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Introduction

HIV Case Management Standards

This document establishes state-wide standards for HIV case management services. Seven Regions provide these services throughout the state. These services are funded through Part B of the Ryan White HIV/AIDS Treatment Modernization Act; administered through the US Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau; and distributed and monitored by the Pennsylvania State Department of Health, Division of HIV/AIDS. The standards set a minimum service level for programs providing Ryan White Part B HIV case management regardless of setting, size, or target population.

Case management standards were developed to:

- Clearly define case management and describe models of case management service;
- Clarify service expectations and required documentation across HIV programs providing case management;
- Simplify and streamline the case management process;
- Encourage more efficient use of resources; and
- Promote quality of case management services.

The overall intent of the Pennsylvania State Department of Health, Division of HIV/AIDS is to assist providers of HIV case management services in understanding their case management responsibilities and to promote cooperation and coordination of case management efforts.

Ongoing changes in the HIV epidemic, the HIV service environment, and the needs of HIV positive individuals over the late 1990's and into the twenty first century necessitated a re-examination of case management practice and standards. For over one year, a workgroup appointed by the Pennsylvania State Department of Health, Division of HIV/AIDS, broadly representative of the different regions and diverse program types offering Ryan White Part B funded HIV case management across the state, met to develop a single set of standards.

The revised case management standards describe two models of HIV case management: Medical Case Management and Non-Medical Case Management. The two models were established to respond to varied levels of client need, client readiness for case management services, and agency resources. Section A of these standards applies to medical case management. Section B applies to non-medical case management. Each region can provide either or both models of case management. It is strongly recommended that newly-diagnosed clients be offered medical case management.

In the format of this document, you will see the standards as well as indicators and examples of evidence related to each of these standards. A “standard” is a criterion required to be met by case management providers. An “indicator” is a more specific

measure which is also required and shows that the related standard is being met. An "example of evidence" is not a requirement but is an example of how the appropriate party may visibly and objectively show that the related indicator and standard is being met.

Although these standards set minimum requirements, The Pennsylvania Department of Health, Division of HIV/AIDS may establish additional requirements, modifying the standards to fit particular settings, objectives, target populations, and/or Departmental initiatives.

Medical Case Management

Medical case management services (including treatment adherence) are a range of client-centered services that link clients with medical care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management, and requires collaboration and coordination between the medical provider and case manager. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments.

Medical case management includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. It also includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Medical case management is a proactive case management model intended to serve persons living with HIV/AIDS with multiple complex psychosocial and/or health related needs, their families and support systems. The model is designed to serve individuals who may require and who agree to an intensive level of case management service provision.

Non-Medical Case Management

Non-medical case management is suitable for persons with discrete needs that can be addressed in the short term. In some cases, non-medical case management serves as a means of assisting an individual who may not need frequent follow up, but requires occasional reassessment to determine if their current level of care is sufficient. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. In regions where both models are used, a determination is made based on a standardized acuity scale, as to whether a client will be enrolled in the medical or non-medical case management model. This acuity scale is implemented state-wide to insure consistent assessment and enrollment wherever both models are used.

Goals and Key Activities

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

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

Key activities include the following:

(1) Assessment of the client's needs and personal support systems;
(2) Development of a comprehensive, individualized service plan in coordination with the client;
(3) Coordination of services required to implement the plan;
(4) Client monitoring and follow-up to assess the efficacy of the plan; and
(5) Periodic re-evaluation and adaptation of the plan as necessary. It includes client-specific advocacy and/or review of utilization of services for all types of case management including face-to-face, phone contact, and any other forms of communication.

A1. Medical Case Management Practice Standards

Standard A1-1: Client Screening

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

- The client's HIV-positive diagnosis.

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

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

  (***NOTE:*** In cases of a new diagnosis, a client is not in care or is returning to care and a CD4 or viral load test has not been performed or medications have not been prescribed, tests or prescriptions must be obtained within 30 days in order for services to continue.)

- Client needs and, given these needs, whether case management services are appropriate for client.
- The types of services (e.g., Targeted Case Management, Ryan White) for which the client is eligible.
- Financial/income status and medical benefits/insurance status.
- Proof of Identification.
- Proof of Residency.
- Proof of Primary Care.
- Payer of Last Resort (refer to Attachment A.)

Indicator A1-1.1: In cases of crisis situations, screening is suspended and the crisis is addressed immediately.

Example of evidence:

- Client file addresses ways that crisis situations were handled.

Indicator A1-1.2: Screening conducted within five working days of request/ referral.

Example of evidence:

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

Indicator A1-1.3: An official, dated diagnosis statement is received by case manager.

Example of evidence:

- Official, dated statement is in client file.

Standard A1-2: Overview of Case Management

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

Indicator A1-2.1: Case management services, grievance procedures, and rights/responsibilities are described to client.

Example of evidence:

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

Standard A1-3: Comprehensive Assessment

Each client who consents to receive case management services receives a comprehensive assessment (see Glossary, Attachment E) within 30 days of the client's initial screening to identify the client's strengths, resources, needs, and problems. This assessment is done face-to-face under circumstances (e.g., time and location) agreeable to the client and case manager and includes the following areas:

- Identification of source if referred to services;
- Date assigned to case manager;
- Basic demographic information (include transgender ;)
- Assessment of previous or current case management services;
- Client's statement of need;
- Client's strengths;
- Summary of physical health history and respective treatment (including, but not limited to, hospitalizations and most recent CD4 and viral load results;)
- Summary of mental health history and respective treatment;
- Summary of substance abuse history and respective treatment;
- Assessment of risk behavior and risk reduction behavior (e.g., risk of transmitting HIV, sexual risk behavior, domestic violence, partner notification;)
- Summary of medical benefits/insurance;
- Legal history, including probation officer, if applicable;
- Housing/living situation (type of housing/household composition;)
- Debt and money management issues;
- Employment issues (current employment; ability to be employed, job training and re-training;)
- Family history/social support;
- Names and addresses of primary physician, dentist, and pharmacist;
- All current prescribed and over-the-counter medications/dosage, including nutritional supplements and other substances used in other therapies (e.g., homeopathic remedies;)
- Assessment of treatment adherence (all medical care and medications;)
- Other formal and informal resources; and
- Any barriers to services (physical, social, financial, etc.)

Indicator A1-3.1: Case manager has identified past sources of services/care and has obtained summaries of pertinent, existing client primary and behavioral health records and legal history, as well as phone numbers and addresses of key providers.

Example of evidence:

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

Indicator A1-3.2: The client is assessed in key areas listed in Standard A1-3.

Example of evidence:

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

Indicator A1-3.3: If medical case management and non-medical case management are available, and following an in-depth assessment, determination of placement will be based on the results of the Statewide acuity scale. (See Attachment D.)

Standard A1-4: Service Coordination Plan

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

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

Indicator A1-4.1: The SCP is completed at the end of the bio-psychosocial assessment; both the client and the case manager sign the SCP; and a copy of the SCP is given to the client.

Example of evidence:

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

Standard A1-5: Referrals and Case Coordination

Each case manager refers to and coordinates services among community-based organizations, primary care providers, housing services, and other providers in managing the care of a client by advocating for the client and collaborating with these entities. (See also General Standard B1.) Case coordination includes communication, information sharing, and collaboration, and occurs regularly with case management and other staff serving the client within and between agencies in the community. Coordination activities may include directly arranging access, reducing barriers to obtaining services, establishing linkages, and other activities recorded in progress notes to ensure retention in care.

Indicator A1-5.1: Case manager makes appropriate referrals to providers.

Example of evidence:

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

Standard A1-6: Documentation

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

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

NOTE: See also, General Standard C1, Indicator C1.4 regarding confidentiality of client records.

Indicator A1-6.1: All documentation, both dated and signed by the case manager, is kept.

Example of evidence:

- Documentation is in client file.

Indicator A1-6:2: There is a policy and procedure in place for tracking, reporting and billing of clients receiving medical case management services.

Example of evidence:.

- Policy and procedure is in place
- Tracking, reporting and billing reports are generated

Standard A1-7: Face-to-Face Contact

The client has face-to-face contact with the case manager at least every 90 days, consistent with client needs. As a result of this contact, the following is noted and recorded in the SCP and/or progress note:

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

Indicator A1-7.1: Progress notes are kept and review of the SCP is completed at least every 90 days.

