



November 14, 2008

Dear Colleague:

The Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA), are pleased to announce the publication of *Recommendations for Case Management Collaboration and Coordination in Federally Funded HIV/AIDS Programs*. These new recommendations were developed jointly by CDC and HRSA with the assistance of the Federal Interagency HIV/AIDS Case Management Work Group. The recommendations were developed through discussions with grantees, case managers, and organizations providing case management services, community forums at national HIV/AIDS conferences, site visits and a literature review.

Collaboration and coordination are essential components of any effective multi-agency community case management system. When collaboration and coordination among case managers is not practiced, this can undermine the efficiency of case management in HIV health-care systems. Uncoordinated systems of case management can also keep clients from accessing services and cause duplication of efforts and gaps in service, waste limited resources, and prevent case managers from achieving shared goals of facilitating quality client care. These recommendations are the first of their kind and describe the use of case management in different settings, examine the benefits and barriers to case management collaboration and coordination, and most importantly identify methods to strengthen linkages between HIV/AIDS case management programs. These recommendations also identify the core components of case management that should be consistent across all Federal funding agencies. These components include: 1) client identification, outreach and engagement (intake); 2) assessment; 3) planning; 4) coordination and linkage; 5) monitoring and re-assessment; and 6) discharge.

The recommendations provide, through real world case studies, examples of effective collaboration and coordination in the delivery of case management services across Federal funding streams resulting in sustained and enduring benefits for clients, providers and funders of HIV/AIDS prevention, care and treatment programs.

We hope you will find these recommendations useful in your efforts to provide a more coordinated and collaborative case management environment benefiting the clients and populations we serve.

Sincerely,

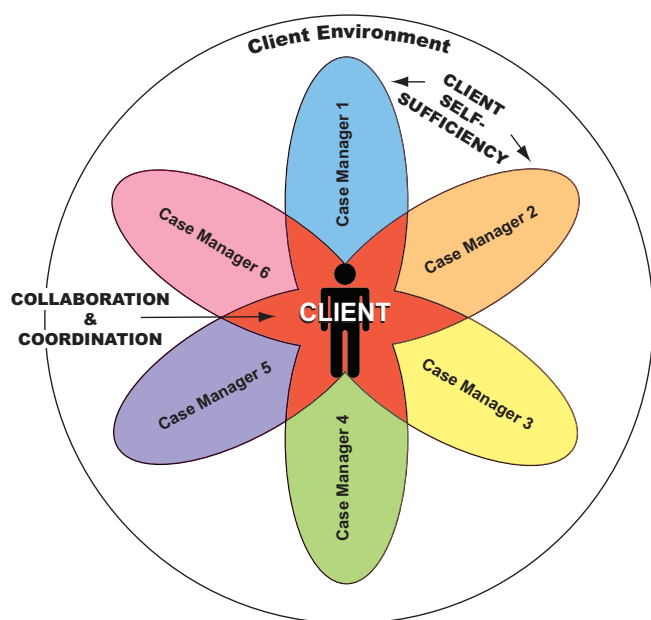
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Recommendations for Case Management Collaboration and Coordination in Federally Funded HIV/ AIDS Programs



**A Coordinated & Collaborative Case Management
Environment for the Client**



U.S. DEPARTMENT
OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control and Prevention
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EXECUTIVE SUMMARY

This document *‘Recommendations for Case Management Collaboration and Coordination in Federally Funded HIV/AIDS Programs’* developed by the Federal Interagency HIV/AIDS Case Management Work Group describes the use of case management in different settings, examines the benefits and barriers to case management collaboration and coordination, and identifies methods for strengthening linkages between HIV/AIDS case management programs.

Case management is widely used in HIV/AIDS programs to facilitate access to care, stable housing and support services for clients¹ and their families. Since the beginning of the HIV epidemic, it has been the cornerstone of programs that seek to address a wide array of medical, socioeconomic and psychosocial factors that affect the functioning and well being of HIV-infected clients and their families.

Data indicate that many people with the disease experience factors—such as homelessness, substance abuse, mental illness, poverty and lack of insurance—that affect their ability to access and benefit from care. Health care programs rely on case managers to help link these clients with services, treatment and support, and monitor their receipt of necessary care and services. Studies have documented the effectiveness of case management in helping clients reduce unmet needs for support services such as housing, income assistance, health insurance, and substance abuse treatment.¹ Other research has demonstrated case management’s effectiveness in helping clients adhere to HIV/AIDS regimens,² enter into and remain in primary care^{3,4} and improving biological outcomes of HIV disease.² Case management has also been associated with higher levels of client satisfaction with care.⁵ The transition of HIV/AIDS from a terminal disease to a chronically managed condition has placed greater emphasis on the provision of case management services that highlight prevention and early entry into treatment.

Despite the potential of case management to increase the efficiency of HIV health care systems by linking clients and their families to needed services, the absence of cooperation between case managers can undermine these objectives. Uncoordinated systems of case management can inhibit client access to services and cause duplication of efforts, gaps in service, waste limited resources and prevent case managers from achieving shared goals of facilitating quality client care.

There are many reasons for lack of collaboration and coordination across programs that provide case management to HIV-infected clients. Federal funders of case management programs maintain separate guidelines, funding cycles and

data requirements. Federal rules, regulations, eligibility criteria, policies and procedures may also differ from those of state funding agencies, a reality that can further complicate efforts to collaborate or coordinate. Competition for clients and funding, long distances between agencies, particularly in rural areas, and limited resources also play a role.

As a result, structural barriers may be created that make it difficult for case managers to work cooperatively with each other. In addition, while some federal funders provide grantees with guidelines for the provision of case management services, others provide no guidance at all.

Legal and ethical issues can affect the ability of case managers to work together effectively, particularly if case management agencies operate under different philosophies and mandates that seem at odds with each other. For example, a practitioner whose focus is on cost containment and service management may find it difficult to achieve common ground with a person who focuses exclusively on psychosocial needs. Differing interpretations of medical privacy requirements among case managers can affect the level of information sharing on client cases. In efforts to assure client confidentiality, some case managers may forego opportunities to safely share important information with other case managers who may be in a position to offer assistance.

In addition, there is wide variation — and much debate — with regard to the educational levels, credentials, and experience required of those who practice case management. These differences reflect the complexity, intensity and type of case management services being provided, however they can create divergent viewpoints on service priorities and best approaches.

While not insignificant, these challenges can be overcome in systems where there is the will and the leadership to make collaboration and coordination a priority undertaking. This document provides examples of communities and systems in which collaboration and coordination has helped case managers complement, rather than interfere with, each other’s efforts on behalf of clients and their families.

Collaboration and coordination, while distinct processes, share a number of key features. Both employ formalized systems of communication, coordinated service delivery, and client-centered approaches, albeit to varying degrees. Both processes require information sharing between participants to set the broader context for their work and gain knowledge of available resources, the services being provided and the populations being served.

¹ The term client refers to any individual (and his/her defined support network), family or group receiving case management services. In some instances, the client may consist of an individual and his/her caregiver or an individual and his/her substitute decision-maker.

In practice, coordination and collaboration reflect different levels of cooperation among agencies or staff. Coordination, for example, generally involves staff of different agencies working together on a case-by-case basis to ensure that clients receive appropriate services⁶. It can involve front-line case managers, supervisors and even organizational leaders. Coordination does not change the way agencies operate or the services they provide, rather, it represents an agreement between partners to avoid overlap in each other's efforts and cooperate to some degree in the delivery of services they already provide.

Collaboration builds on coordination and includes joint work to develop shared goals. It also requires participants to follow set protocols that support and complement the work of others. Unlike coordination, collaboration requires the commitment of agency or system leadership to be effective and produce the kind of sustained change that is central to its objectives. Collaboration has a greater potential to create seamless, client-centered systems of case management, has a greater capacity for extending the reach of limited resources and gets participants closer to establishing a foundation for true systems integration.

While collaboration yields greater benefits for agencies, systems, and clients, instances exist where collaboration is not possible or appropriate. But coordination can be an important strategy for improving interagency communication and promoting more efficient delivery of case management services to HIV-infected persons. Coordination can help lay the groundwork for future collaboration.

To examine these challenges and offer possible strategies for change, the Federal Interagency HIV/AIDS Case Management Work Group was convened in November 2003 under the joint leadership of the Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA). Work Group members included representatives from: the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services (SAMHSA/CMHS), and later from the Center for Substance Abuse Prevention (SAMHSA/CSAP); the Centers for Medicare and Medicaid Services (CMS); the National Institutes of Health's National Institute on Drug Abuse (NIH/NIDA); and the U.S. Department of Housing and Urban Development's Housing Opportunities for Persons with AIDS (HUD/HOPWA) program. Staff of the National Association of Social Workers (NASW) also offered input to the work group's efforts.

Through a process that involved regular work group meetings, discussions with case managers and organizations providing case management services, community forums at national HIV/AIDS conferences, site visits and a literature review, the Work Group developed this document – ***Recommendations for Case Management Collaboration and Coordination in Federally Funded HIV/AIDS Programs.***

A key accomplishment of the Work Group was to identify the core components of case management that remain consistent irrespective of which Federal agency is providing funding. These components include: 1) client identification, outreach and engagement (intake); 2) assessment; 3) planning; 4) coordination and linkage; 5) monitoring and re-assessment; and 6) discharge.

The recommendations (found on pages 22 – 30) are accompanied by examples of successful models to aid case managers, program managers, and grantees in eliminating, or reducing, service gaps and duplication in the delivery of case management services. The examples were chosen specifically because they demonstrate how case management programs have worked across federal funding streams to collaborate and/or coordinate with each other. The recommendations are listed below.

1. Promote, through case manager supervisors, a comprehensive knowledge of the scope, purpose/role, and eligibility requirements of available services provided by each case manager in a collaborative or coordinated arrangement.
2. Develop basic standards for case management that are flexible and adaptable, and define: the principles of case management for your network; the activities that constitute collaboration and/or coordination; the rights and responsibilities of clients being served; how services will be delivered; which case management models will be used; a client acuity system, required qualifications, experience levels and certifications for case managers; training requirements; measures for evaluating the effectiveness and/or quality of case management activities; and others.
3. Develop regionally or locally based client intake forms, processes, and data management systems to decrease duplicative paperwork and data collection.
4. Conduct regular meetings or case conferences with other case managers that serve the same clients and coordinate efforts to build a comprehensive understanding of each client's needs.
5. Formalize linkages through memoranda of understanding, agreements or contracts that clearly delineate the roles and responsibilities of each case manager or case management agency in a collaborative or coordinated arrangement.
6. Conduct cross-training and cross-orientation of staff from different case management agencies serving clients with HIV/AIDS to promote a shared knowledge and understanding of available community resources, and to build awareness among staff of the various approaches to providing case management services.
7. Designate someone in your agency to be a liaison with other HIV/AIDS case management agencies in the local community.

8. Conduct joint community needs assessments to identify where HIV/AIDS service gaps exist, and work with other case managers or case management agencies to address unmet needs through collaborative or coordinated strategies.

A description of the methodology used to develop the recommendations can be found in Attachment A. Other attachments reference HIV/AIDS terms (Att. B), provide a timeline for the development of case management as a practice and describe different types of case management approaches (Att. C), identify the Federal programs that fund case management services for individuals with HIV/AIDS (Att. D), list acronyms used in the document (Att. E), and list references used in the document (Att. F).

These recommendations do not constitute a mandate from the Federal government to its grantees. Rather they are intended to guide grantees in working more cooperatively with each other for the benefit of their clients, their agencies, and the systems in which they work.

I. INTRODUCTION

While the use of case management in HIV/AIDS programs has yielded positive outcomes for clients and their families², systems of HIV/AIDS case management³ have been beset by challenges. Far from being a standardized field of practice, HIV/AIDS case management is often highly tailored and organized in response to the client populations being served, and the administrative and financial needs of the organization that is providing services. While this level of flexibility has enabled case management agencies to design services in response to unique local, organizational and client factors, it also has created uncoordinated systems of case management in which clients must interact with multiple case managers to secure services and assistance. This type of environment contributes to service duplication, inefficiency and client confusion about the specific roles of individual case managers.

In uncoordinated systems of case management, individuals with chronic illnesses, such as HIV, can face difficulties and delays in receiving available assistance. Some clients become confused about how the system works and frustrated by the fact that it requires so much effort and time. As a result, some clients become detached from systems of care while others receive the same services repeatedly as they are juggled between case managers who concentrate on what they are able to provide, rather than what clients need. While the absence of case management can hamper client access to needed services, the existence of multiple case managers working in an uncoordinated system can contribute to the fragmented service delivery that case management is meant to alleviate.

In addition, the Federal agencies that fund HIV/AIDS case management maintain separate legislative and administrative rules, regulations, eligibility criteria, policies, fiscal years and data requirements. As a result, structural barriers may be created that make it difficult for case managers to work cooperatively with each other.

Competition for limited funding, conflicting opinions about client service priorities, and differing organizational missions and philosophies present additional barriers to valuable collaboration or coordination between case managers serving the same clients. A housing case manager, for example, may focus on securing shelter for a client who is homeless before examining other needs. A substance abuse case manager may view treatment of an addiction as a necessary

² The term client refers to any individual (and his/her defined support network), family or group receiving case management services. In some instances, the client may consist of an individual and his/her caregiver or an individual and his/her substitute decision-maker.

³ The term "HIV/AIDS case management" refers to any service provided by a case manager, regardless of his or her area of focus (mental health, substance abuse, housing, prevention, medical), to any person or persons with HIV/AIDS

Case management exists in part to connect an often-fragmented system. Case management serves as a catalyst for quality, cost-effective care by linking the patient, the physician, and other members of the care coordination team, the payer and the community.

Case Management Society of America (CMSA) 2003 consensus paper on case manager/physician collaboration

precursor to medical treatment, particularly if a client does not have acute symptoms of HIV infection. Finding time in the workday to cultivate collaborative relationships can be a difficult task for case managers, agencies, and grantees faced with high caseloads, tight schedules and limited budgets.

To examine the barriers to case management collaboration and coordination and to recommend strategies for improvement, CDC and HRSA convened the Federal Interagency HIV/AIDS Case Management Work Group in November 2003. Work Group members included representatives from: SAMHSA; CMS; NIH/NIDA; and HUD/HOPWA. Staff of the NASW also provided input to the Work Group's efforts.

The Work Group's aim was to create recommendations promoting seamless, coordinated, client-centered systems of HIV/AIDS case management that produce sustained outcomes for clients with multiple needs. In the process of meeting, Work Group members realized that while funders of case management and case management agencies have distinct priorities, areas of emphasis and program objectives, the challenges and goals they face are similar—meeting the multiple needs of clients with HIV/AIDS by maximizing resources and minimizing program and system inefficiency.

The process of developing the recommendations included: 1) four day-long, face-to-face meet-ings of Work Group members to identify key issues in case management collaboration; 2) the review/examination of case management collaboration models based on site visits and interviews with States, local jurisdictions and community-based case managers; 3) two community forums with case managers and other agency staff working in the field; 4) a review of the research and non-research literature on effective programs and practices; 5) an Internet-based search of case management standards, practice and program descriptions; and 6) extensive public and constituent feedback. (For a more detailed description of the methodology used to develop the recommendations, see Attachment A.)

The results of the Work Group's efforts are embodied in this document — ***Recommendations for Case Management Collaboration and Coordination in Federally Funded HIV/AIDS Programs***. The document describes the use of case management in different settings, examines the benefits of and barriers to case management collaboration and coordination, and identifies methods for strengthening linkages between HIV/AIDS case managers. It also encourages greater partnership between HIV/AIDS case managers and those agencies working in maternal and child, correctional, adolescent, and other health care systems. The recommendations are intended to guide grantees as they work to enhance collaboration and coordination among case managers.

