



COUNTY OF LOS ANGELES

Public Health



**HIV/AIDS
CASE MANAGEMENT SERVICES
PROTOCOL**

Table of Contents

INTRODUCTION	3
HIV/AIDS CASE MANAGEMENT	4
ENGAGEMENT IN CARE	4
INTAKE/ELIGIBILITY SCREENING	4
Privacy and Confidentiality	5
COMPREHENSIVE ASSESSMENT	6
Areas for Assessment	7
Risk Behavior Screening	8
HIV/AIDS Education	8
SERVICE PLANNING	9
Developing Goals	9
Linked Referrals	12
FACTORS THAT INFLUENCE BEHAVIOR CHANGE	12
FOLLOW-UP AND MONITORING	13
Preventing Missed Appointments	13
Loss to Follow-Up	14
ADHERENCE	14
Tools for Adherence	15
MULTIDISCIPLINARY TEAM APPROACH	20
WORKING WITH TARGET POPULATIONS	20
YOUTH	20
WOMEN	22
HOMELESS AND marginally HOUSED POPULATIONS	25
INCARCERATED/POST-INCARCERATED	25
ETHICAL CONSIDERATIONS FOR CASE MANAGERS	27
Cultural Competence and Social Diversity	27
Conflicts of Interest	27
Sexual Relationships	27
Sexual Harassment	28
Discrimination	28

INTRODUCTION

The Ryan White CARE Act Program is Federal legislation that addresses the unmet health needs of persons living with HIV disease (PLWH) by funding primary health care and support services that enhance access to and retention in care. First enacted by Congress in 1990, it was amended and reauthorized three times since—in 1996, 2000, and 2006. CARE Act Part A funds the most impacted urban jurisdictions in the county, called “Eligible Metropolitan Areas” (EMAs), and requires each EMA to establish a local “planning council” for the planning, allocation, coordination and delivery of HIV/AIDS services. Los Angeles County’s planning council, the Commission on HIV (COH).

Additional responsibilities include but are not limited to: Setting care/treatment priorities/allocations, developing a comprehensive care plan, assessing the administrative mechanism, which is the Office of AIDS Programs and Policy (OAPP), evaluating service system effectiveness, conducting annual needs assessments, setting minimum service standards/outcomes, and advising the Board of Supervisors.

Like many health problems, HIV disease disproportionately strikes people in poverty, racial/ethnic populations, and others who are underserved by healthcare and prevention systems. HIV often leads to poverty due to costly healthcare or an inability to work that is often accompanied by a loss of employer-related health insurance. Ryan White-funded programs are the "payer of last resort." They fill gaps in care not covered by other resources.

Ryan White services are intended to reduce the use of more costly inpatient care, increase access to care for underserved populations, and improve the quality of life for those affected by the epidemic. In Los Angeles County, the COH allocates funding for case management services to assist clients with accessing, maintaining, and adhering to HIV primary health care and support services, facilitate clients’ understanding of and reduction of risk behaviors, and provide linkages to HIV counseling and testing services for clients’ partners.

HIV/AIDS CASE MANAGEMENT STANDARDS OF CARE

The case manager is on the front line of client services and is responsible for ensuring that clients have access to the services and care that they need. Inherent in the case management role is the responsibility to comply with HIV/AIDS Case Management Standards of Care (SOC). These standards are a blue print to ensure that clients living with HIV/AIDS receive the same quality of care from any provider of case management services and that these services are the highest quality of care. The case manager is a quality management agent because they hold a valuable place in the continuum of care.

Case managers directly impact the access to care for clients, they establish rapport and obtain invaluable information affecting the health of their clients and are many times the first persons sought for help and support by those diagnosed with HIV. This is why it is important to understand that the quality of case management documentation is the proof of the quality of services and the care provided. The compliance to standards and program requirements is the proof of the commitment of the case management agency and of the case manager to the overall

system of HIV/AIDS care in Los Angeles County. The SOC is developed by the Commission on HIV and all case managers should refer to that document when providing services to clients. It can be obtained by visiting the Commission's website at <http://www.hivcommission-la.info>.

Not meant to replace those standards, the purpose of this case management handbook is to provide additional practical guidance to case managers working with clients living with HIV/AIDS in Los Angeles County.