Example of evidence:

- Progress notes and revised SCP is in client file.

Indicator A1-7.2: Problems or critical issues which may hinder access to services are identified and action is taken to resolve them.

Example of evidence:

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

Standard A1-8: Retention in Care

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

Indicator A1-8.1: A policy and procedure is maintained by agencies to retain clients in case management and HIV medical care.

Example of evidence:

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

case file

Standard A1-9: Treatment Adherence

The client's adherence to HIV treatment must be assessed every 90 days following the initial assessment.

Indicator A1-9.1: Treatment adherence activities (including keeping medical appointments, taking prescribed medications, refilling prescriptions, etc.) are tracked for individual clients.

Example of evidence:

- Documentation in client records and SCP demonstrate that treatment adherence activities have been discussed and identified problems addressed.

Indicator A1-9.2: Ongoing engagement in HIV medical care is documented every 180 days.

Example of evidence:

- Documentation in client records of the date of a CD4 count, viral load test, or prescribed ART medications within the last 180 days.

Standard A1-10: Reassessment

Clients will be reassessed on a yearly basis in the key areas cited in Standard A1-3. A new service care plan and acuity scale evaluation must be completed based on the reassessment of the client.

Indicator A1-10.1: The client is assessed in required key areas as per Standard A1-2.

Example of evidence:

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

Standard A1-11: Termination of Services

Case management services are terminated when:

- The client, in consultation with the case manager, indicates services are no longer needed or may be met better by another agency (see General Standards B1, Indicator B1.3 and C5;)
- When twelve months have lapsed since the client's last face-to-face contact or service from the case manager. This time frame incorporates possible movement of a client to/from either case management model;
- For threatening verbal and/or physical behavior by clients toward case manager or agency staff, pursuant to individual agency policies;
- When the client moves to a new service area; or

- When the client is incarcerated for more than a year.

If programs have a waiting list, they may close cases sooner than twelve months if it is properly documented that clients could not be contacted or did not respond to phone/mail.

Indicator A1-11.1: Agencies must have procedures in place for attempting to contact clients who have been lost to follow-up before termination.

Example of evidence:

- Documentation that procedure was followed is in client file.

NOTE: For appropriate indicators and examples of evidence, see General Standard C3 regarding clients rights and responsibilities when refusing services; General Standard C5 regarding appropriate termination and transfer of services; and General Standard B1, Indicator B1.3, regarding provider transfers to other services.

Standard A1-12: Suspension of Services

Case management services may be suspended, but not terminated, when the client is institutionalized (i.e., hospitalized, placed in county jail or treatment facility) for 90 days or less. All efforts should be made to exchange information, as needed, for continuity of care.

Indicator A1-12.1: The client is provided seamless case management services when entering or returning from the institution.

Example of evidence:

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

Indicator A1-12.2: The case manager obtains consent from the client or legal representative for transfer of appropriate records and information, and ensures that the transfer of records/information is made to the respective institution for the sake of continuity of case management services.

Example of evidence:

- Provider has policy on file regarding appropriate transfer of records.
- Client records indicate that policy regarding transfer of records was maintained and consent was given by client.

B1. Non-Medical Case Management Practice Standards

Standard B1-1: Client Screening

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

- The client's HIV-positive diagnosis.

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

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

  (***NOTE:*** In cases of a new diagnosis, a client is not in care or is returning to care and a CD4 or viral load test has not been performed or medications have not been prescribed, tests or prescriptions must be obtained within 30 days in order for services to continue.)

- Client needs and, given these needs, whether case management services are appropriate for client.
- The types of services (e.g., Targeted Case Management, Ryan White) for which the client is eligible.
- Financial/income status and medical benefits/insurance status.
- Proof of Identification.
- Proof of Residency.
- Proof of Primary Care.
- Payer of Last Resort (refer to Attachment A.)

Indicator B1-1.1: In cases of crisis situations, screening is suspended and the crisis is addressed immediately.

Example of evidence:

- Client file addresses ways that crisis situations were handled.

Indicator B1-1.2: Screening conducted within five working days of request/ referral.

Example of evidence:

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

Indicator B1-1.3: An official, dated diagnosis statement is received by case manager.

Example of evidence:

- Official, dated statement is in client file.

Standard B1-2: Overview of Case Management

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

Indicator B1-2.1: Case management services, grievance procedures, and rights/responsibilities are described to client.

Example of evidence:

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

Standard B1-3: Comprehensive Assessment

Each client who consents to receive case management services receives a comprehensive assessment (see Glossary, Attachment E) within 30 days of the client's initial screening to identify the client's strengths, resources, needs, and problems. This assessment is done face-to-face under circumstances (e.g., time and location) agreeable to the client and case manager and includes the following areas:

- Identification of source if referred to services;
- Date assigned to case manager;
- Basic demographic information (include transgender;)
- Assessment of previous or current case management services;
- Client's statement of need;
- Client's strengths;
- Summary of physical health history and respective treatment (including, but not limited to, hospitalizations and most recent CD4 and viral load results;)
- Summary of mental health history and respective treatment;
- Summary of substance abuse history and respective treatment;
- Assessment of risk behavior and risk reduction behavior (e.g., risk of transmitting HIV, sexual risk behavior, domestic violence, partner notification;)
- Summary of medical benefits/insurance;
- Legal history, including probation officer, if applicable;
- Housing/living situation (type of housing/household composition;)
- Debt and money management issues;
- Employment issues (current employment; ability to be employed, job training and re-training;)
- Family history/social support;
- Names and addresses of primary physician, dentist, and pharmacist;
- All current prescribed and over-the-counter medications/dosage, including nutritional supplements and other substances used in other therapies (e.g., homeopathic remedies;)
- Assessment of treatment adherence (all medical care and medications;)
- Other formal and informal resources; and
- Any barriers to services (physical, social, financial, etc.)

Indicator B1-3.1: Case manager has identified past sources of services/care and has obtained summaries of pertinent, existing client primary and behavioral health records and legal history, as well as phone numbers and addresses of key providers.

Example of evidence:

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

Indicator B1-3.2: The client is assessed in key areas listed above.

Example of evidence:

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

Indicator B1-3.3: If medical case management and non-medical case management are available, and following an in-depth assessment, determination of placement will be based on the results of the Statewide acuity scale. (See Attachment D.)

Standard B1-4: Service Coordination Plan

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

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

Indicator B1-4.1: The SCP is completed at the end of the bio-psychosocial assessment; both the client and the case manager sign the SCP; and a copy of the SCP is given to the client.

Example of evidence:

- Signed and dated SCP in client file, with an indication that the client received a copy.

Standard B1-5: Referrals and Case Coordination

Each case manager refers to and coordinates services among community-based organizations, housing services, and other providers in managing the care of a client by advocating for the client and collaborating with these entities. Case managers may also refer clients to HIV and/or primary care providers, as necessary, with minimal follow-up, but coordination of care is not required. (See also General Standard B1.) Case coordination includes communication, information sharing, and collaboration, and occurs regularly with case management and other staff serving the client within and between agencies in the community. Coordination activities may include directly arranging access, reducing barriers to obtaining services, establishing linkages, and other activities recorded in progress notes to ensure retention in care.

Indicator B1-5.1: Case manager makes appropriate referrals to providers.

Example of evidence:

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

Standard B1-6: Documentation

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

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

NOTE: See also, General Standard C1, Indicator C1.4 regarding confidentiality of client records.

Indicator B1-6.1: All documentation, both dated and signed by the case manager, is kept.

Example of evidence:

- Documentation is in client file.

Indicator B1-6:2: There is a policy and procedure in place for tracking, reporting and billing of clients receiving medical case management services.

Example of evidence:.

- Policy and procedure is in place
- Tracking, reporting and billing reports are generated.

Standard B1-7: Face-to-Face Contact

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

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

Indicator B1-7.1: Progress notes are kept and review of the SCP is completed at least every 180 days.

Example of evidence:

- Progress notes and revised SCP is in client file.

Indicator B1-7.2: Problems or critical issues which may hinder access to services are identified and action is taken to resolve them.

Example of evidence:

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

Standard B1-8: Retention in Care

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

Indicator B1-8.1: A policy and procedure is maintained by agencies to retain clients in case management and HIV medical care.