II. BACKGROUND OF CASE MANAGEMENT

1. What is Case Management?

Case management, sometimes referred to as care management, is a client-focused process that expands and coordinates, where appropriate, existing services to clients.⁸ Case management is also referred to as “program coordination” or “service coordination,” phrases that reflect a more client/consumer-centered approach. In its simplest form, case management involves the referral of clients to providers of necessary services, a situation in which case managers act largely as broker agents. At the other end of the spectrum, intensive models feature co-located services to address the broad array of client needs (the team-based approach) or empowerment strategies designed to build client core competencies (the strengths-based model). Given the range of approaches that exist under the mantle of “case management,” there is considerable debate about whether case management is actually a profession, a methodology, or a group of activities.⁹ Some consider it more of an art than a science.¹⁰

Despite the wide variations in practice, the overarching goal of case management is the same in all systems: to facilitate clients' autonomy to the point where they can obtain needed services on their own. While there are exceptions in some jurisdictions, in general, case managers do not provide direct services such as mental health therapy, substance abuse treatment, or legal assistance; rather they assess a client's need for such services and arrange for them to be provided. In general, case management is used to manage functions such as:

- Assessing client service needs;
- Determining client eligibility for benefits and services and aiding clients in applying for assistance;
- Coordinating support services and care from different providers to meet clients' assessed needs;
- Disease management, which generally includes client education, counseling, client appointment/ medication reminders, routine reporting to providers and clients, and other activities to promote quality of care while achieving cost efficiencies;
- Client advocacy; and
- Supportive counseling (not therapy).

2. Evolution and History of Case Management

Early social casework practices were developed in England at the turn of the 18th century to help alleviate the negative impact on individuals of industrialization and urbanization. The late 1800s saw the evolution of Charity Organization Societies and Settlement Houses throughout the United States provide services to the poor in a cost-effective manner. Social services pioneers like Jane Addams, Florence Kelly, Mary Richmond, Joseph Tuckerman and their followers began to place value on objective investigations, accountability, professionalism and training, inter-agency service coordination and client advocacy. These ideas and philosophies have had an enduring influence on the development of modern case management.

In the early 1900s, case management programs were used to address environmental health problems arising from sanitation and immunization practices. By 1909, most States had established health departments and in the following decade social casework diversified itself into the fields of psychiatry, medicine, child welfare, education, and juvenile justice, among others.

The civil rights movement and President Lyndon B. Johnson's War on Poverty in the 1960s and 1970s gave rise to the concept of patient empowerment and health care decision-making.¹¹ At the same time, there was an explosion in programs to address the social and health care needs of individuals, but these programs were complex, fragmented, uncoordinated and difficult for clients to navigate. In response, a growing number of programs began to incorporate case management as an important component of service delivery.

The Allied Services Act of the early 1970s sought better integration of health care services and spurred a number of demonstration projects that laid the foundation for the growth of more formalized case management systems. These programs clearly outlined the role of a service-agent or case manager who was to be accountable for coordination of client health care and social services. The Lower East Side Family Union demonstration project in New York was the first model of case management that operated on the basis of a structured written contract and coordination between agencies.¹² Another important milestone was the Omnibus Budget Reconciliation Act of 1981, which established case management as a service within Medicaid for vulnerable groups, such as the elderly, poor or disabled.

When the AIDS epidemic struck in the 1980s, case management was employed to address the complex needs of both clients and families. Early HIV/AIDS case management consisted of volunteer "buddy" systems as well as more formalized arrangements.¹³ San Francisco's cen-

tralized, community-based HIV-service model of case management, which was effective in controlling costs and achieving client satisfaction, was replicated in other cities by the Robert Wood Johnson Foundation. The program implemented both clinical and community-based case management models to foster flexibility in treating people living with HIV/AIDS. Today a major source of knowledge about the structure, process and efficacy of HIV/AIDS case management comes from the research studies based on these projects. These studies examined differential patterns of HIV/AIDS case management, gaps in service delivery, the role of the case managers, client demographics and other important issues.^{14,15} In 1990, when the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act (now the Ryan White Treatment Modernization Act) was authorized, the existing demonstration projects formed the nucleus of the Ryan White HIV/AIDS Program.¹⁶

In 1991, the National Commission on AIDS noted the value of case management as an intervention strategy for HIV-infected persons, and credited case management with achieving cost savings, reducing the duration and the number of hospitalizations, bringing coherence to the service delivery system, and enhancing patient satisfaction and quality of life.¹⁷

There are now numerous HIV/AIDS case management agencies that target their services to specific, vulnerable populations, such as women and children, the homeless, the unemployed, the chronically ill, those with disabilities and the incarcerated.

(Note: For more information on the development of HIV/AIDS case management, see Timeline in Attachment C)

3. Why case management is important for HIV-infected clients?

According to the 2005 CDC data, approximately one million Americans are living with HIV/AIDS and roughly one quarter are unaware they are infected with the virus.¹⁸ For those infected with the disease, the medical outlook is vastly different today than it was in the early days of the epidemic, when treatment was largely palliative and life expectancies following diagnosis were relatively short. Today's treatments have transformed HIV/AIDS from what was once an acute, fatal condition to a chronic, manageable disease. Individuals with the virus have the potential to live long, productive, fulfilling lives. However, many face barriers that prevent them from receiving the full benefit of available treatment options.

A high percentage of HIV-infected individuals come from populations historically underserved by traditional health care systems. Many struggle with substance abuse problems, homelessness and mental illness. Women, youth and people of color bear the brunt of the disease. One study of clients in the New York City shelter system revealed rates of HIV/AIDS that were 16 times higher, and death rates that were seven times higher, than those of the general population.¹⁹

Despite years of public awareness and education campaigns meant to dispel misconceptions about the disease, HIV-infected individuals still experience stigma from society and within health care systems that can discourage them from seeking care. Further, HIV/AIDS impacts individuals in multiple domains, including the biomedical, psychosocial, sexual, legal, ethical and economic. For those with access to long-term treatment, HIV medications can be very effective but are frequently accompanied by significant side effects that affect quality of life and add to the complexity of managing co-morbidities.

If HIV progresses to AIDS, the damage to the immune system makes clients more susceptible to opportunistic infections and in greater need of acute care and hospitalization. These episodes can be followed by periods of relatively good health, thus illustrating the cyclical nature of HIV/AIDS and the changes in a client's level of need over the course of the disease.

Studies have found a high level of need for care and support services among HIV-infected individuals.²⁰ Research suggests that case management is an effective approach for addressing the complex needs of chronically ill clients.²¹ Case management can help improve client quality of life,^{22,23} satisfaction with care,²⁴ and use of community-based services.²⁵

Case management also helps reduce the cost of care by decreasing the number of hospitalizations a client undergoes to address HIV-related medical conditions.²⁶ On the behavioral front, case management has been effective in helping clients address substance abuse issues, as well as criminal²⁷ and HIV risk behavior.²⁸

Clients with case managers are more likely than those without to be following their drug regimens.²¹ One study found that use of case management was associated with higher rates of treatment adherence and improved CD4 cell counts among HIV-infected individuals who were homeless and marginally housed.²⁹ More intensive contact with a case manager has been associated with fewer unmet needs for income assistance, health insurance, home care and treatment.²¹ Recent studies have found that even brief interventions by a case manager can improve the chances that a newly diagnosed HIV-infected patient will enter into care³⁰.

It is apparent that optimal care for HIV/AIDS clients requires a comprehensive approach to service delivery that incorporates a wide range of practitioners, including doctors, mental health professionals, pharmacists, nurses and dietitians, to monitor disease progression, adherence to medication regimens, side effects and drug resistance. With regard to support services, most programs serving those with HIV/AIDS provide or have referrals to HIV prevention programs, mental health counseling, substance abuse treatment, housing, financial assistance, legal aid, childcare, transportation and other similar services, both inside and outside HIV systems of care. Case managers perform a critical role in facilitating client access to these services, in part, by ensuring they are well coordinated.

4. Case Management Functions/Activities

The primary activities of case management are to identify client needs and arrange services to address those needs. The way in which these activities are carried out is influenced by a variety of factors, including organizational mission, staff expertise and training, availability of other resources and client acuity. A broad variety of activities can be included under the mantle of case management. On a systems level, these activities might include resource development, performance monitoring, financial accountability, social action, data collection and program evaluation.³¹ On a client level, case managers may perform duties that include outreach/case finding, prevention/risk reduction, medication adherence, crisis intervention, health education, substance abuse and mental health counseling, and benefits counseling.

Despite these variations, the Federal Interagency HIV/AIDS Case Management Work Group identified six core functions that are common to most case management programs, irrespective of the setting or model used, based on their review of federally funded programs and case management research. While the emphasis placed on each function may differ across agencies according to organizational objectives, cultures, and client populations, they nonetheless comprise a foundation for the practice of case management. These core functions are listed below.

- **Client identification, outreach and engagement (intake)** is a process that involves case finding, client screening, determination of eligibility for services, dissemination of program information, and other related activities. Intake activities may be based on client health status, geography, income levels, insurance coverage, etc. Case managers should deal with their clients in a culturally competent manner and maintain the confidentiality of their medical information in accordance with privacy rules and regulations (e.g., requirements of the Health Insurance Portability and Accountability Act (HIPAA) – the Federal law

that among other things, governs the sharing of health-related information).

- **Assessment** is a cooperative and interactive information-gathering process between the client and the case manager through which an individual's current and potential needs, weaknesses, challenges, goals, resources, and strengths are identified and evaluated for the development of a treatment plan. The accuracy and comprehensiveness of the assessment depends on the type of tool used, the case manager's skill level and the reliability of information provided by the client.
- **Planning** is a cooperative and interactive process between the case manager and the client that involves the development of an individualized treatment and service plan based on client needs and available resources. Planning also includes the establishment of short-term and long-term goals for action.
- **Coordination and Linkage** connects clients to appropriate services and treatment in accordance with their service plans, reduces barriers to access and eliminates/reduces duplication of effort between case management programs. Coordination includes advocating for clients who have been denied services for which they are eligible.
- **Monitoring and re-assessment** is an ongoing process in which case managers continually evaluate and follow up with clients to assess their progress and to determine the need for changes to service and treatment plans.
- **Discharge** involves transitioning clients out of case management services because they no longer need them, have moved or have died. For clients that move to other service areas, case managers should work to establish the appropriate referrals.

5. Different Approaches to Case Management

HIV/AIDS case management is a field that encompasses a variety of approaches in response to specific program goals, organizational size and structure, local environments, funder requirements and policies, staff skills and expertise and the needs and characteristics of target populations. In HIV/AIDS systems of care, case management is used to describe a diverse array of activities that range from service brokering and referral to psychosocial support and skills building. (See Attachment B, Table 2).

Generalist models mainly emphasize the case manager's role as a care coordinator rather than a provider of direct services. Case managers, therefore, act primarily as gatekeepers, managing the client's use of services and expediting service deliv-

ery through linkage activities. This approach works best for clients without acute or intensive needs.

Specialized or intensive models employ greater interaction between clients and case managers, are generally targeted to specific subgroups of clients, tend to be characterized by smaller caseloads, community outreach and more individualized services.^{32,33} Examples include strengths-based case management, which relies on development of a strong relationship between the client and case manager to help build client skills and capacity,^{34,35,36} intensive case management with individualized care and practical assistance in daily living,^{37,38} and assertive community treatment, a community-based comprehensive treatment and rehabilitative approach.^{39,40} For clients with lower acuity scores and higher levels of need, studies have found that these approaches are more effective than generalist approaches in reducing hospitalizations, improving quality of life, controlling costs and producing higher levels of client satisfaction.³²

Other variations in practice can be attributed to the lack of uniform standards governing the delivery of HIV/AIDS case management services. There are no federally prescribed standards, except in the Medicaid program where established standards for HIV/AIDS programs provide targeted case management through waiver programs. Some States, jurisdictions and networks have sought to develop standards of practice. In instances where this has happened, standards are generally flexible allowing them to be adapted according to the needs of clients or local environments. Standards are often voluntary, rather than mandated.

For more detailed information on case management models, see Attachment C (i).

III. FEDERAL FUNDING: DIFFERENT DEFINITIONS AND REQUIREMENTS FOR HIV/AIDS CASE MANAGEMENT

All Federal agencies (listed below in alphabetical order) represented on the Interagency Work Group fund case management services and research for HIV-infected individuals. Each differs in the amount and type of direction it provides to its grantees regarding the way case management services should be procured, the models of case management used, the experience and credentials required to practice, and the way case management is funded.

To some extent, all Federal agencies recommend that their grantees coordinate with other federally funded case managers serving the same client populations, including those within and outside HIV/AIDS service systems. HRSA requires its grantees, Ryan White-funded case managers, to document the nature and extent of collaboration or coordination with those funded by other Federal, State and local agencies. CDC requires grantees to document the process of referral and fol-

low-up for clients receiving CDC-funded case management. Other agencies urge their grantees to coordinate in the delivery of case management services even if they do not require documentation of these activities.

1. Centers for Disease Control and Prevention (CDC)

In 1997, CDC published guidelines for prevention case management (PCM), a client-centered approach that combines HIV risk-reduction counseling and traditional case management to provide intensive, ongoing individualized prevention counseling and support to HIV-infected and HIV-negative individuals. In late 2005, CDC changed the name of PCM to comprehensive risk counseling and services (CRCS) and clarified that CRCS prevention counselors should provide case management only to clients who cannot be referred to other case management programs, such as those funded by Medicaid and Ryan White. CRCS staff can provide case management and referrals to clients who do not otherwise have access to these services, but must always work with other care providers and case managers to coordinate referrals and services.

Grantees determine the scope and location of services, as well as requirements for licensure, education and professional experience based on State and local laws. While not mandated, CDC recommends minimum qualifications for CRCS staff and provides practice standards for the operation of CRCS programs.

CDC recently funded a 10 city/region demonstration project on a short duration, strengths-based model of HIV case management called Antiretroviral Treatment Access Study (ARTAS) II. The goal was to improve linkage to appropriate care, prevention services, and treatment for persons recently receiving an HIV diagnosis. The secondary goal is to facilitate client transition into ongoing Ryan White or Medicaid-funded case management programs. The project will compare rates of linkage to HIV care providers before and after instituting the linkage case management shown effective in the first ARTAS study⁴¹ (For more information on ARTAS, see attachment D in appendix.)

CDC is also evaluating the costs and effectiveness of enhancing or expanding the use of an already funded, established perinatal HIV case management program to previously un-enrolled HIV-infected pregnant women. Case management services provide for ongoing contact between a trained case manager and an HIV-infected pregnant woman during her pregnancy, through her delivery and up until documentation of her baby's HIV status. The primary goals are to ensure receipt of recommended antiretroviral drugs to prevent perinatal HIV transmission, ensure receipt of adequate prenatal care, and protect the mother's health.

2. Centers for Medicare and Medicaid Services (CMS)/Medicaid

Aspects of case management have been integral to the Medicaid program since its inception. The law has always required states to have interagency agreements under which Medicaid applicants and recipients may receive assistance in locating and receiving needed services. Basic case management functions have also existed as components of each State's administrative apparatus for the Medicaid program and also as integral parts of the services furnished by the providers of medical care. Physicians, in particular, have long provided patients with advice and assistance in obtaining access to other necessary services.

In 1981, Congress, recognizing the value and general utility of case management services, authorized Medicaid coverage of case management services under State waiver programs. States were authorized to provide case management as a distinct service under home and community-based waiver programs. Case management is widely used because of its value in ensuring that individuals receiving Medicaid benefits are assisted in making necessary decisions about the care they need and in locating services.