HIV/AIDS CASE MANAGEMENT

HIV/AIDS case management services are client-centered activities through which care is coordinated. The goals of this intervention are optimal retention in care, compliance with medical and service specifications, and risk behavior reduction. These activities are conducted by qualified case managers who assess the client's physical, psychosocial, environmental, and financial needs and facilitate the client's access to, maintenance of, and adherence to primary health care, support services, and HIV prevention and risk reduction services.

Communication and collaboration among agencies is needed to avoid confusion and duplication of efforts. The case manager should recognize the expertise of other agencies and work with providers across funding streams to respond to client needs. Establishing formal links among agencies can facilitate the information flow and referral process among providers.

Clients may also have a case manager outside the Ryan White service delivery system. The case manager should then work together to meet the client's needs and eliminate duplication of efforts. The client's service plan should acknowledge and reflect this interaction among service providers. Coordination among agencies and direct service staff is essential to ensure the client's continuity of care.

ENGAGEMENT IN CARE

Efforts will be made to engage and retain clients in case management services. The case manager will receive client referrals from outreach workers and will set up an appointment for intake. If a potential client misses an appointment, the case manager will call the potential client within 24 hours of the missed appointment to determine if there was a reason why they did not show up. Staff will attempt to reach the potential client no less than two times during a work week period.

INTAKE/ELIGIBILITY SCREENING

Client intake and eligibility screening is the process of determining client's eligibility for services, collecting client information and obtaining required consents and other documentation. Clients who agree to participate in HIV/AIDS case management services shall complete the intake process with case management staff.

Note: Ryan White clients do not have to be citizens or legal residents of the United States to receive services, they must, however, be able to prove they reside in Los Angeles County.

- The prospective client shall be informed of agency services and limitations, client rights and responsibilities, and client grievance procedures.
- A decision shall be made with the prospective client and agency case management staff to do the following: 1) open a case for the client, 2) not open a case for the client, and/or 3) refer the client to an appropriate agency or service.
- All staff providing these services shall be courteous, responsive, and respectful of clients.

Documentation Includes:

- HIV Diagnosis Form
- General Registration Form which may include date of intake, client name, home address, mailing address, emergency contact name, telephone numbers, etc.
- Proof of Los Angeles County residence
- Consents to Release Information (medical, mental health, and substance abuse)
Consents should be updated yearly. A new form must be initiated any time there is a need for communication with an individual not listed on the current form. If there is no medical provider from which to obtain a medical release, staff shall assist in obtaining access to care and follow-up with medical provider
- Limits of Confidentiality policy which notes that the agency and its staff shall not disclose the client's Protected Health Information without the client's permission, except in situations that involve a client being at risk of harming himself or others, or suspected abuse or neglect of a child or dependent adult. Such statement shall be signed and dated by the case manager and the client. The case manager shall explain the limits of confidentiality to all clients.
- Statement of Informed Consent to Receive Case management Services
- A Statement of Client Rights and Responsibilities
- Grievance Procedures Policy signed and dated by the client

All forms that require a client's consent or signature shall be in client's primary language, e.g. Release of Information, Limits of Confidentiality, Client Rights and Responsibilities, Grievance, Procedures, and Statement of Informed Consent to Receive Case management Services.

Additionally, when an individual is not competent to give consent, written consent may be obtained from the individual's guardian, conservators, or other person lawfully authorized to make health care decisions for the individual. For purposes of providing services in the State of California, a minor shall be deemed not competent to give consent if he is under 12 years of age (California Health and Safety Code Section 121020).

Privacy and Confidentiality

The case manager shall ensure the client's right to privacy and confidentiality when information about the client is released to others. All information about a client and his/her significant

others/family members shall be held in the strictest confidence. Information may be released to other professionals and agencies only with the written permission of the client or his/her guardian. This release shall detail what information is to be disclosed, to whom, and for what purpose. The client has the right to revoke this release by written request at any time.

Case managers shall respect clients' right to privacy and shall not solicit private information from clients unless it is essential to providing services. Once private information is shared, standards of confidentiality apply. Case managers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client.

Case managers shall not discuss confidential information in any setting unless privacy can be ensured, including public or semipublic areas such as hallways, waiting rooms, elevators, and restaurants. Case managers shall protect the confidentiality of clients' written and electronic records and other sensitive information. Case managers shall 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. The case manager shall 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 shall be avoided whenever possible.