Example of evidence:

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

Standard B1-9: Reassessment

Clients will be reassessed on a yearly basis in the key areas cited in Standard B1-2. A new service care plan and acuity scale evaluation must be completed based on the reassessment of the client.

Indicator B1-9.1: The client is assessed in required key areas as per Standard B1-2.

Example of evidence:

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

Indicator B1-9.2: Ongoing engagement in HIV medical care is documented every six months.

Example of evidence:

- Documentation in client records of the date of a CD4 test, viral load test, or prescribed ART medications within the 12 months.

Standard B1-10: Termination of Services

Case management services are terminated when:

- The client, in consultation with the case manager, indicates services are no longer needed or may be met better by another agency (see General Standards B1, Indicator B1.3 and C5;)
- When twelve months have lapsed since the client's last face-to-face contact or service from the case manager. This time frame incorporates possible movement of a client to/from either case management models;
- For threatening verbal and/or physical behavior by clients toward case manager or agency staff, pursuant to individual agency policies;
- When the client moves to a new service area; or
- When the client is incarcerated for more than a year.

If programs have a waiting list, they may close cases sooner than twelve months if it is properly documented that clients could not be contacted or did not respond to phone/mail.

Indicator B1-10.1: Agencies must have procedures in place for attempting to contact clients who have been lost to follow-up before termination.

Example of evidence:

- Documentation that procedure was followed is in client file.

NOTE: For appropriate indicators and examples of evidence, see General Standard C3 regarding clients rights and responsibilities when refusing services; General Standard C5 regarding appropriate termination and transfer of services; and General Standard B1, Indicator B1.3, regarding provider transfers to other services.

Standard B1-11: Suspension of Services

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

Indicator B1-11.1: The client is provided seamless case management services when entering or returning from the institution.

Example of evidence:

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

Indicator B1-11.2: The case manager obtains consent from the client or legal representative for transfer of appropriate records and information, and ensures that the transfer of records/information is made to the respective institution for the sake of continuity of case management services.

Example of evidence:

- Provider has policy on file regarding appropriate transfer of records.
- Client records indicate that policy regarding transfer of records was maintained and consent was given by client.

C1. Case Manager Supervision, Education And Training Standards

Standard C1-1: Minimum Qualifications

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

Indicator C1-1.1: A personnel file (see General Standard E1-3 and General Standard Attachment B) for each case manager indicates that all qualifications are met by each case manager.

Example of evidence:

- Resume indicates appropriate degrees/professional (paid) experience.
- Certification of HIV training in personnel record.
- Other diplomas and certification are noted in personnel record.

Standard C1-2: Professional Norms

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

Indicator C1-2.1: The personnel file (see General Standard E1-3, General Standard Attachment B and Code of Ethics Attachment C) indicates that all professional norms are evident in each case manager's job performance.

Example of evidence:

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

Standard C1-3. Ongoing Education

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

Indicator C1-3.1: A file of written materials kept by the agency regarding each case manager indicates that each and every one of the above ongoing requirements is met or being met by the case manager.

Example of evidence:

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

Standard C1-4: Case Loads

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

Indicator C1-4.1: Internal system exists to determine maximum case load and what actions are taken when a case load exceeds this maximum number.

Example of evidence:

- Written policy is on file at agency.

Standard C1-5: Clinical Supervision

Each case manager receives appropriate clinical supervision and oversight.

Indicator C1-5.1: Each agency providing case management services establishes qualifications for supervisors of case managers.

Example of evidence:

- Qualifications are in writing and on file.

Indicator C1-5.2: A process exists by which each case manager is assigned to, and receives clinical supervision from, a qualified supervisor.

Example of evidence:

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

Indicator C1-5.3: A process exists by which a supervisor or administrator knowledgeable about appropriate client file contents signs off on these files.

Example of evidence:

- Client files contain appropriate sign-off signatures.

Attachment A – Payer of Last Resort

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

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Policy:

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

- HIV+ diagnosis[1]
- Verification of identity
- Verification of residency
- Verification of household income
- Verification of insurance and/or other resources

Procedures:

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

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

2. HIV+ Diagnosis (Required by all agencies)

Acceptable documentation:

- A computer generated lab test obtained directly from the test site
- Documentation submitted by a healthcare provider shall be submitted from the healthcare provider who ordered the testing
- If the above can not be obtained the client shall be referred for repeat testing

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[1]For services available to non-HIV+ persons, documentation of the relationship to an HIV+ person shall be maintained in the client's file.

3. Identity

Acceptable documentation:

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

Acceptable documentation for homeless clients:

- A letter with contact information on company letterhead from a case manager, social worker, counselor, or other professional *from another agency* who has personally provided services to the client

4. Residency

Acceptable documentation:

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

Acceptable documentation for homeless clients:

- A letter with contact information on company letterhead from a case manager, social worker, counselor or other professional *from another agency* who has personally provided services to the client

5. Income:

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

Acceptable income documentation:

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

6. Insurance and other third party resources

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

Funded Providers shall:

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

Fiscal Agents shall:

- Review each funded provider's policies and procedures for the service(s) funded with Ryan White Part B grant monies
- Require that charts and file notes be arranged in an orderly manner

- Verify via a random chart audit, that there are traceable mechanisms in the chart that identify eligibility, HIV+ diagnosis, identity, residency, income and potential sources of third party revenues for each client. Fiscal Agents shall also ensure that providers have a system in place to bill and collect revenue(s) from appropriate third party payers
- Ensure that funded providers do not submit “unknowns” in the category of Medical Insurance on the Care Act Data Report

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

Minimum Qualification Requirements For Case Managers
(See Case Management Standards - Standard C1-1):

Each case manager must:

- Have a bachelor's degree in social work, psychology, or sociology, or other related field; or, for nurses, be classified as a Registered Nurse or have a bachelor's of science in nursing.
- Have a working knowledge of HIV/AIDS. This knowledge base is referred to in General Standard B3, Indicator B3.3, as well as in General Standards E1, regarding qualifications for positions and training.
- Complete all core-training requirements within the first two years of employment as indicated by the Pennsylvania Case Management Coordination Project.
- Be resourceful and creative in accessing required services.
- Possess interpersonal skills which allow effective interaction with clients and multiple providers in private households, residential care facilities, institutions, and medical settings.

Case Manager Professional Norms
(See Case Management Standards - Standard A2-2):

Each case manager must:

- Have a working knowledge of respective client's HIV disease process, based on medical assessments.
- Ensure that clients are involved in all phases of case management practice to the greatest extent possible.
- Ensure that each client receives appropriate assistance through accurate and complete information about the extent and nature of available services.
- Help the client decide which services best meet his/her needs.
- Employ every measure to assure that client information is treated in strict confidence, in compliance with Act 148, including prescribed uses and limitations of releases of information.
- Intervene at the client level to provide and/or coordinate the delivery of direct services to clients and their families, including:
    - Outreach, referral, client identification, and engagement.
    - A comprehensive assessment of the client (assessment of the client's needs and personal support systems.)
    - The development of a comprehensive, individualized service plan.
    - Coordination of the services required to implement the plan.
    - Following clients over time to assess the efficacy of the plan.
    - Advocacy on behalf of the client, including creating, obtaining, or brokering needed client resources.
    - Reassessment of the client's status.
    - Periodic re-evaluation and adaptation of the plan as necessary over the

life of the client (or termination of the case when services are no longer warranted.)

- Keep clear, concise, and complete records
- Carry out his/her duties in a culturally sensitive manner.
- Abide by professional ethics.
- Be pro-active/preventive/wellness-oriented.

Ongoing Requirements for Case Managers
(See Appendix J, Care and Services Standards, Standard A2-3):

- Have knowledge of, and contact with, health care entities, social service agencies, and public entitlement programs in immediate and surrounding communities; have knowledge of service costs and budgetary parameters; and be fiscally responsible in carrying out all case management functions and activities.
- Identify resources and/or weaknesses in the local service system and develop a resource file.
- Coordinate with other agencies providing similar case management services to prevent duplication
- Follow the ongoing training requirements of the Pennsylvania Case Management Coordination Project.
- Maintain active licenses, if applicable.

Minimum Qualification Requirements For Case Management Supervisors
(See Case Management Standards - Standard C1-1):

In addition to the above standards for case managers, each case management supervisor is recommended to have a minimum of two years of supervisory experience.

