management system based on acuity. The level of acuity was determined by one of two methods:

- The first is the utilization of formal acuity assessments (participants were assessed at intake, usually by a professional trained to use a standardized assessment tool)
- The second approach was through an assessment of the participant's presenting problems.

For those using formal assessments (more subjective, though simpler, process that relies on the case manager's or intake professional's interviewing skills to determine the needs of the participant in a variety of areas)

- Regardless of how acuity is determined, the amount and type of services are outlined by the Standards of Care. The acuity score is directly related to the type and/or intensity of services the case manager provides to the participant. The acuity score is, in essence, a statement of the participant's need and then services are provided to address these needs.
- Acuity is then reassessed over time and the participant's services are adjusted to address the level of assessed need. If acuity is low, many sites have a short-term case management service where someone can receive limited assistance around an issue and then are discharged when acuity drops to a certain level.
- Acuity-based caseload systems assign workload based on participant need, rather than the number of participants. (This approach has also been shown to improve the job satisfaction of the case manager.

Multidisciplinary Approach:

- HIV positive individuals have varied levels of complexity in their cases.
- This requires case management between different systems of care to ensure that the participant is receiving all the services they require and that there is solid communication and collaboration across systems (Adams & Grieder, 2004).

- For a system to realize the true benefits of the chronic disease model, care must be delivered in a team approach. The case manager is well positioned to be the coordinator of this team.
- Their role is to ensure that key information is being communicated across providers and that the overall services are seamless, from the participant's perspective.
- In addition, the case manager must be —specifically trained to consider diversity issues - that is, ethnicity, race, gender, sexual orientation, age, socioeconomic status, physical and mental conditions, and environmental differences, within cultural, societal, and historical context (Claiborne & Vandenberg, 2001, p. 221).
- In addition to the multi-disciplinary approach, it is equally important that the participant is empowered to be active in their own care management.

Components of the Treatment/Service Planning Process

Implementation & Coordination:

- Once the assessment and initial connection to services is complete, case management becomes focused on the coordination of service delivery through the implementation of the case management plan.
- Implementation and coordination of the case management plan requires that the case managers reassess the participant's condition on an ongoing basis.

According to the AMCA, for effective implementation of the case management plan, case managers should answer the following questions:

- Does the participant have any new needs that must be incorporated into the case management plan?
- Are the participant and health care team in agreement with the plan?
- What is the appropriate timeframe for implementing the treatments and interventions? Is this timeframe appropriate for resolving the identified problems?
- Does the transitional/discharge plan meet the participant's condition and needs?
- Have all the necessary authorizations for treatment and services been obtained?
- Have the barriers to meeting the plan been addressed or resolved?
- Are the activities and outcomes on target?
- Is care progressing according to the case management plan?
- Are treatments occurring per the established timeline?
- Is the participant ready for discharge (based on acuity)?
- Is the participant being cared for in the appropriate level of care (acuity) or setting?
- Are there any issues with reimbursement? Have all required authorizations been obtained?
- Does the case management plan meet the needs and interests of the participant?
- Are there any legal or ethical risks present?

- What modifications in the case management plan are necessary? (Powell & Tahan, 2008)

One of the key findings about the case management process is the importance of coordination of care through utilization management. Utilization management is when the multi-disciplinary team ensures that the needs of the participant are being met and that services are being provided in a high quality efficient manner (Powell & Tahan, 2008). The AMCA outlines eight goals for utilization management:

1. To ensure effective utilization of health care resources through ongoing monitoring.
2. To determine medical necessity and appropriateness of care.
3. To identify patterns of overutilization, underutilization, and inefficient scheduling of resources.
4. To promote quality participant care and optimal outcomes.
5. To assist in the identification of coordination of care options for members and providers.
6. To facilitate appropriate, safe, timely, and effective discharge to the most appropriate level of care.
7. To provide education concerning the utilization management program to providers and department staff.
8. To identify potential participants in disease management and case management programs. (Powell & Tahan, 2008)

Case managers have become critical to the utilization management process:

- As the professional that crosses over to all aspects of the participant's care, the case manager is well positioned to lead the utilization process, as they have the most holistic understanding of where the participant is in all aspects of their treatment.
- In order to achieve the benefits of increased quality and efficiency, a representative from each service must participate in the process.
- While utilization management does require a certain level of capacity, the investment is realized by improved services and the avoidance of high expenses, such as hospitalizations and emergency room visits (Rizzo & Abrams, 2000).