Any person who willfully or negligently discloses a client's HIV status, as defined in Section 120775 of the Public Health and Safety Code, to a third party, in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization, as described in subdivision (g), or except as provided in Section 1603.1 or 1603.3 or any other statute that expressly provides an exemption to this section, that results in economic, bodily, or psychological harm to the subject of the test, is guilty of a misdemeanor, punishable by imprisonment in the county jail for a period not to exceed one year or a fine of not to exceed ten thousand dollars (\$10,000) or both.

COMPREHENSIVE ASSESSMENT

The Comprehensive Assessment is conducted through face-to-face interviews with the case manager. It is a cooperative and interactive interview process during which the client's medical, physical, psychosocial, environmental, and financial needs are identified as well as risk-behaviors. The comprehensive assessment evaluates client resources and strengths, including family and other close supports that can be utilized during service planning. Case managers specifically assess the case management needs of children and key collaterals and arrange services for them if that will help stabilize the client's support system, enhance family functioning, or assist in attaining service plan goals.

Educational needs about HIV/AIDS are identified including disease progression and treatment information, the client's knowledge of HIV transmission, re-infection, safer sex and harm-reduction, and the need for other support to reduce HIV transmission risk. Assessment is a continuing, evolving process, rather than a discrete activity that can be initiated and completed at a single point in time. Once the intake is completed, a Comprehensive Assessment is conducted

to determine: 1) the client's needs for treatment and support services, 2) the client's current capacity to meet those needs, 3) the ability of those in the client's social support network to help meet the client's needs, 4) the extent to which other service agencies, including the client's primary medical provider, other treatment centers and other case management programs are involved in the client's treatment or care, and 5) the areas in which the client requires assistance in securing services.

Effective communication is essential to facilitate a comprehensive assessment. Open-ended questions and active listening are effective ways to gather information. Encouraging the client to talk will help the case manager learn what the client does and does not know or understand. Listening helps elicit information about a client's needs. The more a case manager knows about what affects a client, the more the case manager will be able to identify solutions and meet needs. Clients do not always volunteer information, especially if they think it is irrelevant or embarrassing. Some clients find it difficult to express their needs. The case manager should explain that the information is needed to link the client with the available services that will help the client with their needs.

Areas for Assessment

Health/Medical: The case manager must know the client's current medical status in order to help the client access medical services. If a client has not recently seen a doctor, the case manager should refer the client for a medical assessment to establish a baseline for the client's HIV status.

Dental Assessment

The mouth is one of the first places in which HIV symptoms may appear, but dental health is often neglected. Even if the client is not having problems with his/her teeth, a dental examination and prophylaxis should be done to create a baseline for future examinations. Case managers should refer clients to oral health care practitioners for a comprehensive dental examination.

Adherence to HIV-Related Treatment: For persons living with HIV and receiving drug treatment, the assessment should address issues related to adherence to HIV-related treatment medication adherence and medical treatment, assessing motivation for and barriers to treatment.

Sexually Transmitted Infection (STI) History: The prevention, diagnosis, and treatment of STI's other than HIV are essential components of any case management program. Acute STI's, particularly those involving lesions on the skin or mucous membrane, facilitate the transmission of HIV. Therefore, clients' history and treatment of STI's should be assessed as well as the date of their last STI medical evaluation.

Substance and Alcohol Use History: A number of factors related to substance and alcohol use should be assessed including the following: history of injecting drugs, alcohol use, and other non-injecting drug use; drug(s) of choice; frequency of use; route of administration; length of time using drugs/alcohol; frequency of needle sharing; treatment

history; psychosocial context of drug/alcohol use; and affect of drug/alcohol use on sexual behavior. The potential relationship between substance use and unsafe sexual behaviors highlight the need for a comprehensive assessment of both injecting and non-injecting drugs.

Mental Health: Several factors related to mental health should be considered including the following: family and personal mental health history; history of treatment, therapy, and hospitalization; suicidal ideation and history; and psychotropic medication history.

Sexual History: A comprehensive sexual history is necessary to fully assess sexual risk behavior and related factors. Areas for assessment include number of sex partners; current partners (nature of relationships); HIV serostatus of partners; sexual behaviors practiced and frequency of behaviors; history of sexual abuse; role of alcohol and drugs during sex; involvement in sex in exchange for drugs/money/and so on; risk behaviors of partners; condom use, including barriers and facilitating factors for condom use; and knowledge of safer sex practices.