3. U.S. Department of Housing and Urban Development (HUD)/ Housing Opportunities for Persons with AIDS (HOPWA)

Case management is an important feature of HOPWA-funded housing programs for HIV-infected individuals. Housing case management is a model that recognizes stable housing as facilitating receipt of other services that promote client well being and self-sufficiency. HOPWA requires the coordination and delivery of supportive services that help address mental illness, substance use, poverty and other factors that place individuals at severe risks of homelessness. Housing case management includes all components of traditional case management and is designed to incorporate the skills and resources clients need to maintain stable living environments. These may include the rights and responsibilities of tenancy, access to employment or mainstream benefits, access to health insurance and assistance to master the skills necessary to maintain tenancy.

HOPWA allows grantees considerable flexibility in assessing needs and structuring housing and other services to meet community objectives. The program measures outcomes through annual progress reports. Outcomes are reported on housing stability, use of medical and case management services, income, and access to entitlements, employment, and health insurance. The program views stable housing as an important means for reducing disparities in access to care.

Housing-based case management is generally considered a core support service of any HOPWA program and helps ensure clear goals for client outcomes related to securing or maintaining stable, adequate, and appropriate housing. Case management helps improve client access to care and services and plays an important role in helping clients achieve self-sufficiency through development of individualized housing plans, which identify both barriers to and objectives for independent living.

HOPWA programs work collaboratively with grantees of the Ryan White HIV/AIDS Program—in some communities they are housed in the same agencies or organizations. HOPWA grantees also participate in local planning efforts to strengthen linkages with Medicaid, locally funded homeless assistance programs, SAMHSA grantees and CDC-funded prevention programs to ensure their clients have access to the range of medical and support systems necessary to maintain their health and achieve housing stability.

4. Health Resources and Services Administration (HRSA)/Ryan White HIV/AIDS Treatment Modernization Act

Administered by the HRSA, HIV/AIDS Bureau, the Ryan White HIV/AIDS Program is the largest Federal funder of HIV/AIDS case management in the United States. HRSA

gives its grantees broad latitude in implementing case management and other services, and Ryan White programs can provide funding for coordinating services, HIV prevention counseling, and psychosocial support. Both medical case management and non-medical case management are funded in many jurisdictions.

The role of Ryan White-funded case management is to facilitate client access to medical care and provide support for adherence. Some grantees supplement case management with benefits counseling and client advocacy services, which focus on assessing eligibility and enrolling clients into Medicaid, disability programs, Medicare, HOPWA, Ryan White AIDS Drug Assistance Programs (ADAP) and others. In general, case management is provided with a range of “wrap-around services” available from many agencies and local health departments.

Credentials for Ryan White-funded case managers and case management models vary based on jurisdictional requirements, standards set by grantees and planning bodies, and the types of services case managers provide. The organizational placement of case managers also varies. Some communities fund case management agencies, some employ case managers in support service agencies, some are employed by clinics and many States use public health nurses as case managers in rural counties.

5. National Institutes of Health (NIH)/National Institute on Drug Abuse (NIDA)

The NIH, through NIDA, funds investigator-initiated research on the effectiveness of case management models to improve access to systems of care for HIV-infected substance users. NIH also supports research on integrated health care systems that include case management as a key component. The research has identified promising case management models that link substance abuse treatment, medical treatment, and after-care programs. These models can help increase the number of days individuals remain drug free, improve their performance on the job, enhance their general health, and reduce their involvement in criminal activities.^{42, 43, 44, 45, 46}

NIH-sponsored research has indicated that there are cost benefits to incorporating case management into the treatment of HIV-infected drug abusers.⁴⁷ Further research is needed to learn which case management approaches are best for clients with varying levels of clinical need. Studies have found that client outcomes improve if the tasks, responsibilities, authority relationships, use of assessment and planning tools, and the exchange and management of client information are delineated in advance of the client’s entry into a treatment program.⁴⁸ This suggests that in addition to clinical fidelity to a given case management model, formal agreements are needed between case managers and other service providers.

NIH/NIDA has funded research exploring different kinds of case management models, including: 1) broker/generalist; 2) strengths-based; 3) clinical/rehabilitation; and 4) Assertive Community Treatment. Irrespective of the model used, research suggests that case management is more successful in improving client access to utilization, engagement/retention in the process of medical and substance abuse treatment when located within a treatment facility rather than in a co-located agency, when the case manager is knowledgeable about the quality and availability of programs and services in the area and when there is ability to pay for services.⁴⁶

6. Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA funds case management through its three centers: the Center for Mental Health Services (CMHS); the Center for Substance Abuse Prevention (CSAP); and the Center for Substance Abuse Treatment (CSAT). Roughly 50 percent of CMHS-funded grantees provide case management services, as do about 20 percent of CSAT grantees. The goal of SAMHSA-funded case management is to facilitate client entry into substance abuse treatment and mental health services, among others. While grantees do not receive specific guidance on the provision of case management services or the use of case management models, CMHS and CSAT both assert that mental health case management and substance abuse treatment case management are most effective when substance use, mental health and medical care are integrated. They also subscribe to the idea that all clients should have a primary case manager who works with other case managers to coordinate services.

CSAP does not provide guidance on case management, but lets grantees design their own approaches based on target populations and other factors. It refers grantees to models used by CDC-funded and Ryan White-funded case managers. As a result, grantees often use a combination of approaches.

SAMHSA guidance encourages grantees to develop linkages with providers of HIV/AIDS and substance abuse treatment services, such as primary care providers, HIV/AIDS outreach programs, mental health programs, and HIV counseling and testing sites, among others. Where collaboration occurs, grantees must identify the role of coordinating organizations in achieving the objectives of their programs.

For more detail on these Federal programs, see Attachment D.

IV. ISSUES, GAPS AND BARRIERS THAT IMPACT ON COLLABORATION AND COORDINATION AMONG HIV/AIDS CASE MANAGERS

A number of factors at the client, system and funding levels make case management collaboration and coordination challenging, though not impossible, to implement. Through discussions with case managers, program managers, grantees and others in the field, the Work Group identified instances in which case managers are working together to optimize client services and achieve greater system efficiency.

These discussions also helped identify a range of factors that inhibit collaboration and coordination among case managers serving HIV-infected clients. For example, the lack of uniform standards for HIV/AIDS case management enables flexibility in service delivery and supports local jurisdictions in the development of case management services that respond to unique local characteristics and needs. At the same time, the absence of a single Federal—and in many cases State or community—approach has contributed to confusion and conflict among case managers about which models of case management should prevail in certain circumstances.

The changing nature of HIV/AIDS epidemic also has contributed to the existing fragmentation in case management systems. When HIV/AIDS was an acute, fatal illness, the need for case management was relatively short-term, from a few months to a few years, and services were more narrowly defined and personalized. Case managers or “buddies” as they were largely

known acted often as friends, visiting clients at home and taking them to medical appointments.⁴⁹

Treatment breakthroughs of the mid-1990s significantly increased the life expectancies and enhanced the physical functioning of HIV-infected individuals. People with HIV were living longer, going back to work and engaging in life in a way that would have been inconceivable only a few years earlier. As a result, case managers re-tooled their approaches to accommodate the increased demand for services to address a broad range of medical, social, economic, and psychological factors affecting clients.⁴⁹ The need for housing, legal, and employment services grew; adherence support became a new and critical aspect of case management. Much of this change was instituted at the agency level, rather than on a system-wide basis, giving rise to an array of uncoordinated services being provided by agencies.

As a result, in a number of jurisdictions, clients with multiple needs often work with four or five case managers. If they need temporary housing, they are assigned a housing case manager. They might also have an adherence case manager if they are enrolled in the Ryan White AIDS Drug Assistance Program (ADAP). A different Ryan White-funded case manager may be assigned as a benefits counselor and aid them in obtaining food stamps or WIC assistance. If eligible for Medicaid, it is likely they would have a fourth case manager to coordinate their services under a Medicaid State waiver program. A SAMHSA-funded case manager might help coordinate mental health counseling. In a system that does not link these case management services, the client will likely undergo several, separate assessments, providing the same information over and over again.

The categorical nature of HIV/AIDS funding presents another challenge, as it imposes diverse policies, client eligibility issues and reporting requirements on case management agencies. Case managers who seek to collaborate or coordinate must find a way to circumvent these differences in developing a common framework for action.

High caseloads and tight budgets reinforce the feeling among some case managers that collaboration and coordination require more effort and time than they can reasonably muster, especially if they question the real value of these approaches in meeting the needs of their clients. The irony is that sharing responsibility for ensuring client access to services can actually help ease the time, budget, and caseload pressures that case managers often feel. Individuals who gave input to the document suggested that leadership commitment to collaboration and coordination, as well as establishment of practice standards that promote these processes, could help engage case managers whose heavy workloads might otherwise deter them from seeking opportunities to link their efforts with other case managers.

1. Financial Issues in Case Management

The high cost of health care and the increasing numbers of individuals living with HIV/AIDS continue to squeeze the budgets of public health agencies and organizations that deliver services to HIV-infected clients. Required to serve more clients with less resources, case management agencies respond in a variety of ways to stresses in the system.

Limited funding has increased competition for scarce resources, a major barrier to the creation of partnerships between agencies serving the same clients. Case managers in the field reported that in communities where funding rivalries are most intense, even those who want to collaborate and coordinate might find themselves up against institutional environments that make it nearly impossible to do so.

As the nature of HIV infection changes from that of an acute medical condition to a long-term, chronic disease, and as budgets tighten in case management agencies, case managers have seen their caseloads increase. High caseloads are also supported by local funding policies that base reimbursements on the number of clients served rather than the type of case management service provided or the client's level of assessed needs. These influences can make agencies reluctant to discharge clients, and result in caseloads for case managers that are well above community standards. In such situations, case managers are hard pressed to carve time out of their schedules to strengthen linkages with other case managers or develop partnerships.

Case managers also pointed to State and jurisdictional funding policies that cap or exclude reimbursement for case conferencing as problematic. They reported that having too many unbillable hours on their timesheets made them susceptible to reprimands from supervisors and agency heads, who themselves would have to submit to scrutiny from local funders.

Categorical funding can inhibit collaboration and coordination based on several factors. Different timelines and funding cycles can make it hard to deliver services in a comprehensive manner. Variations in client eligibility requirements, reimbursement guidelines, quality standards and other restrictions can make it challenging to pool resources for the delivery of seamless services. For example, most Medicaid-funded case managers are reimbursed for a defined set of services, and work largely on providing referrals and monitoring. Conversely, Ryan White-funded case managers provide medical case management and psychosocial case management, among other services. Categorical funding can move case managers toward a more program-specific rather than system-wide view of the services available to meet the diverse needs of clients.

2. Legal and Ethical Issues Related to Case Management Collaboration and coordination

A dilemma faced by many case managers is how to balance the diverse goals of health care systems, organizations and funding streams against their own professional ethics. Ethical considerations are influenced by the model, philosophy or mandate under which a case manager is working: confidentiality versus information sharing, client empowerment versus paternalism, and professional boundaries versus relationship building, to name a few. A system or agency focus on cost containment can be at odds with a case manager's goal of securing the most comprehensive array of supportive services for clients.

Ethics are also shaped by training, education and professional experience. For example, a case manager not trained in cultural competency may exhibit value judgments about a client's behavior that impact on the way services are delivered or needs are assessed.⁵⁰

The variation inherent in how different case managers understand and apply ethics to professional decisions can have an impact on their willingness and ability to work with each other in the interest of their clients. A case manager who believes that central to his or her job is to build a client's trust may feel out of step with a case manager whose main function is to manage the client's use of services. A case manager who has a "zero-tolerance" policy with respect to client drug use may feel his or her efforts are being undermined by a case manager who favors risk reduction. Similarly, a substance abuse case manager may fear that sharing information about a client's drug use will result in a loss of services that could compromise the client's recovery efforts.

The way case managers understand their legal responsibilities to clients can also have an effect on their role in either a collaborative or coordination arrangement. A lack of understanding about medical privacy statutes (and how State and local laws interact with HIPAA) may make case managers hesitant to share client information with other case managers. Further, the intersection of medical privacy laws and substance abuse treatment and confidentiality laws and regulations can generate questions about how to safeguard client medical data while maintaining the flow of information on which collaborative or coordinated relationships depend. In States that criminalize HIV transmission, documenting a client's risk behavior may also present dilemmas. On one hand, disclosing the information could help the client receive important counseling on risk reduction and increase the likelihood that his partners will be informed. On the other, documentation of the behavior might place the client at risk for criminal prosecution. Disclosure of a client's active drug use during a risk assessment could endanger the client's receipt of services from other programs, yet the terms of a collaborative arrangement might require that case managers share information with a client's other case managers.

Collaboration and coordination demand that case managers find a workable middle ground, something that can be difficult to do when professional values and philosophies are in conflict. It is, therefore, important for case managers to determine the extent to which their professional ethics are being employed on behalf of clients and their families, and the extent to which they may be inhibiting potentially beneficial opportunities to work together. Supervisors and agency legal counsels can provide critical guidance and clarity on these issues.

3. System-Level Barriers

While the nature of categorical funding, financial, legal and ethical issues present their own barriers to case management coordination and collaboration, the delivery system for case management services itself can impede cooperation between case managers.

Federal agencies provide a range of guidance on case management services and coordination of care, which enables flexibility within case management systems to address the multiple needs of clients. However, the absence of Federal, State or community consensus on what constitutes case management, the variety of models used and supported, the differing missions and priorities of agencies that fund case management, and discordant funding and reporting periods all present challenges to effective collaboration and coordination and make it hard to identify what will work across jurisdictions.

While the existence of multiple case management models offer important flexibility at the local level, it can also cause confusion about which models should be used and in which circumstances. In addition, the variety of models and standards of practice can magnify philosophical differences about the best models of case management, making it hard for practitioners to come together on behalf of their clients. During listening sessions and in consultations, case managers cited conflict and uncertainty over delivery models (a one-case-manager-per-client approach versus a team approach), the types of services case managers should provide (brokering versus psychosocial support versus advocacy) and how to balance a client's medical versus psychosocial needs.

Case managers may lack knowledge about HIV funding sources, and the separation of programmatic and administrative operations in a case management agency can make it difficult to know the totality of services available to meet a client's needs. For example, case managers cited difficulty in learning about SAMHSA-funded services in their communities, and substance abuse and mental health case managers may be unaware of other HIV/AIDS programs for which their clients are eligible.

The sheer number of case managers serving a single client can act as a barrier to coordination. A client advocate and former staff member of an HIV service organization relayed that it was not uncommon in his experience for a client to have many case managers, none of whom knew of more than one other case manager working with the client. He cited one case in which a client, in addition to having eight case managers working on hospital, veteran's, social security, medical care, and social services benefits, also had two mental health case managers from separate agencies delivering both clinical and referral services. Coordinating the information flow between such a high number of case managers would prove a daunting task for any or all of them, but the lack of formalized coordination would contribute to gaps and duplication in services that would also prove confusing to the client.

The lack of consistency in the systems and models of case management services can foster tensions between case managers serving the same client as they compete to play the

central role in the client's care. This phenomenon was illustrated during the implementation of a CDC demonstration project, which used linkage-to-care case managers to facilitate newly diagnosed clients' entry into primary care and transition into Ryan White- or Medicaid-funded case management. In one site, project staff was unable to recruit clients due to resistance from other case management agencies that viewed the intervention as unnecessary and as encroaching on their territories.

Geography can present a barrier to coordination and collaboration. In rural communities and small towns, geographic distances between agencies can inhibit activities that promote collaboration and coordination. Opportunities to meet face-to-face may be more limited and make it harder to develop trusting relationships, exchange information, strategize on approaches and conduct case conferences. In these cases, case managers may have to rely more heavily on phone and email to advance their efforts.