Case Coordination and Conferencing:

- Case Coordination - includes communication, information sharing, and collaboration, and occurs regularly with case management and other staff serving the client within and between agencies in the community. Coordination activities may include directly arranging access; reducing barriers to obtaining services; establishing linkages; and other activities recorded in progress notes|| (Florida Department of Health Bureau of HIV/AIDS and Hepatitis, 2009, p. 9-1).
- Case Conferencing - a formal, planned, and structured event separate from regular contacts. The goal is to provide holistic, coordinated, and integrated services across providers, and reduce duplication. Case conferences are usually interdisciplinary, and

include one or multiple internal and external providers and, if possible and appropriate, the client and family members or designated care giver(s). Case conferences can be used to identify or clarify issues regarding a client status, needs, and goals; to review activities including progress and barriers towards goals; or to resolve conflicts or strategize solutions. Case conferences may be face-to-face or by phone, held at routine intervals or during significant changes. (Florida Department of Health Bureau of HIV/AIDS and Hepatitis, 2009, p. 9-1)

Retention in Care and Services:

- Retention in care happens long before a participant exits care prematurely
- Utilizing acuity based systems ensures that the case management process is focusing the right level of services to match the participant's needs.
- It is typical that participants with multiple and challenging presenting problems, such as mental health, substance abuse, homelessness or other social or psychological issues, are those who fall out of care.
- Acuity based systems assist the case manager to focus the most attention on these participants proactively, and focus less time and energy on those participants who are able and in a position to better manage their own care and services (Claiborne & Vandenburg, 2001).
- Utilization management is a proactive methodology serving to increase retention.
- Many issues leading to premature exits from care may be identified by one professional in the multi-disciplinary team; however, if the professionals on the case do not meet regularly, these issues may not be brought to the attention of the professionals who could handle conflicts, mental health and substance abuse issues, or social problems that make retention difficult.
- If positioned as the overall coordinator of participant's services delivery, case management has been proven to be an effective tool in improving the overall health of the participant (Rizzo & Abrams, 2008; Claiborne & Vandenburg, 2001; Goodwin, 2004).

Critical Components of HIV Case Management

Self Management:

- Self-management is the participant's ability to partner with health care providers —to management the symptoms, treatment, and lifestyle behavior changes, as well as the psychical and psycho-social concerns, that are a part of living with chronic disease|| (Rukeyser, 2008, p. 9).
- Research has demonstrated that self-management is a critical element in determining appropriate decision making and behaviors that lead to improved health outcomes.
- These outcomes are realized when the participant and professional create a partnership in the participant's care and where responsibility is gradually shifted to the participant as their ability to manage their own care increases (Rukeyser, 2008).

- One of the key components of a self-management is to understand the course of the disease and the evidence-based approaches needed for successful treatment.
- All the professionals within a chronic disease model must be experts on the specific of the disease, treatments, medication side effects, prevention components, and health management. Standards of Care and evidence models should guide services and the case manager's coordination of those services.
- In addition, it is the case manager's responsibility to ensure that these services are delivered without duplication and in a cost effective manner (Powell & Tahan, 2008).

Participant Education:

- An uneducated participant is more likely to be unhealthy and will need higher cost services.
- Participant education has been shown to increase quality through successful treatment implementation and lower cost by decreasing emergency room and inpatient visits.
- The better informed the participant is about their condition, the lower their level of anxiety.
- The sooner the case manager can help a participant understand their disease, the less chance they enter a denial response leading to poor adherence and dangerous behaviors.
- In addition, the better understanding the participant has of the reality of their situations the less chance they have of becoming depressed as a result of their diagnosis (Powell & Tahan, 2008).
- One of the key aspects of participant education is health literacy. The American Medical Association (1999) found that poor health literacy is —a stronger predictor of a person's health than age, income, employment status, educational level and race|| (p. 552)
- Results of poor health literacy include:
 - Discontinued use of prescribed medication when symptoms lessen
 - Changes in the dosage, frequency or time of day a medication is taken
 - Taking someone else's medication for a perceived common symptom (Mullahy, 2009)
- With the pressures and time restraints often placed on physicians and other medical professionals, managing health literacy becomes an important role of case managers.
- This reinforces the need for the case manager to be well trained on, and familiar with, the latest medical terminology and medical treatments, as well as have the ability to effectively teach health literacy to participants.