Attachment C – Code of Ethics

To abide by “professional ethics” referred to in Attachment B under Case Manager Professional Norms, the following Code of Ethics approved in 1996 and revised in 1999 by the National Association of Social Workers (NASW) Delegate Assembly is being suggested as a reference.

Code of Ethics
of the National Association of Social Workers

Approved by the 1996 NASW Delegate Assembly and revised by the 1999 NASW Delegate Assembly

Preamble

The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's focus on individual well-being in a social context and the well-being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living.

Social workers promote social justice and social change with and on behalf of clients. "Clients" is used inclusively to refer to individuals, families, groups, organizations, and communities. Social workers are sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice. These activities may be in the form of direct practice, community organizing, supervision, consultation**,** administration, advocacy, social and political action, policy development and implementation, education, and research and evaluation. Social workers seek to enhance the capacity of people to address their own needs. Social workers also seek to promote the responsiveness of organizations, communities, and other social institutions to individuals' needs and social problems.

The mission of the social work profession is rooted in a set of core values. These core values, embraced by social workers throughout the profession's history, are the foundation of social work's unique purpose and perspective:

- service
- social justice
- dignity and worth of the person
- importance of human relationships
- integrity
- competence.

This constellation of core values reflects what is unique to the social work profession. Core values, and the principles that flow from them, must be balanced within the context and complexity of the human experience.

Purpose of the NASW Code of Ethics

Professional ethics are at the core of social work. The profession has an obligation to articulate its basic values, ethical principles, and ethical standards. The *NASW Code of Ethics* sets forth these values, principles, and standards to guide social workers' conduct. The *Code* is relevant to all social workers and social work students, regardless of their professional functions, the settings in which they work, or the populations they serve.

The *NASW Code of Ethics* serves six purposes:

1. The *Code* identifies core values on which social work's mission is based.
2. The *Code* summarizes broad ethical principles that reflect the profession's core values and establishes a set of specific ethical standards that should be used to guide social work practice.
3. The *Code* is designed to help social workers identify relevant considerations when professional obligations conflict or ethical uncertainties arise.
4. The *Code* provides ethical standards to which the general public can hold the social work profession accountable.
5. The *Code* socializes practitioners new to the field to social work's mission, values, ethical principles, and ethical standards.
6. The *Code* articulates standards that the social work profession itself can use to assess whether social workers have engaged in unethical conduct. NASW has formal procedures to adjudicate ethics complaints filed against its members.* In subscribing to this *Code,* social workers are required to cooperate in its implementation, participate in NASW adjudication proceedings, and abide by any NASW disciplinary rulings or sanctions based on it.

*For information on NASW adjudication procedures, see *NASW Procedures for the Adjudication of Grievances*.

The *Code* offers a set of values, principles, and standards to guide decision making and conduct when ethical issues arise. It does not provide a set of rules that prescribe how social workers should act in all situations. Specific applications of the *Code* must take into account the context in which it is being considered and the possibility of conflicts among the *Code*'s values, principles, and standards. Ethical responsibilities flow from all human relationships, from the personal and familial to the social and professional.

Further, the *NASW Code of Ethics* does not specify which values, principles, and standards are most important and ought to outweigh others in instances when they conflict. Reasonable differences of opinion can and do exist among social workers with respect to the ways in which values, ethical principles, and ethical standards should be

rank ordered when they conflict. Ethical decision making in a given situation must apply the informed judgment of the individual social worker and should also consider how the issues would be judged in a peer review process where the ethical standards of the profession would be applied.

Ethical decision making is a process. There are many instances in social work where simple answers are not available to resolve complex ethical issues. Social workers should take into consideration all the values, principles, and standards in this *Code* that are relevant to any situation in which ethical judgment is warranted. Social workers' decisions and actions should be consistent with the spirit as well as the letter of this *Code*.

In addition to this *Code,* there are many other sources of information about ethical thinking that may be useful. Social workers should consider ethical theory and principles generally, social work theory and research, laws, regulations, agency policies, and other relevant codes of ethics, recognizing that among codes of ethics social workers should consider the *NASW Code of Ethics* as their primary source. Social workers also should be aware of the impact on ethical decision making of their clients' and their own personal values and cultural and religious beliefs and practices. They should be aware of any conflicts between personal and professional values and deal with them responsibly. For additional guidance social workers should consult the relevant literature on professional ethics and ethical decision making and seek appropriate consultation when faced with ethical dilemmas. This may involve consultation with an agency-based or social work organization's ethics committee, a regulatory body, knowledgeable colleagues, supervisors, or legal counsel.

Instances may arise when social workers' ethical obligations conflict with agency policies or relevant laws or regulations. When such conflicts occur, social workers must make a responsible effort to resolve the conflict in a manner that is consistent with the values, principles, and standards expressed in this *Code*. If a reasonable resolution of the conflict does not appear possible, social workers should seek proper consultation before making a decision.

The *NASW Code of Ethics* is to be used by NASW and by individuals, agencies, organizations, and bodies (such as licensing and regulatory boards, professional liability insurance providers, courts of law, agency boards of directors, government agencies, and other professional groups) that choose to adopt it or use it as a frame of reference. Violation of standards in this *Code* does not automatically imply legal liability or violation of the law. Such determination can only be made in the context of legal and judicial proceedings. Alleged violations of the *Code* would be subject to a peer review process. Such processes are generally separate from legal or administrative procedures and insulated from legal review or proceedings to allow the profession to counsel and discipline its own members.

A code of ethics cannot guarantee ethical behavior. Moreover, a code of ethics cannot resolve all ethical issues or disputes or capture the richness and complexity involved in

striving to make responsible choices within a moral community. Rather, a code of ethics sets forth values, ethical principles, and ethical standards to which professionals aspire and by which their actions can be judged. Social workers' ethical behavior should result from their personal commitment to engage in ethical practice. The *NASW Code of Ethics* reflects the commitment of all social workers to uphold the profession's values and to act ethically. Principles and standards must be applied by individuals of good character who discern moral questions and, in good faith, seek to make reliable ethical judgments.

Ethical Principles

The following broad ethical principles are based on social work's core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. These principles set forth ideals to which all social workers should aspire.

Value: *Service*

Ethical Principle: *Social workers' primary goal is to help people in need and to address social problems.*

Social workers elevate service to others above self-interest. Social workers draw on their knowledge, values, and skills to help people in need and to address social problems. Social workers are encouraged to volunteer some portion of their professional skills with no expectation of significant financial return (pro bono service.)

Value: *Social Justice*

Ethical Principle: *Social workers challenge social injustice.*

Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people. Social workers' social change efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice. These activities seek to promote sensitivity to and knowledge about oppression and cultural and ethnic diversity. Social workers strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people.

Value: *Dignity and Worth of the Person*

Ethical Principle: *Social workers respect the inherent dignity and worth of the person.*

Social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers promote clients' socially responsible self-determination. Social workers seek to enhance clients' capacity and opportunity to change and to address their own needs. Social workers are cognizant of

their dual responsibility to clients and to the broader society. They seek to resolve conflicts between clients' interests and the broader society's interests in a socially responsible manner consistent with the values, ethical principles, and ethical standards of the profession.

Value: *Importance of Human Relationships*

Ethical Principle: *Social workers recognize the central importance of human relationships.*

Social workers understand that relationships between and among people are an important vehicle for change. Social workers engage people as partners in the helping process. Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations, and communities.

Value: *Integrity*

Ethical Principle: *Social workers behave in a trustworthy manner.*

Social workers are continually aware of the profession's mission, values, ethical principles, and ethical standards and practice in a manner consistent with them. Social workers act honestly and responsibly and promote ethical practices on the part of the organizations with which they are affiliated.

Value: *Competence*

Ethical Principle: *Social workers practice within their areas of competence and develop and enhance their professional expertise.*

Social workers continually strive to increase their professional knowledge and skills and to apply them in practice. Social workers should aspire to contribute to the knowledge base of the profession.

Ethical Standards

The following ethical standards are relevant to the professional activities of all social workers. These standards concern (1) social workers' ethical responsibilities to clients, (2) social workers' ethical responsibilities to colleagues, (3) social workers' ethical responsibilities in practice settings, (4) social workers' ethical responsibilities as professionals, (5) social workers' ethical responsibilities to the social work profession, and (6) social workers' ethical responsibilities to the broader society.