Another barrier to coordination and collaboration in providing case management services is the lack of systemic incentives to do so. Federal, State and local funders have varying guidance regarding collaboration and coordination among case managers. In the absence of consistent expectations, the Work Group found examples of case management agencies that employed collaboration and coordination to help them conserve costs, reduce overlap and maintain services to clients. However, in the opinion of many case managers and case management agencies consulted by the Work Group, standard recommendations around coordination and collaboration could serve to provide leverage in case manager's efforts to work effectively with other case managers, and could help prod some case managers and agencies who might otherwise be disinclined to work collaboratively with their peers.

4. Client-level effects

While obstacles to collaboration and coordination occur primarily at the system level, the results of these systems affect clients' experiences with care. A lack of collaboration or coordination between case managers can result in client confusion about where and how to get needed services. For example, a client who undergoes multiple assessments with several case managers to qualify for services may feel frustrated and overwhelmed by the amount of time and energy needed to secure health care and social services. In addition, interactions with multiple case managers can make a client feel confused about which case manager can help with which services.

For HIV-infected clients, many of whom face other debilitating conditions, a lack of collaboration or coordination in service delivery can discourage them from seeking help. Shuffling between agencies to apply for and secure services can

become tiresome quickly for a person who is not feeling well, has their children in tow, or is trying to get to appointments while on a lunch hour from work. The third time a person is asked to do an assessment may be the moment at which he or she decides to give up, convinced that the system is unable to meet his or her needs.

V. ACHIEVING COLLABORATION AND COORDINATION IN SYSTEMS OF CASE MANAGEMENT

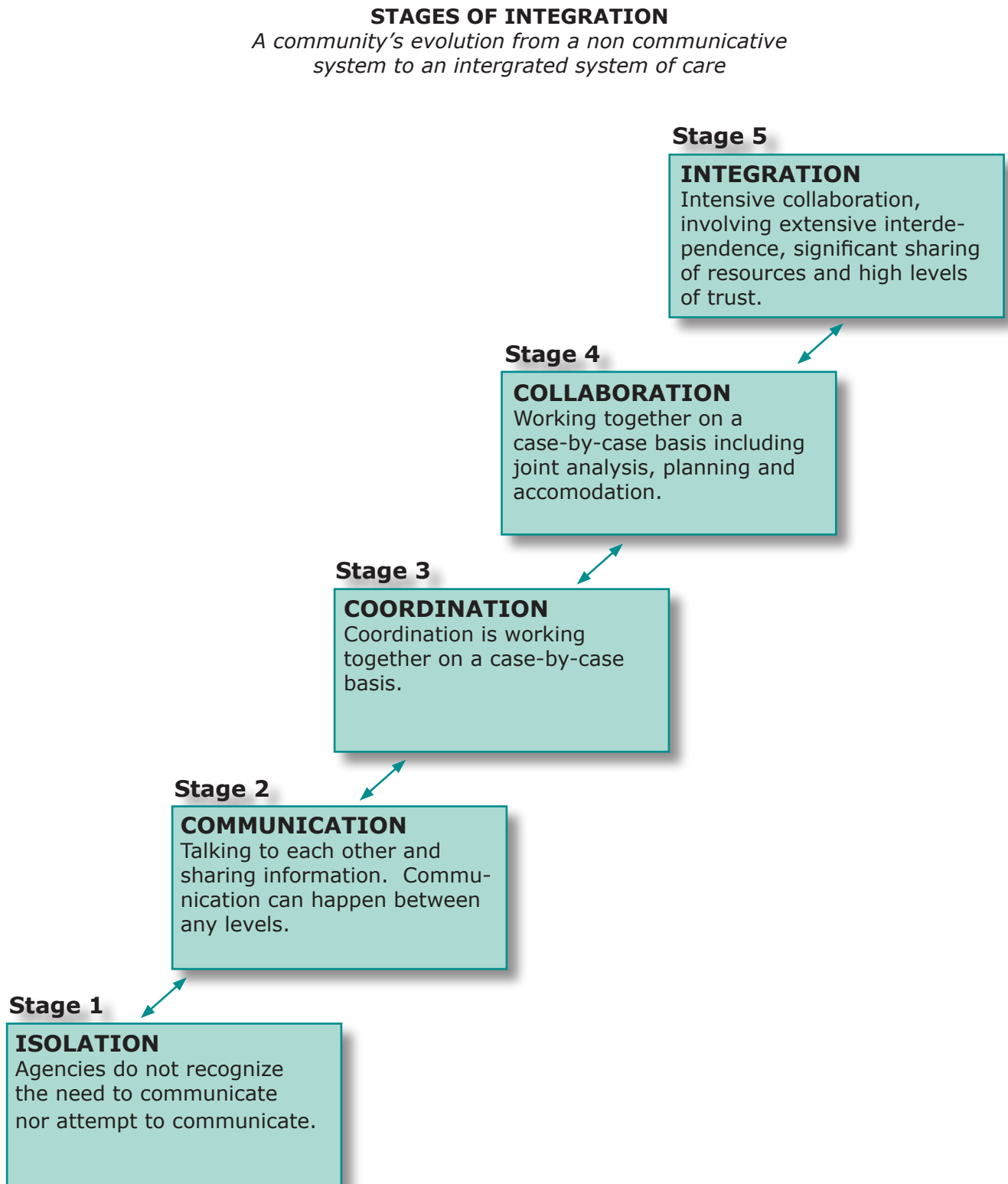
Collaboration and coordination have key aspects in common. Both are processes in which stakeholders engage in greater cooperation toward pursuit of mutual goals. Both highlight formalized systems of communication, coordinated service delivery, comprehensive scope and client-centered approaches. Both require an initial step of information sharing or networking, which helps inform case managers of other resources and services at work in a community, the populations being served and the areas of unmet need.⁵¹ Some case managers who provided input to the Work Group pointed out that data sharing can maintain buy-in to the process of collaboration and coordination, as well as aid case management agencies in addressing service delivery gaps and other issues.

Both processes are also distinct in a number of ways. The role of effective leadership, while beneficial to coordination, is absolutely essential to collaboration. In some instances, a trusted organization that is seen as unbiased and effective can help galvanize others around a common objective and facilitate movement beyond individual agendas for the good of the whole.⁵² This has been the case, where the AIDS Foundation of Chicago took the lead in organizing a collaborative network among more than 60 agencies. Similarly in Portland, the Oregon Health and Science University launched the Partnership Project, a network of case management agencies that coordinates the provision of services to HIV-infected clients. In others, State governments have been effective in initiating collaborative efforts motivated by desires to streamline client services and reduce inefficiency. For example, the Missouri Department of Health initiated the AIDS Case Management Improvement Project (MACMIP) as a partnership of several stakeholders involved in HIV case management in the State.

In their research on systems change in local communities, Burt and Spellman assert that collaboration “cannot happen without the commitment of the powers-that-be.”⁵² They add “if agency leadership is not on board, supporting and enforcing adherence to new policies and protocols, then collaboration is not taking place.” Burt and Spellman note that coordination can occur at lower levels in an organization among staff who are committed to the idea, but that collaboration to bring about lasting change requires leadership.

In earlier work, Burt developed a five-stage scale that conveys varying degrees of cooperation and communication used by stakeholders to engage others working toward similar objectives. At one end of this spectrum, stakeholders work in isolation from each other, don’t attempt to communicate and are distrustful of each other. At the other end, all stakeholders integrate their services to affect systems change. The authors suggest a framework can be used to “benchmark a community’s progress from a situation in which none of the important parties even communicates, up to a point at which all relevant agencies and some or all of their levels (line worker, manager, CEO) accept a new goal, efficiently and effectively develop and administer new resources, and/or work at a level of services integration best suited to resolving the situation.”^{52, 53}

Figure 1: Stages in Integration



Source: based on Burt, Spellman (2007)⁵⁷

Along Burt's scale (represented by the Figure 1), coordination and collaboration represent two mid-point options between **isolation**, a situation characterized by no communication between case managers serving the same client, and **integration**, a situation in which all case managers serving the client are working together to provide comprehensive services.

Coordination is the third stage after isolation and **communication** (information sharing/networking) and generally involves staff of different agencies working together on a case-by-case basis to ensure that clients receive appropriate services. It can involve front-line case managers, supervisors and organizational leaders. Unlike collaboration, coordination does not change the way agencies operate or the types of services they provide, rather it represents an agreement between them to avoid duplicating each others efforts and engage in some level of cooperation in the delivery of available services.

Collaboration builds on coordination and includes joint work to develop shared goals. It also requires participants to follow certain protocols that both support and complement the work of others. Unlike coordination, collaboration requires the commitment of agency or system leadership to be effective and produce the kind of sustained change that is central to its objectives. Collaboration has a greater potential to create seamless, client-centered systems of case management, has a greater capacity for extending the reach of limited resources and gets participants closer to establishing a foundation for true systems integration. Collaboration usually results in varying degrees of systems change.

Integration is the most intensive form of collaboration, involving extensive interdependence among participants, significant sharing of resources and high levels of trust. Integration has tremendous potential to streamline efforts and maximize the use of resources by changing the way programs function internally. Full integration of HIV/AIDS programs would necessitate policy and legislative changes to reduce funding and administrative barriers, and thus is not the focus of this project.

According to collaboration experts Winer and Ray, collaboration requires comprehensive planning, well-defined communication channels, a collaborative structure, sharing of resources, high risks and power sharing among participants.⁵⁴

While collaboration yields greater benefits for agencies, systems and clients, in instances where collaboration is not possible or appropriate, coordination can be an important strategy for improving linkages and communication across agencies, promoting greater use of resources, and achieving greater efficiency in the delivery of case management services. Coordination can help lay the groundwork for future collaboration. An example of coordination might include a formalized referral agreement between agencies that provide case management services to the same populations. The agreement may stipulate the use of common standards for case management to help facilitate coordination between case managers.

Collaboration can happen in a number of ways. Along a continuum, it can range from lower-intensity exchanges, in which the players are more independent, to higher-intensity relationships, in which they are more interdependent. An example of the former might involve two case management agencies designating a liaison to help organize services to the same client populations. An example of the latter might involve 10 case management agencies organizing a network, developing standards of practice that include expectations for collaboration, and creating a centralized data system to track clients at each agency site. In both Oregon and Chicago, one organization has taken the lead in spearheading coordination among multiple agencies providing HIV/AIDS case management.

One approach to collaboration that has been used in some jurisdictions involves teams of case managers from different agencies and Federal funding streams that share responsibility for implementing a client's treatment plan and meet or communicate regularly to coordinate their efforts. Another approach to collaboration may involve one case manager taking the lead in coordinating client care and regularly updating other case managers about a client's status. For example, a substance abuse case manager might have primary responsibility for a client who has HIV/AIDS but whose most pressing treatment issue is his or her substance abuse disorder. As part of a collaborative arrangement, that case manager may work in conjunction with the client's Ryan White-funded case manager to assess jointly the client's readiness to start antiret-

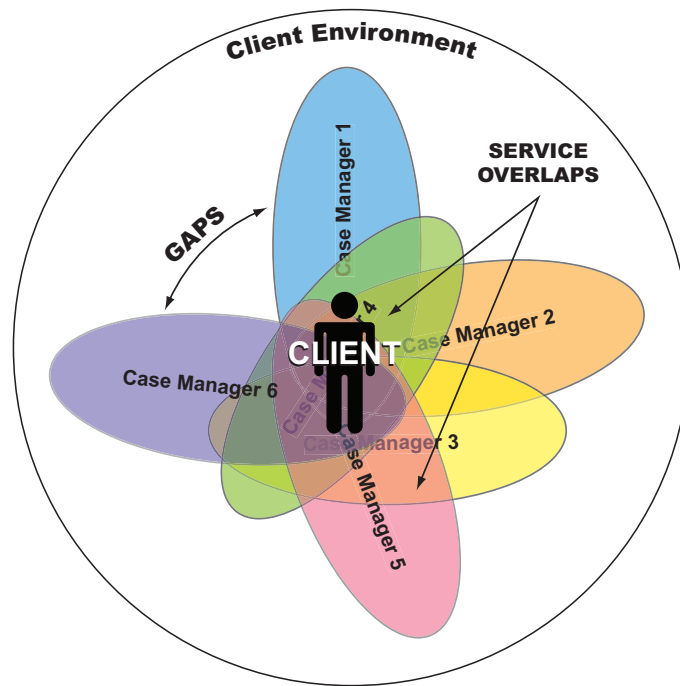
roviral therapy. Once the client’s substance abuse has been sufficiently addressed and he or she is ready to begin antiretroviral therapy, primary responsibility may shift to the Ryan White-funded case manager who then works in the same manner with the substance abuse case manager to monitor the client’s recovery efforts. Such an arrangement can serve clients more effectively and efficiently by simultaneously addressing clients’ diverse needs — medical, psychological and social — rather than responding to them in isolation from each other. It can also maximize limited resources while providing a tightly woven case management safety net.

The Work Group members recognize that effective collaboration and coordination take time and resources, which case managers, agency directors, and grantees have in short supply. Members further recognize the implications of asking case managers, agency directors, and grantees to balance the needs of clients against the time required to develop and sustain effective partnerships. However, it is anticipated that through greater collaboration and coordination, case managers and clients will experience improvements in service delivery, reduced stress, more efficient use of both financial and human resources and other advantages that will make the effort seem beneficial and valuable.

1. Coordinated versus uncoordinated systems of HIV/AIDS case management

While there is general agreement in the HIV/AIDS community that collaboration and coordination in the delivery of case management services is beneficial to both case managers and clients, these approaches have not yet become standard practice within systems of care. For a variety of systemic reasons already discussed, case managers sometimes work in isolation from each other with only a partial view of the services that the client is receiving.

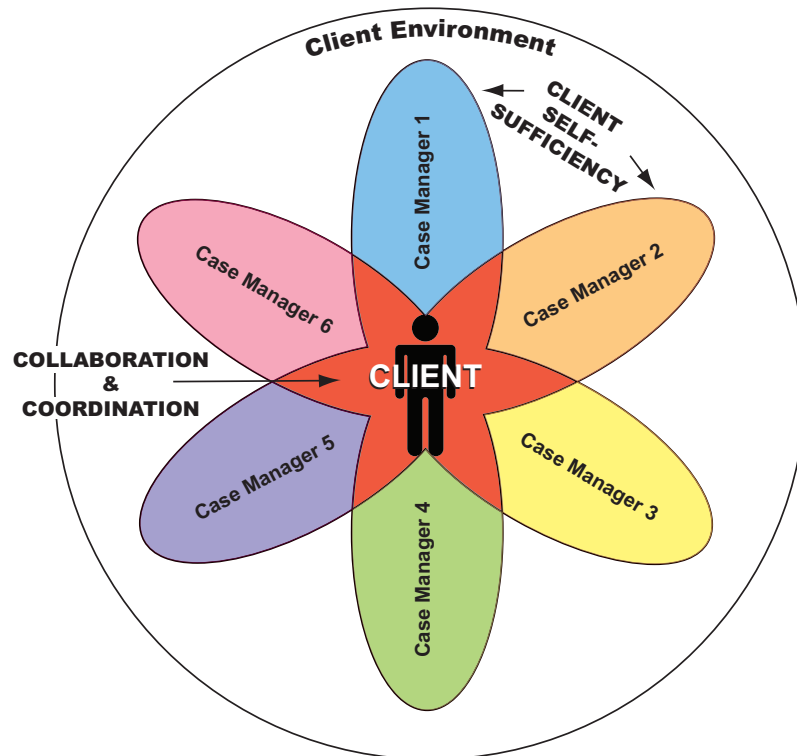
Figure 2: Uncoordinated system of case management



An Uncoordinated Case Management Environment for the Client

The figure above depicts an uncoordinated system of care. The outer circle represents the total client environment. Each case manager’s discipline or scope of service, represented by the shaded ovals in the figure, may cover either a specific or several different needs of the client such as medical care, housing, substance abuse treatment, mental health, HIV prevention or benefits management. Lack of collaboration or coordination results in duplication of services, as signified by the areas where the ovals overlap with each other, or gaps in service that leave client needs unaddressed, as represented by the spaces between and around the ovals.