Risk Behavior Screening

Although the principal function of the case manager is to help the client obtain needed social and practical support services, the case manager also has an important role to play in prevention of HIV transmission. As part of the assessment process, case managers assess the client's knowledge, attitudes, and behaviors toward safer sex, and alcohol and drug use. Based on the results of this assessment, the case manager will provide appropriate information and support to help the client avoid risk behaviors that can lead to further HIV transmission. Case managers also assist clients in confidentially notifying partners and referring them to counseling and testing services.

Social and Environmental Support: Assessing key factors related to social and environmental will provide a more comprehensive picture of the context regarding client's access to and maintenance of HIV specific medical and support services. Areas for assessment include the following: living situation; economic status; sources of income; employment; in or out of school for youth; emotional support sources; history of incarceration; significant others; and connections to friends, family, spiritual, and service providers.

HIV/AIDS Education

HIV Education refers to the provision of up-to-date information about HIV and its related illnesses, treatment options, and ongoing education support. The introduction of new treatments for HIV/AIDS has brought about significant psychological ramifications for clients. The case manager ensures that clients understand HIV disease progression, that they have knowledge about available HIV/AIDS treatments and are aware of how they can access them.

Disclosure of HIV Status

This examines who else, if anyone, in the household or client support system is aware of the client's HIV status. It also determines if the client needs assistance/support in disclosing his or her status and identifies potential caregivers in the event the client may become unable to care for him or herself. Case managers shall assist clients with HIV disclosure issues and partner notification services.

SERVICE PLANNING

The Individual Service Plan (ISP) is a plan that details client goals and objectives and is based on the needs identified in the comprehensive assessment. The ISP is developed in conjunction with the client. Individual Service Plans are considered living documents and should be modified regularly. Each plan includes the client's short- and long-term goals, action steps to be taken by the client, dates and disposition of objectives met, and any modifications to the original goals and/or objectives. Short-term goals address immediate needs, especially those required to stabilize the client or to deal with a crisis situation. Long-term goals reflect the goals that the client wishes to achieve for independence, supportive care, and overall quality of life.

Developing Goals

GOAL: A goal is a statement of a desired intended general outcome. It is something worked toward or aspired to. A goal is the end that one strives to attain (e.g., to reduce feelings of depression). An effective goal focuses on GOALS rather than ACTIVITY. It identifies where the client wants to be, and, in the process, helps determine where they are. Goals tend to be broader, and concentrate on more of a **destination** sense. A goal is a general result (e.g., to reduce feelings of depression). To achieve and maintain this goal, there are actions (tasks/steps) the client must make (e.g., take psychiatric medications as prescribed daily, attend weekly mental health group, etc.).

A standard rule in setting goals with a client is to specify the intended outcome or general condition that will result from the accomplishment or maintenance of the goal, keeping the client as the subject. The case manager should not be mentioned directly or implied in the GOAL statement. An example of a misstated goal is "to refer to mental health counselor." It implies that the case manager has the goal or objective. To re-state as client-directed goal, it can read: "(Client) to reduce substance use."

- To reduce... (use of drugs; feelings of depression)
- To obtain... (HIV medical treatment, stable housing, employment)
- To increase.... (adherence to HIV medication, knowledge of HIV progression)
- To regain..... (custody of children)
- To curtail...(cravings of addiction)
- To alleviate...(stress, tension)
- To resolve...(legal or financial issues)

To achieve and maintain this, there are tasks, or stepping stones, which must take place.

STEPS: Steps are the observable and measurable tasks to be taken toward the completion of the goal (e.g., meet with counselor monthly, take psychiatric medications as prescribed daily, attend weekly mental health group, etc.).

For most of us changes are incremental. Achieving small steps can be recognized as progress. Steps can be celebrated as successes independent of achieving the client goal. Obstacles/barriers can assist in re-thinking steps needed to achieve client goals. For most of us changes are incremental.

Today I Will Do One Thing (Small Steps)

Appropriate action, no matter how small, results in change and growth. Change happens one step at a time. Our task is to help clients keep taking these steps, however small, each and every day in order to achieve their goals, which often take some time.

"Today I will do one thing," reminds clients to keep taking these small steps even when they don't feel like it. One small step taken every day is progress. When we manage to accomplish even one small thing that we set out to do each day, we can feel we are making progress towards our goal.