Some of the standards that follow are enforceable guidelines for professional conduct, and some are aspirational. The extent to which each standard is enforceable is a matter of professional judgment to be exercised by those responsible for reviewing alleged violations of ethical standards.

1. Social Workers' Ethical Responsibilities to Clients

1.01 Commitment to Clients

Social workers' primary responsibility is to promote the well-being of clients. In general, clients' interests are primary. However, social workers' responsibility to the larger society or specific legal obligations may on limited occasions supersede the loyalty owed clients, and clients should be so advised. (Examples include when a social worker is required by law to report that a client has abused a child or has threatened to harm self or others.)

1.02 Self-Determination

Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients' right to self-determination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others.

1.03 Informed Consent

(a) Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent. Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions.

(b) In instances when clients are not literate or have difficulty understanding the primary language used in the practice setting, social workers should take steps to ensure clients' comprehension. This may include providing clients with a detailed verbal explanation or arranging for a qualified interpreter or translator whenever possible.

(c) In instances when clients lack the capacity to provide informed consent, social workers should protect clients' interests by seeking permission from an appropriate third party, informing clients consistent with the clients' level of understanding. In such instances social workers should seek to ensure that the third party acts in a manner consistent with clients' wishes and interests. Social workers should take reasonable steps to enhance such clients' ability to give informed consent.

(d) In instances when clients are receiving services involuntarily, social workers should provide information about the nature and extent of services and about the extent of clients' right to refuse service.

(e) Social workers who provide services via electronic media (such as computer, telephone, radio, and television) should inform recipients of the limitations and risks associated with such services.

(f) Social workers should obtain clients' informed consent before audiotaping or videotaping clients or permitting observation of services to clients by a third party.

1.04 Competence

(a) Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.

(b) Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques.

(c) When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm.

1.05 Cultural Competence and Social Diversity

(a) Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.

(b) Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups.

(c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, and mental or physical disability.

1.06 Conflicts of Interest

(a) Social workers should be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. Social workers should inform clients when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the clients' interests primary and protects clients' interests to the greatest extent possible. In some cases, protecting clients' interests may require termination of the professional relationship with proper referral of the client.

(b) Social workers should not take unfair advantage of any professional relationship or exploit others to further their personal, religious, political, or business interests.

(c) Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries. (Dual or multiple relationships occur when social workers relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively.)

(d) When social workers provide services to two or more people who have a relationship with each other (for example, couples, family members), social workers should clarify with all parties which individuals will be considered clients and the nature of social workers' professional obligations to the various individuals who are receiving services. Social workers who anticipate a conflict of interest among the individuals receiving services or who anticipate having to perform in potentially conflicting roles (for example, when a social worker is asked to testify in a child custody dispute or divorce proceedings involving clients) should clarify their role with the parties involved and take appropriate action to minimize any conflict of interest.

1.07 Privacy and Confidentiality

(a) Social workers should respect clients' right to privacy. Social workers should not solicit private information from clients unless it is essential to providing services or conducting social work evaluation or research. Once private information is shared, standards of confidentiality apply.

(b) Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client.

(c) Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed.

(d) Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made. This applies whether social workers disclose confidential information on the basis of a legal requirement or client consent.

(e) Social workers should discuss with clients and other interested parties the nature of confidentiality and limitations of clients' right to confidentiality. Social workers should review with clients circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. This discussion should occur as soon as possible in the social worker-client relationship and as needed throughout the course of the relationship.

(f) When social workers provide counseling services to families, couples, or groups, social workers should seek agreement among the parties involved concerning each individual's right to confidentiality and obligation to preserve the confidentiality of information shared by others. Social workers should inform participants in family, couples, or group counseling that social workers cannot guarantee that all participants will honor such agreements.

(g) Social workers should inform clients involved in family, couples, marital, or group counseling of the social worker's, employer's, and agency's policy concerning the social worker's disclosure of confidential information among the parties involved in the counseling.

(h) Social workers should not disclose confidential information to third-party payers unless clients have authorized such disclosure.

(i) Social workers should not discuss confidential information in any setting unless privacy can be ensured. Social workers should not discuss confidential information in public or semipublic areas such as hallways, waiting rooms, elevators, and restaurants.

(j) Social workers should protect the confidentiality of clients during legal proceedings to the extent permitted by law. When a court of law or other legally authorized body orders social workers to disclose confidential or privileged information without a client's consent and such disclosure could cause harm to the client, social workers should request that the court withdraw the order or limit the order as narrowly as possible or maintain the records under seal, unavailable for public inspection.

(k) Social workers should protect the confidentiality of clients when responding to requests from members of the media.

(l) Social workers should protect the confidentiality of clients' written and electronic records and other sensitive information. Social workers should take reasonable steps to ensure that clients' records are stored in a secure location and that clients' records are not available to others who are not authorized to have access.

(m) Social workers should take precautions to ensure and maintain the confidentiality of information transmitted to other parties through the use of computers, electronic mail, facsimile machines, telephones and telephone answering machines, and other electronic or computer technology. Disclosure of identifying information should be avoided whenever possible.

(n) Social workers should transfer or dispose of clients' records in a manner that protects clients' confidentiality and is consistent with state statutes governing records and social work licensure.

(o) Social workers should take reasonable precautions to protect client confidentiality in the event of the social worker's termination of practice, incapacitation, or death.

(p) Social workers should not disclose identifying information when discussing clients for teaching or training purposes unless the client has consented to disclosure of confidential information.

(q) Social workers should not disclose identifying information when discussing clients with consultants unless the client has consented to disclosure of confidential information or there is a compelling need for such disclosure.

(r) Social workers should protect the confidentiality of deceased clients consistent with the preceding standards.

1.08 Access to Records

(a) Social workers should provide clients with reasonable access to records concerning the clients. Social workers who are concerned that clients' access to their records could cause serious misunderstanding or harm to the client should provide assistance in interpreting the records and consultation with the client regarding the records. Social workers should limit clients' access to their records, or portions of their records, only in exceptional circumstances when there is compelling evidence that such access would cause serious harm to the client. Both clients' requests and the rationale for withholding some or all of the record should be documented in clients' files.

(b) When providing clients with access to their records, social workers should take steps to protect the confidentiality of other individuals identified or discussed in such records.

1.09 Sexual Relationships

(a) Social workers should under no circumstances engage in sexual activities or sexual contact with current clients, whether such contact is consensual or forced.

(b) Social workers should not engage in sexual activities or sexual contact with clients' relatives or other individuals with whom clients maintain a close personal relationship when there is a risk of exploitation or potential harm to the client. Sexual activity or sexual contact with clients' relatives or other individuals with whom clients maintain a personal relationship has the potential to be harmful to the client and may make it difficult for the social worker and client to maintain appropriate professional boundaries. Social workers--not their clients, their clients' relatives, or other individuals with whom the client maintains a personal relationship--assume the full burden for setting clear, appropriate, and culturally sensitive boundaries.

(c) Social workers should not engage in sexual activities or sexual contact with former clients because of the potential for harm to the client. If social workers engage in conduct contrary to this prohibition or claim that an exception to this prohibition is warranted because of extraordinary circumstances, it is social workers--not their clients--who assume the full burden of demonstrating that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally.

(d) Social workers should not provide clinical services to individuals with whom they have had a prior sexual relationship. Providing clinical services to a former sexual partner has the potential to be harmful to the individual and is likely to make it difficult for the social worker and individual to maintain appropriate professional boundaries.

1.10 Physical Contact

Social workers should not engage in physical contact with clients when there is a possibility of psychological harm to the client as a result of the contact (such as cradling or caressing clients.) Social workers who engage in appropriate physical contact with clients are responsible for setting clear, appropriate, and culturally sensitive boundaries that govern such physical contact.

1.11 Sexual Harassment

Social workers should not sexually harass clients. Sexual harassment includes sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

1.12 Derogatory Language

Social workers should not use derogatory language in their written or verbal communications to or about clients. Social workers should use accurate and respectful language in all communications to and about clients.

1.13 Payment for Services

(a) When setting fees, social workers should ensure that the fees are fair, reasonable, and commensurate with the services performed. Consideration should be given to clients' ability to pay.