Figure 3: Coordinated system of case management



A Coordinated & Collaborative Case Management Environment for the Client

In “re-drawing” this case management system, each oval now represents the unique contributions of individual case managers to a more coordinated or collaborative effort. In this system, each case manager supports and enhances the role of other case managers to address client needs in a comprehensive manner. Areas in which the ovals overlap with each other represent efforts by case managers to link their services, rather than duplicate their efforts and waste resources. The white spaces between the ovals now represent areas of client self-sufficiency, areas that expand as the client moves away from his or her dependence on case management services.

The recommendations included in this document are meant to encourage the “re-drawing” of case management systems, replacing disjointed service provision with greater coordination and collaboration. The Work Group believes that this approach will result in more effective, efficient case management services to clients with HIV/AIDS.

2. Key Elements of successful collaboration and coordination

The parameters of a collaborative or coordinated arrangement can change from situation to situation. The level of engagement depends on many factors mentioned already. Despite the differences, there are several key elements of effective collaboration or coordination. These include:

- **A formalized system of communication:** Case managers who serve the same client populations should establish methods of regular communication so that they can align

their activities with each other. These could include monthly conference calls at designated times, regular case conferences or other approaches that keep them informed and updated about shared clients' progress.

- **A coordinated approach to service delivery:** To avoid duplication and service gaps, case managers' efforts must be in sync with each other. In cases where clients are eligible for case management services from several programs, a "lead" case manager could be designated to coordinate services and communicate regularly with other case managers about a client's progress/status. Such leadership could rotate between team members depending on a client's assessed needs and service priorities.
- **A client-centered approach:** Services should be based on clients' assessed needs rather than service availability, and should accord clients both rights and responsibilities for their own care. Case managers should recognize and address client barriers to care.
- **Comprehensive in scope:** Since most clients with HIV/AIDS face multiple and persistent barriers to care, case management systems should, to the extent possible, enhance client access to a broad range of services in a seamless manner. This could involve development of a "one-stop" model that provides clients with wrap-around services to meet their needs.

3. Changing Current Systems and Building for the Future

For the current system to change, agencies, communities, and States should come together under collaborative or coordinated frameworks where they consistently complement each other's efforts and increase system efficiency by eliminating duplication. This will require some case managers and case management agencies to explore new ways of thinking and address old patterns of organizational behavior, such as isolationism and territoriality. The process can be very difficult and to some degree threatening. Lack of trust, fear of losing organizational autonomy and concerns about ceding responsibilities to others are just some of the factors that can inhibit the development of effective collaborative or coordinated relationships between case management programs. However, as Figure 3 in Section V.1 illustrates, case managers can become part of a larger whole and still retain their uniqueness, and the key to such change is effective and committed leadership. In many ways collaboration, and to a lesser extent coordination, increases the value of each case manager's contribution by making the others dependent on him or her in order to address client needs in a comprehensive manner. By using these approaches, agencies become complementary rather than redundant, improving efficiency overall. While the development of a framework for collaboration or coordination takes time and effort, the end results can prove valuable to both clients and case managers in the long run.

VI. MAKING COLLABORATION AND COORDINATION WORK: TOOLS AND RECOMMENDATIONS

Recommendations for Case Management Collaboration and Coordination in Federally Funded HIV/AIDS Programs highlights efforts by State and local communities to pursue collaboration and coordination in service systems to improve efficiency and enhance client receipt of needed services. The recommendations reflect the belief that greater coordination and collaboration can achieve sustained and enduring benefits for clients, case managers and funders. The effort to develop the recommendations represents the first time that the agencies who fund HIV/AIDS case management — CDC, CMS, HRSA, HUD, NIH, and SAMHSA — have worked together on the issue, and symbolizes the value of working in partnership with others on issues of mutual interest and benefit.

To ensure the usefulness of the document to those working in the field, Work Group members sought the input of case managers, case management agencies and experts regarding: 1) obstacles they experience in efforts to coordinate or coordinate: 2) characteristics of their environments that contribute to collaboration and coordination: 3) the ways in which they had used collaboration or coordination to help them achieve their goals: and 4) how the Federal government could support case managers in their efforts to join forces with those serving the same HIV/AIDS populations.

Over the course of its 2 - year examination, the Work Group found examples of factors that contribute to the fragmentation and service duplication of case management programs. At the same time, promising approaches to collaboration and coordination were identified. Through its data gathering efforts, the Work Group found successful efforts to move beyond legislative, administrative, jurisdictional, and cultural hurdles to provide HIV-infected clients with effective, coordinated services.

A key accomplishment of the Work Group was to identify the core components of case management that remain consistent across agencies, irrespective of the models used or the guidance provided by funders. These components include: 1) client identification, outreach and engagement (intake); 2) assessment; 3) planning; 4) coordination and linkage; 5) monitoring and re-assessment; and 6) discharge. The Work Group believes that these six areas can serve as a foundation for collaboration and coordination among case management programs funded through different sources.

The Work Group's efforts have resulted in the recommendations listed below, which are intended for use by case managers, community-based organizations and funders of case management services for HIV-infected clients. The recommendations are broad in scope, reflecting the fact that case management programs must have the flexibility to tailor their programs to local environments, standards, policies, regulations and the individual needs of the populations they serve. They are designed to work in concert with existing State and local requirements. It is hoped that they will guide HIV/AIDS case managers in working more cooperatively with each other to ensure the delivery of effective, efficient services in response to clients' assessed needs. While use of these recommendations is strongly encouraged, it is not required.

Each recommendation is accompanied by an explanation of the rationale behind it, an example of how it has been applied by an agency or system of case management, and the results of its implementation. These examples do not constitute a complete list of such efforts nationally, but are included because they clearly illustrate the specific recommendation.

1. Recommendation: Case manager supervisors should promote a comprehensive knowledge of the scope, purpose/role, and eligibility requirements of available services provided by each case manager in a collaborative or coordinated arrangement.

Rationale

Funders of case management have different rules and policies governing the provision of case management and client eligibility. Additionally, agencies that provide case management operate under different philosophies, models of practice and standards. These differences often act not only as barriers to collaboration, but contribute to the service gaps that clients experience within case management systems. Information sharing among case managers and case management agencies—either through cross-training, meetings, case conferences or other approaches—can aid case managers in understanding these distinctions and identifying ways in which variations in perspective, policy and practice can be used to address a broader range of client needs, rather than contribute to fragmented, uncoordinated service delivery.

Example

The **Wisconsin State Department of Health** is funded by HRSA (through the Ryan White HIV/AIDS Program) to provide psychosocial case management services and by CDC to provide comprehensive risk counseling and services (CRCS) to individuals at high risk of contracting or transmitting HIV/AIDS. Case managers working in both programs receive training from the State Health Department to delineate their individual roles in client care and to minimize duplication of services. This has been a challenging undertaking, in part because of conflicts among case managers about which client needs should take priority. However the Health Department feels that this effort will be beneficial in the long run, resulting in better case management services to clients and greater efficiency in the system. Further, the agency is researching models of case management collaboration for use in its programs.

Results

Wisconsin reports that this effort has helped reduce conflict, confusion, and duplication of efforts between psychosocial case managers and those providing prevention services by clarifying the distinctions between their roles and responsibilities with regard to the client. In addition, it has helped clarify the distinctions between the two types of case management for psychosocial case managers who perform both.

- 2. Recommendation: Develop basic standards for case management that are flexible and adaptable, and define: the principles of case management for your network; the activities that constitute collaboration and/or coordination; the rights and responsibilities of clients being served; how services will be delivered; which case management models will be used; a client acuity system; required qualifications, experience levels, and certifications for case managers; training requirements; measures for evaluating the effectiveness of case management activities; and others.**

Rationale

Fundamental, flexible standards set a benchmark for the way case management services are defined and delivered. Standards can help ensure that a minimum quality of service is provided to all clients across a network by establishing training and educational requirements, client eligibility protocols, types of services to be provided, confidentiality rules, cultural competency guidelines, and other parameters. Standards set targets for service provision that make it easier to evaluate the effectiveness of case management and make improvements where necessary. The availability of high quality, effective case management services is important to both clients and case managers. It is also important for funders, who want to ensure that their investments are being used to target areas of greatest need.

Examples

AIDS Foundation of Chicago (AFC) operates the Northeast Illinois HIV/AIDS Case Management Cooperative, a collection of 49 agencies providing case management services to more than 5,000 HIV-infected clients through a model of integrated service delivery. AFC receives funding from Ryan White Parts A and B, Housing Opportunities for Persons with AIDS (HOPWA) Program and from the Medicaid case management waiver program through the Illinois Office of Rehabilitative Services. The organization conducts a competitive application process for the award of case management contracts.

All case management agencies in the cooperative adhere to set standards, policies, procedures, and quality management protocols. These include the assignment of one case manager per client to assess needs and obtain services, the use of an acuity score to determine client loads, the use of a standardized intake and assessment forms, the provision of case management to any client regardless of income level, and the provision of case management services to any clients eligible for the AIDS Medicare waiver program when these clients are referred to AFC. Case managers also assess client needs for emergency financial assistance and rent subsidies.

This standardization helps ensure that case management activities are of commensurate quality across the network. Quality monitoring of case management services is based, in part, on the submission of monthly reports and client-level data by all agencies in the cooperative. That data is then entered into a centralized network database. AFC also conducts evaluations of the case management services provided at each agency within the network.

In addition, case managers must attend monthly meetings, coordinated and/or conducted by AFC staff, and complete a combination of both elective and mandatory training sessions each year. All newly hired case managers must attend an orientation training to build their skills and learn about the system. Case managers are surveyed regarding the skills, knowledge and expertise necessary to meet network standards of practice, comply with funder requirements, and effectively respond to client needs.

Operations of the cooperative are overseen by a governance committee, which makes policy recommendations, sets priorities and periodically reviews the quality of the case management being provided. The committee — comprised of case managers, case management supervisors and consumers — meets once a month and assists AFC staff in implementing a periodic site visit program to all agencies to monitor the provision of case management against standards and policies. The committee also identifies system-wide needs for technical assistance.

The **Missouri AIDS Case Management Improvement Project (MACMIP)**, is a state-wide quality improvement process that has resulted in a unique partnership of all grantees with statewide CM standards, policies, procedures, and data collection systems. This partnership involves several stakeholders including Missouri Department of Health and Senior Services (DHHS) Prevention and Care teams; the Missouri AIDS Case Management Improvement Process Advisory Group, the Missouri Ryan White Part B Quality Improvement Collaborative (MO-hat-ters), and other HIV and non-HIV case management providers. Through MACMIP, Missouri has created a new case management process and developed new standards of care for case management services. These standards have some built in flexibility as well as integrated performance measures to enable the State to trend data over time.⁵⁵

Results

Through implementation of case management standards, AFC has been able to reduce duplication of services among case management agencies and reduce the number of case managers per client. Standardization has also helped the network in its quality monitoring activities by establishing a basis for evaluating the effectiveness of case management provided by all agencies. This in turn has increased the tendency of case managers to make appropriate in-network referrals because they are confident about the quality and type of case management that their clients will receive.

In Missouri, due to the multi-agency connections within and outside of the HIV services, clients are able to “surface” anywhere in the system and get their unique needs met seamlessly. Collaboration has resulted in an environment of supportiveness rather than competitiveness. As a Part B Grantee put it – “The virus is the enemy, not each other.” Improving collaboration through MACMIP has helped the State maximize its resources, reengage clients to HIV care, and improve the overall quality of care.

3. Recommendation: Develop regionally or locally based client intake forms, processes, and data management systems to decrease duplicative paperwork and data collection.

Rationale

Many agencies use individualized intake forms, despite the fact that they request much of the same information from clients. At the same time, clients in uncoordinated systems of care often interact with several case managers to get the services they need. The result is that cli-

ents frequently have to provide the same information to case managers over and over again. This places time constraints not only on clients, but on case managers as well. A standardized intake form completed once and then shared with other case managers in the local care system could provide agencies with necessary client data while preventing clients from having to submit to needless, multiple assessments. A regional, centralized data management system could help case managers track client progress and service utilization, aid in addressing gaps in service, and prevent situations in which clients seek the same services from multiple agencies. In consultations with case managers working in the field, the Work Group heard that lack of standardization in intake forms was both costly and time-consuming to case management agencies.

Examples

Missouri has a statewide database for HIV/AIDS case management. The system provides easy access to client demographic and service utilization information. Clients who have performed an initial assessment can then access case management services from multiple entry points throughout the State. In addition, support services agencies can view the same client file once the electronic referral is made. Further data for outcomes can be shared by multiple programs (i.e. housing programs might be able to cross reference the clients with substance use history or their engagement in care based on viral load reports). Coordination of services is achieved more easily because case managers work from the same information source. The system ensures quick access to information, allows case management agencies to review their processes and make improvements, and speeds the targeting of educational efforts and support to areas of greatest need.

AIDS Foundation of Chicago maintains a centralized, confidential client registry for its coordinated case management system. The registry aids the organization in tracking client service utilization and movement through the system. Demographic and referral information is updated every 6 months as case managers review client service plans and reassess needs.

In Jacksonville, Florida, the use of a standardized assessment tool allows clients to enter the system from multiple entry points once their eligibility for services has been established. The standardized assessment helps case managers identify the client's level of acuity to determine the intensity of the intervention. The assessment feeds into a central database that enables case managers to track client service use. Because almost all Ryan White-funded case managers are certified by the State Medicaid agency, in many cases clients can retain their original case manager as they transition from enrollment in Ryan White to Medicaid. This approach helps build client-case manager relationships and maximize resources.

Results

The use of a common client intake form and database has facilitated the sharing of client demographic and service utilizations information in all three communities. Each reports that the use of common data forms and tracking mechanisms has enabled them to streamline their efforts and reduce service duplication by ensuring that clients do not receive similar services from different agencies. In many instances, this standardization has also reduced the number of case managers working with clients because it provides case managers with information that helps them make appropriate referrals. The approach has been time saving for both clients and case managers because it allows clients to access the system through diverse entry points without having to repeat the intake and assessment processes.

In addition, the effort to develop a standardized client assessment for case management services in Jacksonville ultimately led to the development of a case management cooperative, a coordinated effort among case management agencies serving HIV-infected clients. The cooperative meets monthly to coordinate services, share information, gain professional support, receive training, and work on joint projects.

4. Recommendation: Conduct regular meetings or case conferences with other case managers that serve the same clients and coordinate efforts to build a comprehensive understanding of each client's needs, desires, values, and interests.

Rationale

Effective and regular communication is a critical component of any collaborative or coordinated relationship. Good communication can be fostered through regular meetings (in person or on the phone) of case managers who serve the same clients. Case conferencing enables case managers to construct a more comprehensive view of the client's needs and the resources available to meet them. Among other things, the regular scheduling of such meetings can help ensure that clients are being monitored effectively and that case managers are staying informed about other resources in the community from which their clients may benefit.