SAMPLE GOALS (And Steps to achieve those goals)

Goals often require many steps in order to achieve the goal. Examples are highlighted below:

- 1) Goal: Alleviate feelings of (sadness, nervousness, anxiety, depression; hearing voices, seeing things, emotional turmoil/conflict);
 - ✓ CM will schedule appointment with Mental Health Staff
 - ✓ Client will attend Mental Health appointment.
 - ✓ Client will follow recommendation by Mental Health specialist
 - ✓ CM will follow-up with Client to ensure that client attends appointment

- 2) Goal: Reduce High Risk Behavior
 - ✓ Client will use condoms at least 50% of the time
 - ✓ CM will provide client with safer risk strategies during the next three visits
 - ✓ Client will apply these strategies
 - ✓ CM will continue to follow-up with client to ensure safer sex practices

- 3) Goal: Obtain stabilize Housing
 - ✓ CM will help client negotiate a housing arrangement w/ family, significant other, etc
 - ✓ CM will make appointment with housing case manager
 - ✓ Client will keep appt. and complete housing application

- 4) Goal: Improve knowledge and understanding of HIV/AIDS
 - ✓ CM will assess client knowledge of HIV/AIDS

- ✓ Clt will attend HIV 101 education workshop
 - ✓ Client will meet with treatment educator
 - ✓ CM will re-assess client knowledge of HIV/AIDS
- 5) Goal: Reduce or Eliminate Substance Use (Name Substance used)
- ✓ CM will introduce stages of change (SOC) to client over the next four sessions
 - ✓ CM will explore client's readiness for change
 - ✓ CM and client will develop a change plan
 - ✓ CM will develop a change plan
 - ✓ CM will revisit plan of change
- 6) Goal: Obtain a stabilize income
- ✓ CM will refer client to financial screener (GR, Social Security, Human resource, etc.)
 - ✓ Client will keep appointment w/ financial screener
 - ✓ Client will provide all documentation require to complete the financial process
 - ✓ CM will follow-up on client progress
- 7) Goal: Increase adherence to medical appointments
- ✓ Client will schedule medical appointment
 - ✓ Client will attend next two medical appointment
 - ✓ CM will periodically confirm compliance by calling medical clinic
- 9) Goal: Improve Support System
- ✓ CM will refer client to women's support group
 - ✓ Client will attend support group at least _____ times in the next six weeks
 - ✓ CM will confirm linkage to support group
- 10) Goal: Resolve Legal Issues
- ✓ CM make a referral to lawyer
 - ✓ Client will keep appointment
 - ✓ Client will follow plan outlined by lawyer

Referrals for Service

Case management is effective when it utilizes all the resources of the community on behalf of the client. The case manager must learn to utilize all of these resources and to make referrals to them as needed. Ryan White funded services cannot be relied on to meet all client needs. Ryan White services should be used only to fill gaps that cannot be filled by the other resources in the larger community.

Client needs are constantly changing and the availability of resources also fluctuates. It is the case manager's job to identify gaps in the service delivery system and consider different approaches to address the client's needs when necessary. The case manager must also help clients differentiate between what they want, what they need, and what each program can provide.

Linked Referrals

Successful case management depends upon coordination among providers to meet clients' needs based on the accurate assessment of those needs. The case manager advocates for the client by collaborating and working with individual service providers. To be effective, the case manager must learn how to work with providers to ensure that referrals are well received and services are delivered. The distinguishing characteristic of a linked referral is that verification is obtained regarding the client's access to referred service(s). Case managers conduct ongoing monitoring and follow-up with client and/or provider(s) to confirm completion of referrals, services acquisition, maintenance of services, and adherence to primary medical care, HIV prevention and risk reduction, and other support services. Documentation of such linkages is maintained within each client record.