(b) Social workers should avoid accepting goods or services from clients as payment for professional services. Bartering arrangements, particularly involving services, create the potential for conflicts of interest, exploitation, and inappropriate boundaries in social workers' relationships with clients. Social workers should explore and may participate in bartering only in very limited circumstances when it can be demonstrated that such arrangements are an accepted practice among professionals in the local community, considered to be essential for the provision of services, negotiated without coercion, and entered into at the client's initiative and with the client's informed consent. Social

workers who accept goods or services from clients as payment for professional services assume the full burden of demonstrating that this arrangement will not be detrimental to the client or the professional relationship.

(c) Social workers should not solicit a private fee or other remuneration for providing services to clients who are entitled to such available services through the social workers' employer or agency.

1.14 Clients Who Lack Decision-Making Capacity

When social workers act on behalf of clients who lack the capacity to make informed decisions, social workers should take reasonable steps to safeguard the interests and rights of those clients.

1.15 Interruption of Services

Social workers should make reasonable efforts to ensure continuity of services in the event that services are interrupted by factors such as unavailability, relocation, illness, disability, or death.

1.16 Termination of Services

(a) Social workers should terminate services to clients and professional relationships with them when such services and relationships are no longer required or no longer serve the clients' needs or interests.

(b) Social workers should take reasonable steps to avoid abandoning clients who are still in need of services. Social workers should withdraw services precipitously only under unusual circumstances, giving careful consideration to all factors in the situation and taking care to minimize possible adverse effects. Social workers should assist in making appropriate arrangements for continuation of services when necessary.

(c) Social workers in fee-for-service settings may terminate services to clients who are not paying an overdue balance if the financial contractual arrangements have been made clear to the client, if the client does not pose an imminent danger to self or others, and if the clinical and other consequences of the current nonpayment have been addressed and discussed with the client.

(d) Social workers should not terminate services to pursue a social, financial, or sexual relationship with a client.

(e) Social workers who anticipate the termination or interruption of services to clients should notify clients promptly and seek the transfer, referral, or continuation of services in relation to the clients' needs and preferences.

(f) Social workers who are leaving an employment setting should inform clients of appropriate options for the continuation of services and of the benefits and risks of the options.

2. Social Workers' Ethical Responsibilities to Colleagues

2.01 Respect

(a) Social workers should treat colleagues with respect and should represent accurately and fairly the qualifications, views, and obligations of colleagues.

(b) Social workers should avoid unwarranted negative criticism of colleagues in communications with clients or with other professionals. Unwarranted negative criticism may include demeaning comments that refer to colleagues' level of competence or to individuals attributes such as race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, and mental or physical disability.

(c) Social workers should cooperate with social work colleagues and with colleagues of other professions when such cooperation serves the well-being of clients.

2.02 Confidentiality

Social workers should respect confidential information shared by colleagues in the course of their professional relationships and transactions. Social workers should ensure that such colleagues understand social workers' obligation to respect confidentiality and any exceptions related to it.

2.03 Interdisciplinary Collaboration

(a) Social workers who are members of an interdisciplinary team should participate in and contribute to decisions that affect the well-being of clients by drawing on the perspectives, values, and experiences of the social work profession. Professional and ethical obligations of the interdisciplinary team as a whole and of its individual members should be clearly established.

(b) Social workers for whom a team decision raises ethical concerns should attempt to resolve the disagreement through appropriate channels. If the disagreement cannot be resolved, social workers should pursue other avenues to address their concerns consistent with client well-being.

2.04 Disputes Involving Colleagues

(a) Social workers should not take advantage of a dispute between a colleague and an employer to obtain a position or otherwise advance the social workers' own interests.

(b) Social workers should not exploit clients in disputes with colleagues or engage clients in any inappropriate discussion of conflicts between social workers and their colleagues.

2.05 Consultation

(a) Social workers should seek the advice and counsel of colleagues whenever such consultation is in the best interests of clients.

(b) Social workers should keep themselves informed about colleagues' areas of expertise and competencies. Social workers should seek consultation only from colleagues who have demonstrated knowledge, expertise, and competence related to the subject of the consultation.

(c) When consulting with colleagues about clients, social workers should disclose the least amount of information necessary to achieve the purposes of the consultation.

2.06 Referral for Services

(a) Social workers should refer clients to other professionals when the other professionals' specialized knowledge or expertise is needed to serve clients fully or when social workers believe that they are not being effective or making reasonable progress with clients and that additional service is required.

(b) Social workers who refer clients to other professionals should take appropriate steps to facilitate an orderly transfer of responsibility. Social workers who refer clients to other professionals should disclose, with clients' consent, all pertinent information to the new service providers.

(c) Social workers are prohibited from giving or receiving payment for a referral when no professional service is provided by the referring social worker.

2.07 Sexual Relationships

(a) Social workers who function as supervisors or educators should not engage in sexual activities or contact with supervisees, students, trainees, or other colleagues over whom they exercise professional authority.

(b) Social workers should avoid engaging in sexual relationships with colleagues when there is potential for a conflict of interest. Social workers who become involved in, or anticipate becoming involved in, a sexual relationship with a colleague have a duty to transfer professional responsibilities, when necessary, to avoid a conflict of interest.

2.08 Sexual Harassment

Social workers should not sexually harass supervisees, students, trainees, or colleagues. Sexual harassment includes sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

2.09 Impairment of Colleagues

(a) Social workers who have direct knowledge of a social work colleague's impairment that is due to personal problems, psychosocial distress, substance abuse, or mental health difficulties and that interferes with practice effectiveness should consult with that colleague when feasible and assist the colleague in taking remedial action.

(b) Social workers who believe that a social work colleague's impairment interferes with practice effectiveness and that the colleague has not taken adequate steps to address the impairment should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations.

2.10 Incompetence of Colleagues

(a) Social workers who have direct knowledge of a social work colleague's incompetence should consult with that colleague when feasible and assist the colleague in taking remedial action.

(b) Social workers who believe that a social work colleague is incompetent and has not taken adequate steps to address the incompetence should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations.

2.11 Unethical Conduct of Colleagues

(a) Social workers should take adequate measures to discourage, prevent, expose, and correct the unethical conduct of colleagues.

(b) Social workers should be knowledgeable about established policies and procedures for handling concerns about colleagues' unethical behavior. Social workers should be familiar with national, state, and local procedures for handling ethics complaints. These include policies and procedures created by NASW, licensing and regulatory bodies, employers, agencies, and other professional organizations.

(c) Social workers who believe that a colleague has acted unethically should seek resolution by discussing their concerns with the colleague when feasible and when such discussion is likely to be productive.

(d) When necessary, social workers who believe that a colleague has acted unethically should take action through appropriate formal channels (such as contacting a state licensing board or regulatory body, an NASW committee on inquiry, or other professional ethics committees.)

(e) Social workers should defend and assist colleagues who are unjustly charged with unethical conduct.

3. Social Workers' Ethical Responsibilities in Practice Settings

3.01 Supervision and Consultation

(a) Social workers who provide supervision or consultation should have the necessary knowledge and skill to supervise or consult appropriately and should do so only within their areas of knowledge and competence.

(b) Social workers who provide supervision or consultation are responsible for setting clear, appropriate, and culturally sensitive boundaries.

(c) Social workers should not engage in any dual or multiple relationships with supervisees in which there is a risk of exploitation of or potential harm to the supervisee.

(d) Social workers who provide supervision should evaluate supervisees' performance in a manner that is fair and respectful.

3.02 Education and Training

(a) Social workers who function as educators, field instructors for students, or trainers should provide instruction only within their areas of knowledge and competence and should provide instruction based on the most current information and knowledge available in the profession.

(b) Social workers who function as educators or field instructors for students should evaluate students' performance in a manner that is fair and respectful.

(c) Social workers who function as educators or field instructors for students should take reasonable steps to ensure that clients are routinely informed when services are being provided by students.

(d) Social workers who function as educators or field instructors for students should not engage in any dual or multiple relationships with students in which there is a risk of exploitation or potential harm to the student. Social work educators and field instructors are responsible for setting clear, appropriate, and culturally sensitive boundaries.

3.03 Performance Evaluation

Social workers who have responsibility for evaluating the performance of others should fulfill such responsibility in a fair and considerate manner and on the basis of clearly stated criteria.