Adherence:

- Another key component of a successful disease management system is a focus on treatment adherence.
- The literature demonstrates the effectiveness of the utilization of self-management principles, such as behavioral contracting, skills training, self-monitoring, prompts and reminders, self-efficacy enhancement, and social support.
- Non-adherence is a significant issue relevant to chronic disease treatment success. In one study of those receiving treatment for a chronic disease, it was found that 79% of the

participants relapsed to previous negative lifestyle choices that directly impacted their diagnosis, and 50% dropped out of treatment within one year.

- Falling back into old/harmful patterns of behavior lowers the quality of care a system can provide and participants end up utilizing higher level of services due to the resulting crisis (Rizzo & Abrams, 2008).
- Research also defines a critical role for the case manager when it comes to the issue of adherence.
- The implementation of psychosocial support interventions is shown to increase overall treatment adherence. In their role, case managers are positioned to be a primary support professional in the care system.
- While coordination and implementation of services are critical, of equal importance is their ability to provide psychosocial support to the participant.
- Research also demonstrates the power of psychosocial support related to HIV care.
- Findings show that depression increases the symptoms of HIV infection by causing a decline in CD4 count and increasing the risk of mortality.
- Stressful life events and a lack of social support have been linked to increasing one's chance for developing AIDS.
- Client focused psychosocial interventions have been shown to decrease depressed mood and reduce other negative health factors. Furthermore, those in psychosocial support services have demonstrated lower levels of anxiety, anger, total mood disturbance and stress after their HIV medical treatment (Rizzo & Abrams, 2008).
- The explanation for the above results demonstrates the power and role of psychosocial support in chronic disease care.
- Many research studies conclude that these outcomes are due to the ability of case managers and other psychosocial support professionals to increase medical compliance and treatment adherence through the strategic implementation of psychosocial support programs.
- It is this area where the case manager can have the most impact if they are properly trained in health literacy, adherence monitoring and counseling skills (Rizzo & Abrams, 2008).

Psychosocial Support Components:

- The first key component of a psychosocial support role is to assist the participant in exploring the personal meaning of the chronic illness.
- Another key component is teaching adaptive coping skills for successful community functioning.
- Group experiences should be another key component of any psychosocial support program.

Resource Knowledge:

- The case manager must be aware of the resources available, both within the system of care and in other social and medical systems.
- Most participants enter into case management services with a lack of knowledge about the services in the care system or larger community.
- It is the role of the case manager to provide this expertise and help customize services based on the specific needs of the participant.

- While resource knowledge and providing referrals may appear to be a straight forward process, in reality, there are many variables which may influence the scope of services the participant is offered through case management (Harley & Rainey, 2003).
- Jenkins and Laditka (2000) demonstrated that when resources are plentiful there is less collaboration, creativity and flexibility among service providers.
- When providers can offer a number of services in house or within a closed system, case management can easily become provider-based and within-wall focused service.
- In contrast, when resources are low, collaboration and creativity dramatically increase.
- There are two possible exceptions to collaboration in low resource scenarios:
 - The first is that some agencies will approach scarcity by taking a competitive stance instead of a collaborative one.
 - The second involves —exclusivity networking|| where a few key agencies partner only with each other. This results in a limited number of resource and service options for the case manager and participant. Both scenarios limit diversity and creativity needed to provide quality services (Harley & Rainey, 2003).
- The existence of bounded provider networks is another key research finding on HIV case management:
 - Bounded provider networks describe the case managers' connections with resources, both internal to their agencies and to the overall care and social support systems.
 - The research shows that these networks were created by past successful experiences of the case managers connecting participants to providers in an efficient way.
 - A case manager's bound provider network is often based on relationships with other professionals who were easy to work with and provided the needed service in a timely manner (Harley & Rainey, 2003).
 - Further, the networks are often specific to the case manager's experience.
- It is important that the case management system have a way to educate the case manager about services within the TGA, but also in other systems of care and services.
- It is easy to fill a case manager's day with participant appointments and organizational meetings; it is more difficult to find time for researching and networking with new resources and learning about other systems of care.
- The recent increase in funding in the Denver TGA has brought many great new services into the TGA; but if research is correct this same positive aspect may be preventing case managers from learning and accessing systems of care that are not as known in the HIV community.