FACTORS THAT INFLUENCE BEHAVIOR CHANGE

Factor	Description	Elements of Effective Intervention
Knowledge About Risk	Accurate understanding of behaviors that confer risk, behavior changes needed to reduce risk, and the rationale underlying risk-reduction changes	Clear identification of behavior practices that create risk; practical advice on behavior changes needed to reduce risk, taking into account the realities of the client's lifestyle and relationships
Perceived Personal Vulnerability	Personalization of risk; believing oneself to be potentially vulnerable for contracting HIV/AIDS	Discussion that accurately communicates the client's risk level, encourages the client's self-appraisal of risk, and induces realistic perception of threat
Behavior Change Intention	Readiness for change and committing oneself to risk-reduction effort	Assessing, together with the client, his or her readiness for change and setting achievable risk-reduction goals through counseling and/or contracting
Self-Efficacy	Believing oneself capable of successfully making risk-reduction behavior changes and perceiving that this change will protect against HIV/AIDS	Assigning incremental risk-reduction "tasks" that can easily be accomplished to establish a sense of competency and a success record; counseling that challenges a client's sense of fatalism
Skill Level	Behavioral competence in areas necessary for change implementation including condom use or other safer sex practices; sexual assertiveness skills to refuse risk pressures; safer sex negotiation skills; not sharing needles; use of clean needles; etc.	Skills training and practice; self-management or identification of patterns, habits, or activities that increase vulnerability to risk and development of alternative plan to address these behavioral "triggers"
Reinforcement of Behavior Change Efforts	Positive rather than negative outcomes associated with behavior change efforts, including positive partner response, self-praise, and reinforcement; belief that behavior change is consistent with peer group norms	Follow-up counseling contracts that suggest and reinforce change efforts, discussion of problems encountered, and encouragement of self-praise of risk-reduction change
Environmental Barriers	Experience fewer environmental constraints to perform a behavior rather than not to perform it	Discussion of barriers to performing risk-reduction behaviors; development of strategies to overcome those barriers and to create easier access to the resources required to enact change

FOLLOW-UP AND MONITORING

Follow-up and monitoring are inseparable. It is through systematic follow-up that the case manager and client discover whether the goals outlined in the ISP are achievable and when they need revision. Follow-up is the constant monitoring and evaluation of the client's needs, risks, and progress through on-going contact. It is an on-going process that ensures that services are consistent with meeting ISP goals and evaluates whether goals and steps are being carried out. Follow-up ensures that the care and treatment which the client is receiving is appropriate and coordinated.

- Ongoing contact with the client, family and significant others allows the case manager to assess the quality and appropriateness of the services provided, and the current status of the client's situation.
- Follow-up includes direct, face-to-face contacts as well as telephone contacts. The client, family or significant other shall be contacted as often as needed. Follow-up may also occur through indirect contact with the client, e.g. when the client has interactions with other agency staff, health-care or social service providers.

Preventing Missed Appointments

Missing appointments can be a serious barrier to achieving client goals. Not only can a missed appointment be a sign of decreased motivation on the part of a person, but it can also represent a missed opportunity for a person and a provider to discuss adherence and other issues. Steps should be taken to minimize the number of appointments missed. Most importantly, a person should be made to feel that he/she is always welcome and that his/her time and presence are highly valued. Strategies for minimizing missed appointments include:

- Flexibility - Individuals may have difficulty keeping appointments at certain times or on certain days. A wide variety of appointment times, including evenings and weekends if possible, should be made available. Drop-in capability can also increase accessibility, especially when individuals need immediate concerns addressed.
- Reminders - Phone calls made or note cards sent a few days before the appointment can reduce the chance of a person missing appointments. Some electronic scheduling programs can automatically generate reminder cards or phone lists. An individual's phone numbers and addresses should be verified at each visit to make sure that they are correct and reliable. Staff must keep issues of confidentiality in mind when contacting an individual and should discuss with the individual at his/her initial visit the best way to contact him/her between visits.
- Client Input - The person should be asked what could be done to improve his/her appointment keeping.
- Organizers - Individual organizers can be used as a reminder of appointments as well as a medication adherence tool.

- Follow-up on Missed Appointments - Determining why a person misses appointments, especially if doing so is routine, may reveal a barrier that can be resolved. There are many barriers (e.g., a person may have no transportation or may not have anyone to care for minor children) for which assistance can be offered.

Loss to Follow-Up

A client falling out of care is the most severe impediment to managing client care. Loss to Follow-Up can occur when a client leaves the area, lacks a permanent residence, is reluctant to participate in the program, or from inadequate follow-up on the part of the case manager. Every effort should be made to avoid inadequate follow-up by the case manager. Case managers need to determine whether more frequent contact is needed in order to avoid potential dropout. Case managers should actively follow-up with clients who have missed a case management appointment within twenty-four (24) hours of the broken appointment. If follow-up cannot be conducted within the twenty-four (24) hour time period, the case manager shall document reason(s) follow-up was delayed.