Examples

The Kansas City Free Health Clinic (KC Free Clinic) in Kansas City, Missouri, provides free medical care, dental care, behavioral health care, and comprehensive HIV prevention, and treatment to uninsured and under-insured individuals in the Kansas City community. The Clinic hosts a Multidisciplinary Care Team meeting on a weekly basis. The meeting is co-facilitated by the director of primary care (Program C grantee), a case management supervisor and a peer treatment adherence coordinator. Multiple in-house and outside providers such as case managers, substance abuse counselors, mental health therapists/counselors, peer treatment advocates and other appropriate professionals all report on their work with clients. The case management supervisor at KC Free coaches and guides case managers from the outside agencies to work within the internal multidisciplinary team meeting to foster collaboration and avoid service duplication and gaps. Common assessment forms developed by KC Free Clinic are used by all outside partners to collect standard information from shared clients. This strategy avoids multiple formats and more importantly repetitive assessments with clients. The primary focus of the meetings is on HIV medical care and the services that support successful engagement and retention in care. The meeting is documented with a care plan that includes mutually agreed upon goals for the patient and team. The care plan is distributed to all professionals who are involved in the client's care, including the case managers.

Prior to joining the Northeast Illinois HIV/AIDS Case Management Cooperative, the **Erie Family Health Center** in Chicago had established its own collaborative case management system with two local provider agencies that served its client population — Community Outreach Intervention Project and El Rincon Supportive Services. Together, these agencies provided integrated medical and mental health services to HIV-infected drug users from Puerto Rican and Mexican communities.

A vital aspect of the program was the use of a team approach to case management. In instances when case managers had clients in common, they met on a schedule to conduct client assessments and follow-up service planning. These case management teams also held case conferences with client providers to discuss a range of issues such as client progress in treatment, return and failure rates, scheduling flow, service utilization and the results of client satisfaction surveys.

Established in 1995, the **Oregon Health and Science University (OHSU) Partnership Project** is a consortium of 13 public and private medical and social service agencies in the Portland metropolitan area. The OHSU Partnership Project coordinates case management services to HIV-infected clients and their families. It coordinates closely with other Ryan White and non Ryan White funded HIV/AIDS service organizations, case management providers, the State and Multnomah County Health Department.

As the lead agency, OHSU coordinates a monthly meeting for all case managers who participate in the consortium. Also in attendance are representatives from Multnomah County's aging and disability services division, state adult and family services and the Social Security

Administration. The purpose of the meeting is to network, share information and coordinate the implementation of case management service plans.

Results

At the **Kansas City Free Health Clinic**, multi-agency collaboration regarding case management assessments and care plans for shared clients has created a “one stop shop” for the clients. Case managers, medical providers and other professionals are supporting each other’s work toward shared goals and objectives with clients rather than competing or duplicating efforts. The regular meetings and sharing of information between the Clinic’s multidisciplinary team, including case managers, and external case management providers ensures that everyone involved with a shared client are focused on priorities determined through consensus. As a result, services are provided more efficiently and effectively with little chance of duplication or gaps.

For the **Erie Family Health Center**, the case conferences provided an opportunity to review client information that had been entered into a centralized database used for tracking and monitoring. They also enabled team members to get feedback on their performance and suggestions for improvement where necessary, and laid the foundation for greater coordination necessary to join the Northeast Illinois HIV/AIDS Case Management Cooperative.

The **OHSU Partnership Project** reports that by increasing cooperation and awareness among case management agencies, it has been able to extend each agency’s human, fiscal, and programmatic resources, maximize resources and eliminate duplication of efforts. Client surveys show high levels of overall satisfaction (72 percent) with case management services; 64 percent of clients rated service quality as excellent.

5. Recommendation: Formalize linkages through memoranda of understanding, coordination agreements, or contracts that clearly delineate the roles and responsibilities of each case manager or case management agency in a collaborative or coordinated arrangement.

Rationale

Collaboration and coordination require division of skills, sharing of resources, and trust between participants, albeit to varying degrees. Formalized agreements, such as memoranda of understanding or contracts, can reinforce these elements of collaboration or coordination by clarifying and describing the role of each case manager in serving the client. Formal agreements can help alleviate problems that arise from territoriality and competition because the processes or activities they identify are jointly defined, established and settled on by all participants. They can also help institutionalize the practice of collaboration and/or coordination within agencies and networks by setting forth a framework for these approaches.

Examples

In **Missouri**, Ryan White Part A programs in Kansas City and St. Louis, along with the State Part B program, took the lead in case management collaboration. Early on, State and local health agency officials and elected leaders had called on programs to work together to maximize resources. This expectation was formalized through memoranda of understanding, inter-agency agreements, and contracts between the Medicaid agency, public health agencies and social service agencies. Together these agencies administer Ryan White, Medicaid waiver, HOPWA, SAMHSA, and CDC funding, along with other non-HIV case management programs that serve the homeless, incarcerated, disabled, and maternal and child health populations. This means that case management is coordinated between both HIV and non-HIV systems of care and that services are seamless at the client level.

In Portland, Oregon, the **OHSU Partnership Project** has legal agreements with member agencies that outline the policies, requirements, and guidelines for case management services. In addition, agencies within the Partnership Project staff the effort through direct financial contribution or in-kind personnel donation.

Results

Formalized agreements have helped to clarify case manager roles and responsibilities and reduced barriers to access for clients. Missouri reports that intergovernmental agreements are also important in conveying an expectation of, and commitment to, collaboration and coordination on the part of agency and elected leaders. Formalized agreements have helped drive a system of collaboration for case management services that has led to the establishment of a statewide case management database, case management standards, standardized clients satisfaction surveys, and goals for seamless case management services that necessitate collaboration.

The use of formalized agreements in the OHSU Partnership Project has helped ensure direct access to individual agency resources for clients. In addition, they have improved inter-agency understanding and communication among participants that has proven critical to the delivery of effective case management services.

6. Recommendation: Conduct cross-training and cross-orientation of staff from different case management agencies serving clients with HIV/AIDS to promote a shared knowledge and understanding of available community resources, and to build awareness among staff of the various approaches to providing case management services.

Rationale

Different case management agencies advocate diverse philosophies and models of practice. A case manager working in a mental health program may prioritize a client's service needs differently than a housing case manager. A Medicaid case manager and a CRCS case manager have different practice goals. In many communities, case managers work in parallel tracks, unaware that they are serving the same clients. Cross-training between different case management agencies can help bridge the divide by educating case managers about each other's efforts, making them better able to share responsibilities and resources in addressing the needs of common clients. Cross-training also exposes case managers to other perspectives and models of practice that can expand their skills and knowledge and enhance the services they deliver.

Examples

Missouri has implemented a statewide system of case management services for people with HIV/AIDS. Case managers who participate in the system are funded through the Ryan White HIV/AIDS Program, Medicaid, CDC, HUD/HOPWA, and SAMHSA. Per their contractual agreements, all case managers are required to attend monthly regional case management meetings to receive training, information, and resources. These meetings are convened by Regional Quality Service Managers (State employees) in coordination with local and regional case management supervisors. In addition, the State takes the lead in convening periodic, statewide meetings of case management agencies.

Jacksonville, Florida's case management cooperative brings together Ryan White-, Medicaid and HOPWA-funded case managers for monthly meetings to provide cross training, engage in problem solving on client issues and increase awareness about HIV resources available locally. Responsibility for chairing the meetings is rotated among member agencies, and all members participate in determining meeting topics and agendas. In addition, cooperative members participate in an off-site retreat each year that focuses on team building, discussion of challenges, and development of strategies for strengthening the system.

Results


In **Missouri**, collaborative meetings of regional case management staff has helped keep case managers informed about available services, improved client access to services and helped maximize limited resources to the benefit of clients and agencies alike.

In **Jacksonville, Florida**, monthly meetings of the case management cooperative has increased both trust and cooperation between case management agencies and reduced the intense competition for resources that previously characterized the local environment. In addition, through better communication agencies have been able to streamline the use of resources by clients, implement more effective procedures for assessing eligibility for services, and standardize case management activities across the system.

7. Recommendation: Designate someone in your agency to be a liaison with other HIV case management agencies in the local community.

Rationale

Strong relationships are a vital aspect of any collaborative or coordinated effort. Managing those relationships effectively is best done through designation of a point person who considers collaboration or coordination activities as essential to the perfor-



mance of his or her job. Designating a liaison signals to partners that an agency or organization is committed to collaboration or coordination. Liaisons enhance information sharing between agencies in a network that can result in both more effective client referrals and increased client access to a broader range of available services. Informal relationships do not have the structures in place to ensure that collaboration and coordination take place.

Examples

The **Azalea Project** of the Northeast Florida Healthy Start Coalition in Jacksonville is a collaborative effort among local service provider agencies, the county health department and the University of Florida OB clinic to provide integrated substance abuse and HIV prevention services to African-American women of childbearing age and their families. The Coalition serves as the project lead, employing a coordinator who supervises case management staff at all agencies and serves as a liaison between agencies. Through the liaison, the Coalition convenes regular meetings of case management staff to promote information sharing, engage in problem solving, and enable networking to improve case management services.

In **Missouri**, the State has Regional Quality Service Managers that are responsible for ensuring coordination among case management agencies participating in the statewide collaborative system of case management. These individuals work with local and regional case management supervisors to convene monthly meetings, as required by contractual arrangements, and to promote information sharing and networking among collaborative case management partners.

Results

The use of liaisons in both the Missouri and Florida systems of case management has helped formalize the collaborative and coordinated relationships between agencies serving the same client populations.

In **Missouri**, the use of Regional Quality Service Managers has helped eliminate geographical barriers to communication and information flow by enabling case managers from across the State to offer regular updates and feedback that help shape the statewide system of case management.

The use of liaisons in the **Azalea Project** has strengthened linkages between agencies that provide case management services to clients with HIV/AIDS and has supported these agencies in reaching their target population of women and youth at high risk for HIV infection and substance abuse. As a result, client access to services has been increased in part through the designation of treatment slots in local substance abuse programs for pregnant and parenting women.

- 8. Recommendation: Conduct joint community needs assessments to identify where HIV/AIDS service gaps exist, and work with other case managers or case management agencies to address unmet needs through coordination or collaborative strategies.**


Rationale

Needs assessments form the basis for HIV/AIDS service planning, and as such have an impact on the organization and delivery of case management services. Needs assessments gather information on the state of the HIV epidemic locally, service needs of clients, provider capacity to meet those needs, available resources, and service gaps. By collaborating in the development of needs assessments, agencies and programs can contribute to a more comprehensive picture of the state of HIV/AIDS services in a jurisdiction, including emerging trends in the epidemic that will shape future service needs. This leads to better service planning and targeting of case management resources. In addition, collaboration in the needs assessment process can lay the groundwork for future and increased cooperation among case management agencies.

Examples

In **Jacksonville, Florida**, the Ryan White Programs from Parts A, B, C, and D conduct a comprehensive community needs assessment in conjunction with SAMHSA-funded programs, Medicaid providers and other community organizations and providers. Case management is one of the primary issues featured in the multistage information and data gathering process. Case management agencies, case managers, and clients all contribute information to the process. Everyone collaborates in the development of a community needs assessment and coordinated HIV/AIDS service plan for the city.

In **Portland, Oregon**, the primary goals of the **Oregon Health and Science University (OHSU)/Partnership Project (PP)** are to standardize case management services, decrease competition, minimize duplication, make services accessible for clients and leverage public and private dollars. In 2002 and 2005, the Project participated in two significant community needs assessments. In collaboration with the Oregon Department of Human Services and the Care Coalition (State of Oregon planning body for Part B), the Project conducted a survey of clients in the Targeted Grant Area (TGA) and the rest of the State to as-



ness service availability and use. More recently the Project collaborated with the Quest Center (a local integrative health care center which receives Ryan White Funds for Mental Health) and Portland State University in a needs assessment survey to assess what importance clients place on case managers in helping them access, obtain, and maintain insurance and other necessary services.

Results

In **Jacksonville, Florida**, the comprehensive community needs assessment has resulted in a more efficient use of case management resources including the elimination of service duplication. As a consequence of the assessment process the community discovered the local sheriff's office was providing transitional case management for soon to be released inmates in the county jail. This was duplicating Ryan White program funded case management providing the same service. The Ryan White case managers were able to disengage servicing this population and focus on other clients in the community while at the same time coordinating with the jail-based case managers on post release issues including the transfer of clients to ongoing community case management. Another finding resulted in the centralization of the client eligibility process. Case managers no longer conduct eligibility screening on clients. This is a centralized function handled by another entity in the city. The result has been clients only being assessed for eligibility for services once and case managers having more time to provide case management services.

The needs assessment conducted by the **OHSU/Partnership Project** has provided the State valuable quantitative and qualitative data on what case management services clients were receiving and where they saw gaps. This has helped the State and the TGA Planning Council develop priorities and allocations for the next several years, including case management. Their second survey with the Quest Center helped the Center to assess at what level it was realistic to charge clients so they could continue to receive treatments.



VII. CONCLUSION

Case management has been a staple of HIV/AIDS programs since the early days of the HIV epidemic, emerging as a complex area of practice that encompasses a broad range of models, approaches, and standards. For clients with HIV/AIDS, particularly those who face significant barriers to care, case management can act as a bridge to critical services and treatment.

At its core, case management is comprised of several basic functions that are common across settings, including client identification, outreach and engagement, assessment, planning, coordination and linkage, monitoring and reassessment, and discharge. Concurrently, case management is subject to wide variations in practice that are influenced by differences in program philosophy and goals, organizational cultures, client needs, and funding requirements and guidelines. While these distinctions have provided case management with an important level of flexibility, in some cases they have also resulted in uncoordinated systems of case management characterized by competition, isolation, and distrust.

This absence of collaboration and coordination can minimize the positive impact of case management for HIV-infected clients. For example, in situations where clients have multiple case managers who do not work together or communicate, gaining access to services can prove time-consuming and cause client confusion about each case manager's role in his or her care. Lack of coordination and collaboration leads to overlap of efforts and ineffective use of resources, consequences case management agencies can ill afford given tight budgets and high caseloads.

There are challenges to the development of case manager partnerships at the system, agency, and client levels. Funder budget cycles and program requirements are not uniform, and sometimes conflict. The array of case management practice models has led to divergent views about case management's responsibility to the client versus the system. The evolution of HIV/AIDS from an acute illness to a chronic disease has expanded the scope and duration of client needs. Confusion about privacy regulations can make case managers reluctant to share client information. Competition, lack of resources and high caseloads can inhibit the relationship building upon which collaboration and coordination depend. In rural areas, geographical distances between agencies can prevent communication and awareness of other resources.

While substantial, these challenges can be overcome with strong leadership, vision, and commitment to the principles of collaboration and coordination and with an understanding of the benefits these processes confer on clients, case managers, and systems of care. As important is the application of key aspects of coordination and collaboration—formalized communication systems, comprehensive client services, client-centered services and coordinated strategies.

Following 2 years of data gathering, stakeholder input, and examination of promising practices, the Federal Interagency HIV/AIDS Case Management Work Group has developed specific recommendations to promote greater collaboration and coordination within systems of HIV/AIDS case management. These recommendations call for: promotion of comprehensive knowledge of scope, purpose, and requirements of services provided within and across case management agencies; regular meetings and case conferences; use of formalized agreements and memoranda of understanding; development of regionally/locally based client intake forms, processes, and data management systems; designation of agency liaisons; and joint work in the development of needs assessments and service planning. The Work Group found that jurisdictions employing these strategies experienced decreased competition and increased cooperation among case managers and their agencies, more efficient use of resources, reductions in service duplication, enhanced client access to services, client satisfaction with case management services, and improved communication among case management agencies and staff. Based on the examples and experiences discussed in this document, these recommendations are provided with the expectation that their implementation will generate system improvements for both case managers and their clients.