3.04 Client Records

(a) Social workers should take reasonable steps to ensure that documentation in records is accurate and reflects the services provided.

(b) Social workers should include sufficient and timely documentation in records to facilitate the delivery of services and to ensure continuity of services provided to clients in the future.

(c) Social workers' documentation should protect clients' privacy to the extent that is possible and appropriate and should include only information that is directly relevant to the delivery of services.

(d) Social workers should store records following the termination of services to ensure reasonable future access. Records should be maintained for the number of years required by state statutes or relevant contracts.

3.05 Billing

Social workers should establish and maintain billing practices that accurately reflect the nature and extent of services provided and that identify who provided the service in the practice setting.

3.06 Client Transfer

(a) When an individual who is receiving services from another agency or colleague contacts a social worker for services, the social worker should carefully consider the client's needs before agreeing to provide services. To minimize possible confusion and conflict, social workers should discuss with potential clients the nature of the clients' current relationship with other service providers and the implications, including possible benefits or risks, of entering into a relationship with a new service provider.

(b) If a new client has been served by another agency or colleague, social workers should discuss with the client whether consultation with the previous service provider is in the client's best interest.

3.07 Administration

(a) Social work administrators should advocate within and outside their agencies for adequate resources to meet clients' needs.

(b) Social workers should advocate for resource allocation procedures that are open and fair. When not all clients' needs can be met, an allocation procedure should be developed that is nondiscriminatory and based on appropriate and consistently applied principles.

(c) Social workers who are administrators should take reasonable steps to ensure that adequate agency or organizational resources are available to provide appropriate staff supervision.

(d) Social work administrators should take reasonable steps to ensure that the working environment for which they are responsible is consistent with and encourages compliance with the NASW Code of Ethics. Social work administrators should take reasonable steps to eliminate any conditions in their organizations that violate, interfere with, or discourage compliance with the Code.

3.08 Continuing Education and Staff Development

Social work administrators and supervisors should take reasonable steps to provide or arrange for continuing education and staff development for all staff for whom they are responsible. Continuing education and staff development should address current knowledge and emerging developments related to social work practice and ethics.

3.09 Commitments to Employers

(a) Social workers generally should adhere to commitments made to employers and employing organizations.

(b) Social workers should work to improve employing agencies' policies and procedures and the efficiency and effectiveness of their services.

(c) Social workers should take reasonable steps to ensure that employers are aware of social workers' ethical obligations as set forth in the NASW Code of Ethics and of the implications of those obligations for social work practice.

(d) Social workers should not allow an employing organization's policies, procedures, regulations, or administrative orders to interfere with their ethical practice of social work. Social workers should take reasonable steps to ensure that their employing organizations' practices are consistent with the NASW Code of Ethics.

(e) Social workers should act to prevent and eliminate discrimination in the employing organization's work assignments and in its employment policies and practices.

(f) Social workers should accept employment or arrange student field placements only in organizations that exercise fair personnel practices.

(g) Social workers should be diligent stewards of the resources of their employing organizations, wisely conserving funds where appropriate and never misappropriating funds or using them for unintended purposes.

3.10 Labor-Management Disputes

(a) Social workers may engage in organized action, including the formation of and participation in labor unions, to improve services to clients and working conditions.

(b) The actions of social workers who are involved in labor-management disputes, job actions, or labor strikes should be guided by the profession's values, ethical principles, and ethical standards. Reasonable differences of opinion exist among social workers concerning their primary obligation as professionals during an actual or threatened labor strike or job action. Social workers should carefully examine relevant issues and their possible impact on clients before deciding on a course of action.

4. Social Workers' Ethical Responsibilities as Professionals

4.01 Competence

(a) Social workers should accept responsibility or employment only on the basis of existing competence or the intention to acquire the necessary competence.

(b) Social workers should strive to become and remain proficient in professional practice and the performance of professional functions. Social workers should critically examine and keep current with emerging knowledge relevant to social work. Social workers should routinely review the professional literature and participate in continuing education relevant to social work practice and social work ethics.

(c) Social workers should base practice on recognized knowledge, including empirically based knowledge, relevant to social work and social work ethics.

4.02 Discrimination

Social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, or mental or physical disability.

4.03 Private Conduct

Social workers should not permit their private conduct to interfere with their ability to fulfill their professional responsibilities.

4.04 Dishonesty, Fraud, and Deception

Social workers should not participate in, condone, or be associated with dishonesty, fraud, or deception.

4.05 Impairment

(a) Social workers should not allow their own personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties to interfere with their professional judgment and performance or to jeopardize the best interests of people for whom they have a professional responsibility.

(b) Social workers whose personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties interfere with their professional judgment and performance should immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others.

4.06 Misrepresentation

(a) Social workers should make clear distinctions between statements made and actions engaged in as a private individual and as a representative of the social work profession, a professional social work organization, or the social worker's employing agency.

(b) Social workers who speak on behalf of professional social work organizations should accurately represent the official and authorized positions of the organizations.

(c) Social workers should ensure that their representations to clients, agencies, and the public of professional qualifications, credentials, education, competence, affiliations, services provided, or results to be achieved are accurate. Social workers should claim only those relevant professional credentials they actually possess and take steps to correct any inaccuracies or misrepresentations of their credentials by others.

4.07 Solicitations

(a) Social workers should not engage in uninvited solicitation of potential clients who, because of their circumstances, are vulnerable to undue influence, manipulation, or coercion.

(b) Social workers should not engage in solicitation of testimonial endorsements (including solicitation of consent to use a client's prior statement as a testimonial endorsement) from current clients or from other people who, because of their particular circumstances, are vulnerable to undue influence.

4.08 Acknowledging Credit

(a) Social workers should take responsibility and credit, including authorship credit, only for work they have actually performed and to which they have contributed.

(b) Social workers should honestly acknowledge the work of and the contributions made by others.

5. Social Workers' Ethical Responsibilities to the Social Work Profession

5.01 Integrity of the Profession

(a) Social workers should work toward the maintenance and promotion of high standards of practice.

(b) Social workers should uphold and advance the values, ethics, knowledge, and mission of the profession. Social workers should protect, enhance, and improve the integrity of the profession through appropriate study and research, active discussion, and responsible criticism of the profession.

(c) Social workers should contribute time and professional expertise to activities that promote respect for the value, integrity, and competence of the social work profession. These activities may include teaching, research, consultation, service, legislative testimony, presentations in the community, and participation in their professional organizations.

(d) Social workers should contribute to the knowledge base of social work and share with colleagues their knowledge related to practice, research, and ethics. Social workers should seek to con-tribute to the profession's literature and to share their knowledge at professional meetings and conferences.

(e) Social workers should act to prevent the unauthorized and unqualified practice of social work.

5.02 Evaluation and Research

(a) Social workers should monitor and evaluate policies, the implementation of programs, and practice interventions.

(b) Social workers should promote and facilitate evaluation and research to contribute to the development of knowledge.

(c) Social workers should critically examine and keep current with emerging knowledge relevant to social work and fully use evaluation and research evidence in their professional practice.

(d) Social workers engaged in evaluation or research should carefully consider possible consequences and should follow guidelines developed for the protection of evaluation and research participants. Appropriate institutional review boards should be consulted.

(e) Social workers engaged in evaluation or research should obtain voluntary and written informed consent from participants, when appropriate, without any implied or actual deprivation or penalty for refusal to participate; without undue inducement to participate; and with due regard for participants' well-being, privacy, and dignity. Informed consent should include information about the nature, extent, and duration of the participation requested and disclosure of the risks and benefits of participation in the research.

(f) When evaluation or research participants are incapable of giving informed consent, social workers should provide an appropriate explanation to the participants, obtain the participants' assent to the extent they are able, and obtain written consent from an appropriate proxy.

(g) Social workers should never design or conduct evaluation or research that does not use consent procedures, such as certain forms of naturalistic observation and archival research, unless rigorous and responsible review of the research has found it to be justified because of its prospective scientific, educational, or applied value and unless equally effective alternative procedures that do not involve waiver of consent are not feasible.

(h) Social workers should inform participants of their right to withdraw from evaluation and research at any time without penalty.

(i) Social workers should take appropriate steps to ensure that participants in evaluation and research have access to appropriate supportive services.