ADHERENCE

It's not that patients with HIV/AIDS are adherence "slackers" or "underachievers." They adhere far better than the general population. One often-quoted 1960s study found that only 19 percent of patients in the general population could adhere to a 10-day course of antibiotics. In recent studies, the average adherence rate to treatments for chronic illnesses was about 50 percent. That is far below the self-reported adherence rates of most patients on HAART, which is between 56 and 88 percent. Unfortunately, even 88 percent is not enough over the long term.

In some studies, adherence of anything less than 95 percent has been linked to treatment failure. Adherence at lesser rates fosters development of virus mutations. Some research has found that the risk of developing resistance is highest with adherence in the 80 to 90 percent range. The possibility of quick development of a resistant virus is worrisome because it limits treatment options for the patient. So adherence is something at which patients, ideally, need to be almost flawless for most regimens. That's a hard standard to reach.

Highly active antiretroviral therapy (HAART) involving the use of several medications at a time has become the standard regimen to achieve maximum viral suppression. However, these drug regimens are demanding and often "unforgiving." The amount of time the drugs remain active in the bloodstream and their interactions with food and other drugs make timing and regularity of dosing essential to effectiveness. Missing even a few doses can lead to an increase in viral replication. Given the high frequency of mutation in HIV, this can rapidly lead to drug resistance and treatment failure. For the individual, this outcome means loss of an effective therapy to suppress the virus in his/her body. The broader public health consequence of treatment failure is the possible spread of drug-resistant virus in the community. It is important, therefore, for both the individual and the community to ensure that the necessary supports for treatment adherence are available.

INTERVENTIONS TO IMPROVE ADHERENCE

Multifaceted approaches that address patient, regimen, and societal barriers are the most effective way to improve adherence to HIV medical care. Specific interventions include educating the client about the goals of medication therapy and the importance of adherence; soliciting family and social support; providing clear dosing instructions and reminders; monitoring adherence and intensifying management when necessary; and enlisting other health professionals to reinforce adherence. Each contact between case manager and the client should be seen as an opportunity for the promotion of medication adherence.

The technique of motivational interviewing uses a series of well-defined strategies to move the client toward the end goal of self-motivation to change behavior and becoming adherent to HIV medical care. The basic principles of motivational interviewing are:

- Assessment of the client's readiness or willingness to change.
- Use of specific techniques to move people toward change based on their present state of willingness.
- Assist the client in creating a favorable climate for change to occur.
- Explore, address, and, to an extent, resolve ambivalence and resistance.

On the surface, this sounds like a potentially long process. In practice, however, motivational interviewing need not take more than 5 to 10 minutes per session with the client. Motivational interviewing is a client-centered method of communicating with the goal of enhancing a person's internal self-motivation to increase adherence to medical treatment. The technique is directive in nature and is designed to facilitate the client's exploration and resolution of reasons for ambivalence and resistance. In the truest sense, motivational interviewing is employed to stimulate client self-motivation. After all, it is the client who ultimately decides to make a change in lifestyle for the better, not the adherence case manager.

It is essential to reinforce adherent behavior whenever possible by simply telling clients they are doing a good job at self-management despite all obstacles. The case manager should also routinely ask clients for anything that is needed to continue with good adherence to the service plan. It is vitally important to remember that the clients themselves are ultimately responsible for implementing and sustaining behavior changes, and often the case manager or a family member will be the only person who notices. Get in the habit of celebrating success with your clients!

Tools for Adherence

Adherence tools are helpful for many individuals. These can include: pillboxes, alarms, or reminder systems such as phone calls or organizers, home visits, pill charts, personalized educational materials, and medical diaries. Providers should make these devices available to individuals and should work with them to incorporate these tools into an adherence support regimen. The following list includes tools currently in use:

- **Pillboxes** are containers for storing medication with dividers for each day and each dose within the day. Some pharmacies will distribute pillboxes "pre-loaded" with the

appropriate medications. Some pillboxes have removable compartments for a 1-day supply of medications that can be discreetly packed into a pocket or purse to maintain confidentiality and can reduce the inconvenience of carrying a large pillbox. Pillboxes with electronic reminder alarms are available.