APPENDICES

A. ATTACHMENT: METHODOLOGY

The process of developing *Recommendations for Case Management Collaboration and Coordination in Federally Funded HIV/AIDS Programs* included: 1) four day-long, face-to-face meetings of the Federal Interagency HIV/AIDS Case Management Work Group to identify major issues for incorporation into the recommendations; 2) examination of case management collaboration and coordination models based on site visits and interviews with community-based case managers; 3) two community forums with case managers and other agency staff working in the field; 4) a review of the research and non-research literature on effective programs and practices; 5) an Internet-based search of case management standards, practices, and program descriptions; and 6) extensive public and constituent feedback.

Work Group Meetings and Case Conferencing: The Work Group was convened in November 2003 to examine the role of Federal, State, and local policies in influencing the nature and provision of case management services. From November 2003 to February 2005, the Work Group held face-to-face meetings, conference calls and email exchanges to gather information about each Federal agency's funding, policies, requirements, and models related to the delivery of HIV/AIDS case management services.

In comparing information from each agency, the Work Group concluded that greater collaboration and coordination among case management programs (including at the Federal level) would better address the multiple needs of people living with HIV/AIDS. While acknowledging the differences in agencies' oversight and funding of case management activities, they also identified common goals—ensuring client access to needed HIV/AIDS services, maximizing Federal HIV/AIDS resources and reducing duplication of efforts. Further, Work Group members envisioned their efforts as contributing to the development of more seamless systems of case management across funding streams and agencies.

Case Manager Assessment: Work Group members attended the 2004 National Conference on Social Work and HIV/AIDS, sponsored by Boston College and held in Washington, DC. At the conference, qualitative and quantitative assessments were conducted with 159 of 500 conference participants—case managers, consumers, social workers—to gauge their perspectives on the need for and value of recommendations on collaboration and coordination, and their receptivity to using such recommendations.

The assessments revealed that:

- Nearly 90 percent of respondents had in the past or were now providing case management services;
- More than 80 percent of respondents indicated a need for recommendations on collaboration and 76 percent thought that recommendations would help improve services to clients;
- Many respondents thought greater collaboration and/or coordination could help them extend limited budgets by sharing responsibilities for ensuring client access to services;
- A number of respondents expressed hope that recommendations would help link case managers with different approaches, training, and perspectives, including peer and client advocates whose roles incorporated aspects of case management but whose functions were different; and

- Many respondents believed suggestions on how to collaborate or coordinate could spur action among case managers who might otherwise feel they do not have the time or know how to initiate collaborative/coordinated relationships.

Telephone Discussions: As the result of receiving recommendations on innovative models of coordinated services, the Work Group held phone discussions with 20 federally funded agencies providing case management services to HIV-infected individuals, as well as State health officials across the country. Topics included funding sources for case management, collaboration efforts in the provision of case management, barriers encountered, and gaps/duplication in services. A number of agency and grantee staff discussed having a mixture of funding from Federal, State, local and private sources. Some said they did not know the sources of funding for the services they were providing.

A variety of collaborations were described. One agency provided fiscal and administrative oversight for a case management consortium of more than 60 agencies. A number of sites described efforts to collaborate in the development and adoption of case management standards. Some sites described cooperation between teams of case managers that would work together to provide complementary services to the same clients, and who would provide referrals to each other based on clients' assessed needs and priorities.

These discussions also revealed a number of common barriers to collaboration and coordination across sites. These included lack of clarity regarding funder expectations around collaboration and coordination, inconsistent eligibility requirements, different reporting periods, competition for funding, the absence of formalized relationships, little or no incentives to work together, and different organizational goals and processes. In addition, a number of those interviewed discussed their inability to build relationships with other case managers due to lack of time and resources.

In general, interviewees expressed receptivity to recommendations and suggestions from Federal agencies about how they could link more effectively with other case managers across the various funding streams.

Community Forums: Two community forums were held to obtain input from grantees and case managers working in federally funded HIV/AIDS programs.

An informal listening session was held with participants of the 2004 Ryan White Grantee Conference in Washington, D. C. This open forum gave grantees an opportunity to describe the systems of HIV/AIDS case management in their local communities and provide information on issues related to collaboration and coordination. Forum participants expressed many views on the role of case management with HIV-infected clients. They talked about the need for some level of standardization in a field that employs many practice models, despite the difficulties that would confront such an effort. Some participants expressed support for the "one case manager/one client" approach, while others favored the use of case management teams. Several participants talked about successful collaboration across Ryan White programs within States and local areas, while some described challenges in working with other Ryan White-funded case managers. Many participants asked for guidance in coordinating with other systems of care.

A second listening session was held in June 2005 with case managers, program managers, CDC staff and others to gain input on experiences in the field with the use of CDC-funded Prevention Case Management (PCM), now referred to as Comprehensive Risk Counseling and Services (CRCS). Participants cited some confusion about the role of CRCS with regard to other types of case management, and said this lack of understanding led to conflict with other case managers and social workers serving the same client populations. Challenges were also reported with recruitment, engagement, and retention of clients. Many participants said that interpretations of 1997 CDC guidance on PCM varied among case managers, causing confusion about the scope and responsibility of those practicing CRCS. In 2006, CDC released a supplement to its 1997 guidance, clarifying the role of CRCS primarily as a prevention intervention. The supplement also directs CRCS case managers to refer clients, where possible, to existing case management services, and to coordinate services and referrals with other case managers and health care providers. More information on current CRCS policies is available at http://www.cdc.gov/hiv/topics/prev_prog/crcs.

Site Visits: Work Group members conducted site visits to two case management programs that have demonstrated success with collaboration. The site visits helped members gain insight into why the collaborative arrangements were developed, how they have been implemented, what benefits they have produced, and what obstacles or challenges staff have faced in implementing them.

- **Chicago, Illinois: The AIDS Foundation of Chicago** is a centralized HIV/AIDS case management cooperative funded by the Ryan White Program, HOPWA and Medicaid.
- **Kansas City Free Health Clinic.** The clinic blends funding from the Ryan White Program (Part A, B & D), and CDC to support generalist case managers who are responsible for a variety of tasks such as authorizing AIDS Drug Assistance Programs (ADAP), Housing Opportunities for People with AIDS (HOPWA), State Plan Personal Care/AIDS Waiver (Medicaid funded service) among others.

Literature Review: A literature review was conducted to identify information on case management models, standards of practice and strategies that could be used in the development of the recommendations. An examination of case management research revealed important information about the evolution of case management and its role in health care, and identified concepts and terminology that are inherent in its practice. The Work Group also reviewed data and information from studies on interagency collaboration and service integration outside the field of HIV/AIDS, some of which focused on case management and some of which did not.

B. ATTACHMENT: TERMS

The following terms are used in this Manual. The primary sources for most of these definitions are publications of the U. S. Department of Health and Human Services.

Adherence	Following the recommended course of treatment by taking all prescribed medications for the entire course of treatment, keeping medical appointments and obtaining lab tests when required.
Advocacy	The act of assisting someone in obtaining needed goods, services, or benefits, (such as medical, social, community, legal, financial, and other needed services), especially when the individual had difficulty obtaining them on his/her own. Advocacy does not involve coordination and follow-up on medical treatments.
Broker	To act as an intermediary or negotiate on behalf of a client.
Client	Any individual (and his/her defined support network), family, or group receiving case management services. In some instances, the client may consist of an individual and his/her caregiver or an individual and his/her substitute decision-maker.
Coordination	A process that involves staff of different agencies working together on a case-by-case basis to ensure that clients receive appropriate services. Coordination does not change the way agencies operate or the types of services they provide. Rather, it represents an agreement between agencies to avoid duplication of efforts and engage in some level of cooperation in the delivery of services that are already available.
Collaboration	A process that involves agencies or staff in joint work to develop and achieve shared goals and requires them to follow set protocols that support and complement each other's work. Collaboration requires the commitment of agency or system leadership to be effective and produce the kind of sustained change that is central to its objectives. Collaboration generally involves system changes to some degree.
Community-Based Services	Services are available within the community where the client lives. These services may be formal or informal.
Community-Based Organization:	A service organization that provides medical and/or social services at the local level.
Comprehensive Risk Counseling and Services	A client-centered prevention activity that combines HIV risk reduction counseling and traditional case management to provide ongoing, intensive, individualized prevention counseling and support. CRCS staff does not provide case management if clients can, or have been, referred to case managers.

Confidentiality The process of keeping private information private.

Cultural Competency Refers to whether service providers and others can accommodate language, values, beliefs, and behaviors of individuals and groups they serve.

Health Insurance Portability and Accountability Act (HIPAA) HIPAA, passed by Congress in 1996, provides comprehensive Federal protection for personal health information. HIPAA has standardized the way health information is used, has established universal billing codes for the electronic processing of insurance claims and has made health insurance more portable for clients.

Medical Case Management A range of client-centered services that link clients with health care, psychosocial, and other services, and which include coordination of, and follow-up on, client medical treatments. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments.

Ryan White HIV/AIDS Program Passed by Congress in 1990, the original Ryan White Comprehensive AIDS Resources Emergency (CARE) Act provided emergency assistance to communities most affected by the HIV epidemic, and funded financial assistance to State and other public or private nonprofit entities. The Ryan White HIV/AIDS Treatment Modernization Act of 2006, which renamed the Ryan White CARE Act to the Ryan White HIV/AIDS Program, emphasizes the provision of life-saving and life-extending services for people living with HIV/AIDS.

C. ATTACHMENT: CASE MANAGEMENT TIMELINE AND CLASSIFICATIONS

i. Case Management Timeline

DATE	CASE MANAGEMENT MILESTONES
1820	John Griscom establishes the Society for the Prevention of Pauperism to investigate the habits and circumstance of the poor and to suggest plans by which they could help themselves.
1863	The State of Massachusetts enacts the Nation's first Board of Charities to oversee, manage and coordinate the operations of social service institutions and prisons.
Late 1800s	Growth of Charity Organization Societies and Settlement Houses.
1898	The New York Summer School for Applied Philanthropy (later to become the Columbia University School of Social Work) was established to professionally train volunteers as social caseworkers.
Early 1900s	Case management-type programs are employed by the United States Public Health Service to address environmental issues such as sanitation and immunization.
1901-1909	States organize the first health departments.
1910-1920	Social casework infiltrates diverse fields such as psychiatry, medicine, child welfare, schools, and juvenile courts.
1917	Mary Richmond's book Social Diagnosis is published and propels casework from one of several approaches used by charity workers into a major form of practice.

1918	Smith College starts the first training program for psychiatric social workers.
1921	The New York School of Social Work and the National Committee On Mental Hygiene start a number of demonstration child guidance clinics that popularize the team concept of treatment, which involves psychiatrists and social workers.
Mid-1920s	“Community Chest Movement,” “Council of Social Agency,” and “Central Councils” created to coordinate the financing and administration of charities.
1926	Social Work Service created as an organizational component of the Central Office of the Veterans Bureau.
1935	Social Security Act makes funds available for social casework.
1963	The Federal Community Mental Health Center Act establishes federally funded case management as an alternative to hospitalization for clients with mental illness.
1973-74	The Older Americans Act creates a network of State and local agencies to coordinate and provide services to older individuals and their families. Case Management is a central component of the services provided by these networks.
1974	The Lower East Side Family Union demonstration project in New York is the first case management model to operate based on a structured written contract to coordinate activities between agencies. The project pioneers the “integration of services” model of casework practice.
1975	The Education for All Handicapped Children Act mandates access to free, appropriate public education for children with disabilities.
	The Developmentally Disabled Assistance and Bill of Rights Act establishes funding for State protection and advocacy systems, which use case management for the coordination of client services.
1977	The Community Support Program is established by the National Institute of Mental Health to meet the need for community-based mental health services, and case management becomes a central component of the system.
1978	The report from the President’s Commission on Mental Health identifies case management as a critical component of services to persons with chronic mental illness.
1981	The Omnibus Budget Reconciliation Act institutes Medicaid case management for several vulnerable groups including the elderly, the disabled, persons with mental illness, and clients with HIV/AIDS.
1985	HRSA’s HIV/AIDS Service Demonstration Program starts in four urban areas to establish models of service delivery for persons living with HIV/AIDS.
1986	The Education of the Handicapped Act Amendments mandate case management as part of an early intervention system for infants and toddlers with disabilities and their families.
1989	The white paper <i>Caring for People</i> encourages local social service departments to adopt case management for building an individual’s package of care.
1990	The AIDS Housing Opportunity Act is approved to provide targeted housing assistance to HIV-infected individuals and their families.
1991	The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act is passed and provides support for HIV/AIDS case management as a core component in the delivery of HIV services.
1992	The Housing Opportunities for Persons with AIDS (HOPWA) program is funded. Regulations are issued and include case management among an array of important services for HOPWA clients.

2006 The Ryan White HIV/AIDS Treatment Modernization Act of 2006 is passed, reauthorizing programs under the former Ryan White CARE Act Program. The Act renames the program to the Ryan White HIV/AIDS Program and places an emphasis on the provision of life-saving and life-extending services to people living with HIV/AIDS.

ii. Case Management Classifications

A variety of case management models have been described in the literature over the past two and a half decades. They may be based on variables like case manager's service/role, location, type, and level of intervention. A few of these classifications are presented below:

Ross, (1980)⁵⁶

- **Minimal:** Includes outreach, assessment, planning & referral.
- **Coordination:** Includes minimal services + advocacy, developing natural support system, direct services and reassessment.
- **Comprehensive:** Includes monitoring, crisis intervention and education in addition to minimal and coordination activities.

Levine and Fleming (1985)⁵⁷

- **Generalist Model:** Entrusts all client-care responsibilities to one individual case manager.
- **Specialist Model:** Several practitioners work as a team to deliver services to the client.

American Hospital Association (1992)⁵⁸

- **Primary care case management:** The primary care physician coordinates all aspects of patient care.
- **Medical case management:** Medical monitoring of patients with severe illnesses or injuries.
- **Social case management:** Coordinates social and economic resources for a non-acute population residing in the community in order to prevent costlier care.
- **Medical-social case management:** Merges medical and social case management by using an array of health, social, and economic resources.
- **Vocational case management:** Assists persons with disabilities find gainful employment.

Solomon (1992)⁵⁹:

- **Full Support:** Interdisciplinary team provides the whole range of clinical and support services to clients. Includes Assertive Community Treatment model.
- **Personal Strengths or Developmental-Acquisition:** Case manager helps clients identify and build on strengths to achieve self-sufficiency in obtaining needed services and resources.
- **Rehabilitation:** Case manager combines therapeutic approaches with activities that enhance client access to services, including involvement of support networks to help client achieve and maintain recovery.
- **Expanded Broker of Generalist:** Similar to the broker model that focuses on helping clients access needed care and services through the provision of referrals.

Austin (1996)⁶⁰

- **Broker:** Assesses client needs and allocates services of the agency to which referrals are being made but do not determine the cost of their care plans.
- **Service Management:** Management of essential services and entitlements. The case manager is fiscally responsible for the plans developed which are limited by available services that can be authorized.
- **Managed Care:** Authorizes services and management of benefits for high cost/high risk beneficiaries. Managed care incorporates prospective payment. A care plan includes a client-specific plan that comprises services, activities, and material resources.

Cline (1996)⁶¹

- **Medical Care:** Inpatient-based case management
- **Catastrophic Care:** Insurance company-based case management
- **Long-Term Care:** Community-based case management

Mueser and colleagues (1998)³²

- Standard Case Management: Includes Broker and Clinical Case Management models where case managers act as service brokers without employing clinical skills.
- Intensive Comprehensive Care: Includes Assertive Community Treatment and Intensive Case Management models, which usually incorporate teams of case managers who have frequent interactions with clients and work with them over the long term to focus on issues of daily living.
- Rehabilitation-oriented Community Care: Includes the Strengths-based and Rehabilitation models where the case managers provide services based on the individual client’s desires and goals, rather than goals defined by the system.