(j) Social workers engaged in evaluation or research should protect participants from unwarranted physical or mental distress, harm, danger, or deprivation.

(k) Social workers engaged in the evaluation of services should discuss collected information only for professional purposes and only with people professionally concerned with this information.

(l) Social workers engaged in evaluation or research should ensure the anonymity or confidentiality of participants and of the data obtained from them. Social workers should inform participants of any limits of confidentiality, the measures that will be taken to ensure confidentiality, and when any records containing research data will be destroyed.

(m) Social workers who report evaluation and research results should protect participants' confidentiality by omitting identifying information unless proper consent has been obtained authorizing disclosure.

(n) Social workers should report evaluation and research findings accurately. They should not fabricate or falsify results and should take steps to correct any errors later found in published data using standard publication methods.

(o) Social workers engaged in evaluation or research should be alert to and avoid conflicts of interest and dual relationships with participants, should inform participants when a real or potential conflict of interest arises, and should take steps to resolve the issue in a manner that makes participants' interests primary.

(p) Social workers should educate themselves, their students, and their colleagues about responsible research practices.

6. Social Workers' Ethical Responsibilities to the Broader Society

6.01 Social Welfare

Social workers should promote the general welfare of society, from local to global levels, and the development of people, their communities, and their environments. Social workers should advocate for living conditions conducive to the fulfillment of basic human needs and should promote social, economic, political, and cultural values and institutions that are compatible with the realization of social justice.

6.02 Public Participation

Social workers should facilitate informed participation by the public in shaping social policies and institutions.

6.03 Public Emergencies

Social workers should provide appropriate professional services in public emergencies to the greatest extent possible.

6.04 Social and Political Action

(a) Social workers should engage in social and political action that seeks to ensure that all people have equal access to the resources, employment, services, and opportunities they require to meet their basic human needs and to develop fully. Social workers should be aware of the impact of the political arena on practice and should advocate for changes in policy and legislation to improve social conditions in order to meet basic human needs and promote social justice.

(b) Social workers should act to expand choice and opportunity for all people, with special regard for vulnerable, disadvantaged, oppressed, and exploited people and groups.

(c) Social workers should promote conditions that encourage respect for cultural and social diversity within the United States and globally. Social workers should promote policies and practices that demonstrate respect for difference, support the expansion of cultural knowledge and resources, advocate for programs and institutions that demonstrate cultural competence, and promote policies that safeguard the rights of and confirm equity and social justice for all people.

(d) Social workers should act to prevent and eliminate domination of, exploitation of, and discrimination against any person, group, or class on the basis of race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, or mental or physical disability.

Attachment D – Acuity Scale Requirements

In regions where both medical and non-medical case management models are used, at the completion of a comprehensive assessment, a determination is made based on a standardized acuity scale, as to whether a client will be enrolled in the medical or non-medical case management model and in which the client is willing to participate. The acuity scale must include at a minimum the following areas:

- Immediate Needs
- Medical Needs (examples: current health, recent hospitalizations, adherence to treatment, oral health, barriers to care, etc.)
- Behavioral Health Needs (examples: mental health issues/diagnosis, substance abuse issues, etc.)
- Life Management Needs (examples: financial issues, money management, housing issues, legal issues, benefits, etc.)
- Risk Reduction Needs (examples: prevention, health education issues, risk reduction strategies, etc.)

Regions that offer both models of case management must use the following statewide acuity scale which addresses these areas and clearly establishes the two levels of case management.

Attachment E – Glossary

Note- Glossary is in Appendix I of the Operations Manual. This will need to be referenced for consistency in definitions. Please use HRSA definitions where available.

ACT 148 (Confidentiality of HIV-Related Information) – In 1988 the Pennsylvania legislature passed the act, to prevent unauthorized HIV testing or disclosure of a person's HIV status without consent.
www.pde.state.pa.us/health_physed/lib/health_physed/20/19/148of1990.pdf

Acuity Scale – An acuity scale is a tool used to determine the level of case management services a client needs.

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

Case Coordination – Includes communication, information sharing, and collaboration. Occurs regularly with case management and other staff serving the client within and between agencies in the community. Coordination activities may include directly arranging access, reducing barriers to obtaining services, establishing linkages, and other activities recorded in progress notes to ensure retention in medical care.

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

CD4 Cell Count – The number of T-helper lymphocytes per cubic millimeter of blood. The CD4 count is a predictor of immunity. As CD4 cell count declines, the risk of developing opportunistic infections increases. The normal adult range for CD4 cell counts is 500 to 1500 per cubic millimeter of blood. (The normal range for infants is considerably higher and slowly declines to adult values by age 6 years.) A CD4 count of 200 or less is an AIDS-defining condition. CD4 counts should be rechecked at least every 6 to 12 months if CD4 counts are greater than 500/mm3. If the counts are lower, testing every 3 months is advised. (In children with HIV infection, CD4 values should be checked every 3 months.)

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

Code of Ethics – The Code of Ethics sets forth values, principles, and standards to guide decision-making and conduct when ethical issues arise. This code is relevant to all social workers, regardless of their professional functions, the settings in which they work and the populations they serve. This code is to be adopted/followed by all case managers regardless of educational major and/or license.

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

ELISA – Enzyme-Linked Immunosorbent Assays (ELISA) combine the specificity of antibodies with the sensitivity of simple enzyme assays, by using antibodies or antigens coupled to an easily assayed enzyme that possesses a high turnover number. ELISAs can provide a useful measurement of antigen or antibody concentration.

General Standard – Set of minimum requirements that a Coalition/Provider must follow when providing services to an individual with HIV/AIDS. Coalition/Provider agencies can exceed the standards if they wish. (Division of HIV/AIDS Coalition Operations Manual Appendix I)

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

HAART (Highly Active Antiretroviral Therapy) – HAART is an HIV treatment using multiple antiretroviral drugs to reduce viral load to undetectable levels and maintain/increase CD4 levels.

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

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

HIV Diagnosis – A copy of the documentation (i.e. Western Blot test) that verifies an individual is HIV-positive. This proof of status must be obtained within 30 days from the date of intake to continue the provision of services.

Non-Medical Case Management – Non-medical case management is suitable for persons with discrete needs that can be addressed in the short term. In some cases, non-medical case management serves as a means of assisting an individual who may not need frequent follow up, but requires occasional reassessment to determine if their current level of care is sufficient. This model can also be used to engage a client into medical case management. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.

Medical Case Management – Medical case management services are a range of client-centered services that link clients with medical care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. 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.

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

Pennsylvania Case Management Project – The Pennsylvania Case Management Project is a Ryan White Part B program funded through the PA Department of Health and administrated by the AIDS Activities Coordinating Office (AACO.) The Project's goal is to improve coordination of HIV/AIDS case management services throughout Pennsylvania (outside of the Philadelphia Eligible Metropolitan Area) through training for publicly funded case managers and supervisors including PA Department of Public Welfare Targeted Case Managers. The Pennsylvania Case Management Project provides training for case managers practicing within regional HIV/AIDS planning coalitions.

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

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

Screening – Initial process by which it is determined whether a potential client meets general eligibility for services, is in need of crisis assistance, and/or could

benefit from a referral to other services. (See also assessment.)

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

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

Targeted Case Management – Targeted case management is a service which provides targeted medical assistance clients with access to comprehensive medical and social services to encourage the cost effective use of medical care and community resources, while ensuring the client's freedom of choice and promoting the well-being of the individual. Individuals eligible for this service have Acquired Immune Deficiency Syndrome (AIDS) or Symptomatic Human Immune Deficiency Virus (HIV) disease and are receiving medical assistance benefits. Certain groups such as the State Blind and Healthy Horizons enrollees are excluded. With the exception of medical assistance recipients who are enrolled in a Health Maintenance Organization (HMO), Health Choices or a Medical Assistance Hospice Programs are categorically and medically needy recipients who fall into the AIDS target group and are eligible for case management services.

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

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

Unmet Need – To determine the needs of individuals with HIV disease who know their HIV status and are not receiving HIV-related services and develop strategies to identify and bring into care individuals with HIV disease who are not in care and may

be unknown to any health or social support system.

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

Western Blot – A test for detecting the specific antibodies in a person's blood. A Western blot test is used to confirm a positive screening (ELISA) test result. All positive HIV antibody tests must be confirmed with a Western blot test.