Training:

- Case management training is necessary to establish a solid knowledge base for all case managers.
- By incorporating the research results, a strong case management training program can be established to ensure case managers have the skill set needed to manage complex cases and crisis situations.

- The first important skill set needed to be a successful case manager is an ability to assess and reassess participant acuity:
 - With more and more TGAs, EMAs and Part B Programs moving to a chronic disease model with acuity at its core, the case manager must be able to determine initial acuity and then reassess periodically.
 - In order for an acuity system to work across different providers, the system must implement it with a high level of consistency so that an assessment of acuity is based on the implementation of a tool and not the skill set of the case manager (Powell & Tahan, 2008).

- The next important skill set needed for successful case management is the ability to create and implementing a treatment plan. Three sets of specific skills need to be utilized in order to be able to provide successful treatment planning services:
 - First, the case manager must understand and be able to implement the counseling and clinical skills needed to conceptualize the participant's needs and work with the participant to create a plan for services.
 - Having the knowledge and ability to identify and refer participants to the needed services is also important. It is extremely inefficient and ineffective for every case manager to establish their own knowledge of the service environment.
 - This requires the system to develop resource databases and networking opportunities in order for the case manager to learn and connect with the services critical to the health and well-being of their participants (Harley & Rainey, 2003).

- Also important is being able to facilitate the utilization management process
 - Managing a multi-disciplinary team can be a difficult task.
 - If a case management system is going to realize the quality and efficiency benefits of utilization management, they must give the case managers training and support around this role.
 - Putting a group of professionals in a room to talk about a case does not work without strong structure and facilitation (Rizzo & Abrams, 2000).

- Another key component to strong case management skills is the ability to assess and develop a participant's health literacy.
 - As one of the critical indicators to overall health, health literacy is central to any case manager's work.
 - In order to ensure that the participant is properly adhering to their prescribed treatment, the case manager must help them understand HIV, how the disease is impacting them and how the participant's behavior is impacting their overall health.
 - The first step in teaching health literacy is become highly knowledgeable in HIV.

- Lastly, the clinical ability to offer psychosocial support to the participant is critical to effective case management.
 - The case manager is positioned to provide counseling to participants in collaboration or in lieu of a therapist.

- In many care systems, this role along with the ability to clinically conceptualize a case demands a graduate education.
- While this is not the case in the majority of TGAs, EMAs and Part B Programs, it does not eliminate the need for case managers to have the ability to understand complex psychological diagnosis or substance abuse issues (Livneh & Antonak, 2005).
- To address the above needs, some TGAs, EMAs and Part B Programs have taken two approaches:
 - The first is to require specific qualifications for those providing case management services. For case managers, a bachelor degree (usually in the area of social services or nursing) is the typical requirement. Often times, this educational requirement can be replaced by several years of HIV/AIDS specific experience (Georgia Department of Community Health, 2009; Kansas Department of Health, 2002; Minnesota Department of Human Services, 2005; HIV Case Management and Support Services Program, 2009). In addition, more sites have implemented minimum educational requirements for case management supervisors (see Supervision section below).
 - The second approach is the development of case manager certification programs to support their case managers and ensure that participants are receiving a high level of service. This is another relatively new national trend that many TGAs, EMAs and Part B Programs are requiring, a standardized level of training for their case management professionals.
 - The Standards of Care survey identified several sites that have implemented Case Manager Certification Programs. Detroit, Newark, Los Angeles, Kansas, Oregon, Minnesota, and Houston are all requiring case managers to go through a certification process. While these programs differ between sites, their end goal is to ensure that all case managers have a baseline and common understanding of HIV, psychosocial interventions (including health literacy and adherence) and resources in the community (Los Angeles County Commission on HIV, 2006; Newark EMA HIV Health Services Planning Council, 1997; Harris County Public Health and Environmental Services, 2009; Southeastern Michigan HIV/AIDS Council, 2007; Kansas Department of Health, 2002; Minnesota Department of Human Services, 2005; HIV Case Management and Support Services Program, 2009; Wisconsin AIDS/HIV Program, 2003).