Bedell, Cohen, Sullivan, (2000)⁶²

- Broker: Case managers rely mostly on referrals.
- Full Service: Interdisciplinary team providing the whole range of clinical and support services to clients. Includes Assertive Community Treatment model.
- Hybrid: A mix of both broker and direct services. Includes Intensive Case Management model, the Strengths model, and the Rehabilitation model.

D. Attachment: Federal Agency Funding for HIV/AIDS Case Management

The Federal agencies listed below (in alphabetical order) fund case management services and research for people living with HIV/AIDS. They differ in the level and type of direction they give to grantees regarding the way case management services should be procured, the models of case management used, the experience and credentials required to practice, and the way case management is funded.

All Federal agencies that fund HIV/AIDS case management recommend their grantees coordinate with other federally funded case managers serving the same client populations. HRSA requires its grantees to document the nature and extent of collaboration between Ryan White-funded case managers and those funded by other Federal, State and local agencies. CDC requires its grantees to document client referrals and their outcomes. Other agencies do not require documentation of collaborative efforts among case managers.

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Centers for Disease Control and Prevention (CDC)

CDC is an agency within the U.S. Department of Health and Human Services (HHS) that promotes health and quality of life by preventing and controlling disease, injury, and disability. CDC operates 11 Centers including the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. CDC monitors the status and characteristics of the HIV epidemic and conducts epidemiologic, laboratory, and surveillance investigations.

In 1997, CDC published guidelines and a literature review for conducting prevention case management (PCM), a client-centered approach that combines HIV risk-reduction counseling and traditional case management to provide intensive, ongoing, individualized prevention counseling and support to HIV-infected and HIV-negative individuals (CDC, 1997a, 1997b). In late 2005, CDC changed the name of PCM to comprehensive risk counseling and services (CRCS). CDC also clarified that CRCS prevention counselors should not provide case management if clients have, or can be referred to, other case management programs, such as those funded by Medicaid and the Ryan White. CRCS staff can provide case management and referrals to clients who do not otherwise have access to these services, but must always work with other care providers and case managers to coordinate referrals and services.

All other aspects of the 1997 guidance remain in effect. In 2006, CDC released the CRCS Implementation Manual and Forms to supplement the 1997 guidance. The manual and forms consolidate lessons learned from 10 years of implementing PCM. The manual and forms are very practically based and the forms can be revised and used as agencies see fit. Current information on CRCS as well as the manual and forms are available at www.cdc.gov/hiv/topics/prev_prog/crcs

Like HRSA, CDC lets grantees determine the scope and location of services, as well as the licensure, educational, and professional experience requirements in accordance with State and local laws. While not mandated, the 1997 guidance recommends minimum qualifications for CRCS staff, especially related to the performance of certain tasks. CRCS counselors can be social

workers, psychologists, mental health counselors, paraprofessionals, and others. In addition, the agency provides grantees with practice standards for the operation of CRCS programs.

To facilitate the linkage of recently diagnosed HIV-infected persons to primary medical care and permanent case management, CDC developed a short duration, strengths-based model of case management. Officially known as ARTAS I (Antiretroviral Treatment Access Study), or more commonly referred to as “linkage case management,” this model was tested in a randomized clinical trial in four cities (Atlanta, GA, Baltimore, MD, Los Angeles, CA, Miami, FL) during 2000-2002. Clients at each site were randomized to receive either passive referral (standard of care) or a brief case management intervention. The results were very promising. Persons served by case managers had a greater chance of being linked to care and stayed in care longer versus those who only received a passive referral. The average cost was \$600–\$1,200 per client.

The success of ARTAS I has lead CDC to implement this strategy in real world settings through a demonstration project. In September 2004, ARTAS II was launched in 10 sites (5 local or State health departments and 5 community-based organizations). The ARTAS II demonstration project will compare rates of linkage to HIV care providers before and after instituting the linkage case management shown effective in the first ARTAS study. Findings of the study will strengthen CDC’s understanding of how well linkage case management works in typical HIV program settings in the United States. CDC staff overseeing the project have emphasized the importance of the sites collaborating and coordinating with existing Ryan White and Medicaid case management services (if they are not already funded by Ryan White or Medicaid to provide case management). Findings from ARTAS II are expected to be available in 2007. More information is available at www.cdc.gov/hiv/topics/prev_prog/AHP/resources/factsheets/ARTASSII.htm

The CDC Perinatal HIV Case Management project, launched in 2006, provides 1 year of funding to evaluate the costs and effectiveness of an already funded, established perinatal HIV case management program. CDC is also seeking to expand the program to previously un-enrolled HIV-infected pregnant women including those who, without case management, would be most likely to transmit HIV to their infants. Case management services include ongoing contact between a trained case manager and an HIV-infected pregnant woman during her pregnancy and through delivery and documentation of her infant’s HIV status. Primary goals of the project include: (1) preventing perinatal HIV transmission; (2) ensuring receipt of adequate pre-natal care; and (3) ensuring receipt of recommended antiretroviral drugs to prevent perinatal HIV transmission and protect the woman’s health. Other goals include linkage to HIV care following delivery for both mother and infant, reduction in maternal behaviors associated with transmission of HIV to an uninfected sex or needle-sharing partner, and increased maternal ability to plan future pregnancies.

For more information, visit www.cdc.gov.

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Centers for Medicare and Medicaid Services (CMS)/Medicaid

Aspects of case management have been integral to the Medicaid program since its inception. The law has always required States to have interagency agreements under which Medicaid applicants and recipients may receive assistance in locating and receiving needed services. Basic case management functions have also existed as components of each State’s administrative apparatus for the Medicaid program and also as integral parts of the services furnished by the providers of medical care. Physicians, in particular, have long provided patients with advice and assistance in obtaining access to other necessary services.


In 1981, Congress, recognizing the value and general utility of case management services, authorized Medicaid coverage of case management services under State waiver programs. States were authorized to provide case management as a distinct service under home and community-based waiver programs. Case management is widely used because of its value in ensuring that individuals receiving Medicaid benefits are assisted in making necessary decisions about the care they need and in locating services.

For more information, visit www.cms.hhs.gov

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U. S. Department of Housing and Urban Development (HUD)/Housing Opportunities for Persons with AIDS (HOPWA)

HUD is a Federal department whose mission is to increase home ownership, support community development and increase access to affordable housing free from discrimination. To fulfill this mission, HUD embraces high standards of ethics, management, and accountability and forges partnerships with community-based organizations that leverage resources and improve the department’s ability to be effective in its efforts.



HUD's HOPWA program funds case management, housing information services, and permanent housing placement for HIV-infected individuals enrolled in its housing programs, which provide rental assistance, short-term rent and mortgage payments, utility assistance, and operating costs for supportive housing facilities. HOPWA also provides services to eligible clients using other housing resources. Case management is an important feature of HOPWA's programs and is used to assist clients in accessing and maintaining safe, decent, and affordable housing and access care. HOPWA programs are expected to work closely with Ryan White-funded programs to ensure care and services for HIV-infected clients. In addition, HOPWA programs participate in joint planning efforts with Medicaid, SAMHSA, CDC, and other housing programs to address a range of client needs.

Housing-based case management is generally considered a core supportive service of any HOPWA program and helps ensure clear goals for client outcomes related to securing or maintaining stable, adequate, and appropriate housing. In addition, case management is important in helping clients improve their access to care and other needed supportive services. Case management can play an important role in helping clients achieve self-sufficiency through development of individualized plans, which identify factors contributing to a client's housing instability and creates objectives and goals for independent living.

HOPWA allows grantees considerable flexibility in assessing needs and structuring housing and other services to meet community objectives. However, the regulations also require access to necessary supportive services for clients. Grantees must conduct ongoing assessments to determine client needs. The HOPWA program measures outcomes through Annual Progress reports (APR and CAPER) as well as through its IDIS system. Outcomes are reported on housing stability, use of medical and case management services, income, access to benefits, employment, and health insurance. HOPWA views the housing resources provided as a base from which to enhance client access to care and reduce disparities.

HOPWA funds are provided through formula allocations, competitive awards, and national technical assistance awards. Ninety percent of HOPWA funds are allocated by formula to qualifying cities for eligible metropolitan statistical areas (EMSAs) and to eligible States for areas outside of EMSAs. Eligible formula areas must have at least 1,500 cumulative cases of AIDS as reported by CDC and a population of at least 500,000. One-quarter of the formula is awarded to metropolitan areas that have a higher than average per capita incidence of AIDS. In FY 2006, 83 metropolitan areas and 39 States qualified for HOPWA formula awards, which total \$256.2 million.

Ten percent of HOPWA funds are awarded by competition, the procedures for which are established annually in the Department's SuperNOFA (Notice of Funding Availability) process. In FY2006, approximately \$28.6 million was made available for HOPWA competitive grants with priority given to expiring permanent supportive housing grants that have successfully undertaken housing efforts. Remaining funds are made available for two types of new HOPWA projects: (1) Long-Term Projects in Non-Formula areas; and (2) Special Projects of National Significance (SPNS). In addition, the program funds technical assistance, training, and oversight activities. These resources can be used to provide HOPWA grantees and project sponsors with assistance to develop skills and knowledge needed to effectively develop, operate, and support project activities that result in measurable performance shown in housing outputs and client outcomes. About 500 nonprofit organizations and housing agencies operate under current HOPWA funding and provide support to over 71,000 households. For more information, visit www.hud.gov/offices/cpd/aidshousing/programs/.

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Health Resources and Services Administration (HRSA)/ Ryan White HIV/AIDS Treatment Modernization Act

HRSA is the primary HHS agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable. HRSA grantees provide health care to uninsured people, people living with HIV/AIDS, pregnant women, mothers, and children. The agency also trains health professionals and improves systems of care in rural communities. Among other functions, HRSA administers the Ryan White HIV/AIDS Program, which provides treatment and services for those affected by HIV/AIDS, evaluates best-practice models of health care delivery, and administers education and training programs for health care providers and community service workers who care for persons living with HIV/AIDS.

The Ryan White HIV/AIDS Program is the largest source of Federal funds for HIV/AIDS case management. HRSA gives its grantees broad latitude in implementing case management services, and both psychosocial case management and medical case management are funded in many jurisdictions. Ryan White Programs can provide reimbursement for coordinating services, HIV prevention counseling, and psychosocial support.

The role of Ryan White-funded case management is to facilitate client access to medical care and provide support for treatment adherence. Some grantees supplement case management activities with benefits counseling and client advocacy, which focus

on assessing eligibility and enrolling clients into Medicaid, disability programs, Medicare, HOPWA, and other HUD programs, food voucher programs, State High Risk Insurance Pools, Ryan White AIDS Drug Assistance Programs (ADAP), pharmaceutical company compassionate-use programs, and others. In general, Ryan White case management is provided with a range of “wrap-around services” available from many agencies and local health departments.

Credentials for Ryan White-funded case managers vary based on jurisdictional requirements, standards set by grantees and planning bodies, and the types of services case managers provide. Case management models also vary among jurisdictions based on local needs and other factors. As the epidemic has evolved, so has the provision of Ryan White-funded case management services. Early in the HIV epidemic, most case management followed the psychosocial model. However, as the Ryan White HIV/AIDS program has continued to emphasize entry into and retention in primary care for people living with HIV/AIDS, and the coordination of support services that promote those goals, medical case management has become more prevalent. A Ryan White-funded case manager may remind a client to take medicine (as part of funded adherence activities under Part B) or might work with clients on behavior modification to reduce risk, similar to a CDC-funded CRCS case manager.

The organizational placement of case managers also varies. Some communities fund case management agencies, some employ case managers within agencies that provide many support services, some are placed in clinics and many States use public health nurses in rural counties as case managers.

For more information, visit www.hrsa.gov.

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National Institutes of Health (NIH)/National Institute on Drug Abuse (NIDA)

NIH, through NIDA, funds investigator-initiated research on the effectiveness of case management models to improve access to systems of care for HIV-infected substance users. NIH/NIDA also supports research on integrated health care systems that include case management as a key component. The research has identified promising case management models that link substance abuse treatment, medical treatment, and aftercare programs. These models can help increase the number of days individuals remain drug free, improve their performance on the job, enhance their general health, and reduce their involvement in criminal activities.⁶³

NIH-sponsored research has indicated that there are cost benefits to incorporating case management in the treatment of HIV-infected drug abusers.⁶³ Further research is needed to identify which case management approaches work best for clients with varying levels of clinical need. Studies have found that client outcomes improve if the tasks, responsibilities, authority relationships, use of assessment and planning tools, and the exchange and management of client information are delineated in advance of the client’s entry into a treatment program.⁴⁸ This suggests that in addition to clinical fidelity to a given case management model, formal agreements are needed between case management agencies.

NIH has funded research exploring different case management models. In particular, the following four models have been shown to be effective in different populations with varying degrees of pathology: (1) broker/generalist; (2) strengths-based; (3) clinical/rehabilitation; and (4) Assertive Community Treatment. Irrespective of the model used, research suggests that case management appears to be more successful in improving client access to utilization, engagement/retention in the process of medical and substance abuse treatment when located within a treatment facility rather than in a co-located agency, when the case manager is knowledgeable about the quality and availability of programs and services in the area and when there is ability to pay for services.⁴⁶

For more information, visit www.nida.nih.gov

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Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA funds case management through its three centers: the Center for Mental Health Services (CMHS); the Center for Substance Abuse Prevention (CSAP); and the Center for Substance Abuse Treatment (CSAT). Roughly 50 percent of CMHS-funded grantees provide case management services, as do about 20 percent of CSAT grantees. The goal of SAMHSA-funded case management is to facilitate client entry into substance abuse treatment and mental health services, among others. While grantees do not receive specific guidance on the provision of case management services or the use of case management models, CMHS and CSAT both assert that mental health case management and substance abuse treatment case management are most effective when substance use, mental health, and medical care are integrated. They also subscribe to the idea that all clients should have a primary case manager who works with other case managers to coordinate services.

CSAP does not provide guidance on case management, but lets grantees design their own approaches based on target populations and other factors. It refers grantees to models used by CDC-funded and Ryan White-funded case managers. As a result, grantees often use a combination of approaches.

SAMHSA guidance encourages grantees to develop linkages with providers of HIV/AIDS and substance abuse treatment services, such as primary care providers, HIV/AIDS outreach programs, mental health programs, and HIV counseling and testing sites, among others. Where collaboration occurs, grantees must identify the role of coordinating organizations in achieving the objectives of their programs.

For more information, visit www.samhsa.gov.

E. ATTACHMENT: ACRONYMS

Following is a list of acronyms that have been used in the document or are commonly used in Federal HIV/AIDS programs.

ADAP	AIDS Drug Assistance Program
AFC	AIDS Foundation of Chicago
AIDS	Acquired immunodeficiency syndrome
ARTAS	Antiretroviral Treatment Access Study
CBO	Community-based organization
CDC	Centers for Disease Control and Prevention
CMHS	Center for Mental Health Services (SAMHSA)
CMS	Centers for Medicare and Medicaid Services
CSAP	Center for Substance Abuse Prevention (SAMHSA)
CSAT	Center for Substance Abuse Treatment (SAMHSA)
CRCS	Comprehensive Risk Counseling and Services
EMSA	Eligible metropolitan statistical area
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human immunodeficiency virus
HRSA	Health Resources and Services Administration (U.S. Department of Health and Human Services)
HOPWA	Housing Opportunities for Persons with AIDS
HUD	U.S. Department of Housing and Urban Development
NASW	National Association of Social Workers
NCHHSTP	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (CDC)
NIH	National Institutes of Health
NIDA	National Institute on Drug Abuse (NIH)
PCM	Prevention Case Management (now called CRCS)
SAMHSA	Substance Abuse and Mental Health Services Administration
SPNS	Special Projects of National Significance
STD	Sexually transmitted disease


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