Supervision:

- In addition to certification, LA, Boston, New York City, Portland, Baltimore, Florida, Minnesota and Ohio are now requiring a higher level of education and experience to supervise case managers.
- These sites have recognized that the work of case management requires a clinical aspect of supervision and requires that the supervisor have, at minimum, a master's degree in social work or a related discipline.
- In addition, some sites have also required documentation that the supervisor and case manager discuss every participant involved in the agency program, either annually or every six months.

- The Ohio standards go on to detail both clinical and administrative supervision
 - Clinical supervision should address the following:
 - Clinical skill development
 - Use of theories/interventions
 - The helping relationship and delivery of clinical services to clients
 - Case presentation
 - Understanding and identification of transference/counter transference
 - Continuing education
 - Identification and referral to community resources
 - Emotional support of case manager with regard to client-related issues
 - Crisis interventions
 - Clinical Documentation
 - Administrative supervision should address the following:
 - Documentation
 - Punctuality
 - Relationships with colleagues
 - Job performance
 - Reliability
 - Continuing education/ professional growth opportunities
 - Emotional support to case manager in relation to job performance, organizational issues
- HIV case management may not be as — professional as case managers in other systems of care who require graduate degrees in social work or nursing; however, if the findings of the standards assessment are any indication, many TGAs, EMAs and Part B Programs are moving in.

Quality Management & Case Management:

- While chronic disease management within the larger healthcare setting has been given the resources necessary to develop evidence-based best practices, the lack of formal case management structure has made this more elusive in HIV case management.
- HIV case management has developed in a dispersed and de-centralized way to meet the local needs of rural and urban settings, diverse populations, and disparate local resources and service networks.
- This puts a great deal of importance on individual TGAs, EMAs, States and agencies to develop their own quality management systems (Chernesky & Grube, 2000).
- Quality management takes a certain level of expertise, capacity and motivation but the results ensure that participants are getting the best care possible.
- HRSA has placed emphasis on the development of quality programs for many years through Special Projects of National Significance (SPNS) grants targeting the development of best

practices, Quality Collaborative Demonstration Projects, and local quality initiatives funded with the jurisdiction's Quality Management dollars.

- HRSA currently allows for 5% of the total TGA award to be dedicated to Quality Management activities (US Department of Health and Human Services, Part A Manual, n.d.).

HIV AIDS Bureau (HAB) Quality Management Expectations:

HAB expects quality management programs to have the following key characteristics:

1. Be a systematic process with identified leadership, accountability, and dedicated resources available to the program;
2. Use data and measurable outcomes to determine progress toward relevant, evidenced based benchmarks;
3. Focus on linkages, efficiencies and provider, and client expectation in addressing outcome improvement;
4. Be a continuous process that is adaptive to change and that fits within the framework of other programmatic quality assurance and quality improvement activities (i.e., Joint Commission on the Accreditation of Hospitals Organization (JCAHO), Medicaid, and other HRSA Programs); and
5. Ensure that data collected are fed back into the quality improvement process to assure that goals are accomplished and that they are concurrent with improved outcomes. (National Quality Center, 2008, p. 5)

HRSA has also outlined their expectations for the following key elements in a Quality Management Program:

1. A written Quality Plan
2. Quality infrastructure/quality committee
3. Performance measures and baseline data
4. Annual goals
5. Participation of stakeholders
6. Capacity building: education on quality improvement concepts, performance measurement, analysis tools, and technical assistance
7. Prioritize and develop specific improvement projects/teams
8. Process to assess and evaluate findings
9. Clear process for sharing information
10. Evaluation of the Quality Plan implementation. (National Quality Center, 2006)

National Quality Management Programs for Case Management:

- As a part of the review of national standards of care, the authors examined available Ryan White Grantee Quality Management Plans to look for information about quality programs

implemented on the local level as well as systemically in a jurisdiction and/or collaboratively between sites.

- Twenty Five sites, both Part A and B, identified quality expectations either in a plan, described on their website, or in standards of care. These quality plans varied greatly.
- The most common elements included: 1) quality assurance practices, 2) capacity building/training, 3) performance measurement/outcome measurement processes, and 4) quality improvement initiatives.

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