- **Electronic Devices** can range from beepers to alarms to watches. Although these devices are useful, they all have limitations. Pagers that coordinate with the Internet to provide automatic text messages at dosing times are available. Providers and patients have found that alarms and pagers with text-messaging capacity are more successful than simple beepers. Electronic devices should be discreet to help the patient feel that his/her confidentiality is not at risk.
- **Reminders (Telephone/email)** on a regular or intermittent schedule can help with adherence. Such reminders can be labor-intensive for the staff and, of course, require that the person be accessible by telephone. It is important that the staff ensure that the patient is comfortable with the frequency of calls **or email correspondence**. Case managers must also take care to ensure that confidentiality is preserved.
- **Home Visits** by case managers can provide valuable information about life circumstances and environmental barriers to adherence. Such visits can also provide the encouragement necessary to help individuals maintain their regimens.
- **Pill Charts** visually display pills and include the name and dosage of each medication. Pill charts can be especially helpful for individuals who have literacy problems.
- **Organizers** are calendars that help individuals develop good medication-taking habits as well as organize appointments and other commitments. Organizers can help prevent missed appointments.
- **Personalized Educational Materials** can be developed in written, audio, or visual formats and can be tailored to meet each patient's adherence needs. Personalized written materials can be generated with the aid of a computer. A digital camera can be used to make images of the number of pills required for daily doses taken by an individual at different times of the day.
- **Medication Diaries** are journals in which the patient records when he/she takes or skips doses or experiences side effects. Keeping such journal records can assist patient and provider in identifying patterns and uncovering reasons for missing doses of medication. Medication diaries provide a source for measuring missed doses.

BRIEF INTERVENTIONS

Clients make changes for different reasons, and an intervention that works well for one client may not work for another. Brief interventions are components of the journey toward behavior change and can be integral steps in the process. For some clients, assistance with the decision to make the change will be enough to motivate them to start changing the behavior, whereas others may need more intensive interventions throughout the change process. Brief interventions are sessions that can be tailored to different populations, and many options are available to enhance

interventions and care. It should be noted, however, that brief interventions are not a substitute for specialized care for clients with a high level of need. The goals of this intervention are optimal retention in care, compliance with medical and service specifications, and risk behavior reduction.

To help clients change their behavior, case managers should utilize well-defined strategies to move the client toward the end goal of self-motivation to change behavior. The basic principles of motivational interviewing are:

- Assessment of the client's readiness or willingness to change.
- Use of specific techniques to move people toward change based on their present state of willingness.
- Assist the client in creating a favorable climate for change to occur.
- Explore, address, and, to an extent, resolve ambivalence and resistance.

On the surface, this sounds like a potentially long process. In practice, however, the intervention need not take more than 5 to 10 minutes per session with the client. This client-centered method of communicating has the goal of enhancing a person's internal self-motivation. The technique is directive in nature and is designed to facilitate the client's exploration and resolution of reasons for ambivalence and resistance.

Five Elements of a Brief Intervention

There are five elements critical to a brief intervention to change behavior. A brief intervention consists of five basic steps that remain consistent regardless of the number of sessions or the length of the intervention:

1. Introducing the issue in the context of the client's health
2. Screening, evaluating, and assessing
3. Providing feedback
4. Talking about change and setting goals
5. Summarizing and reaching closure

Case managers may not have to use all five of these components in every session. It is more important to use the components that reflect the needs of the client and his personal style. Before eliminating steps in the brief intervention process, however, there should be a well-defined reason for doing so. Moreover, a vital part of the intervention process is monitoring to determine how the client is progressing after the initial intervention has been completed. Monitoring allows the case manager and client to determine gains and challenges and to redirect the longer-term plan when necessary. Following are descriptions of the five basic steps.

Introducing the Issue

In this step, the case manager seeks to build rapport with the client, define the purpose of the session, gain permission from the client to proceed, and help the client understand the reason for the intervention.

Case management tips: Help the client understand the focus of the interview. State the target topic clearly and stress confidentiality; be nonjudgmental and avoid labels. Do not skip this opening; without it, the success of the next steps could be jeopardized.

Screening, Evaluating, and Assessing

In general, this is a process of gaining information on the targeted problem; it varies in length from a single question to several hours of assessment on the targeted topic of change. It could involve a structured or non-structured interview or a combination of both, coupled with questionnaires or standardized instruments, with the extent of the process determined largely by the setting, time, and available resources.

Case management tips: Before you begin the brief intervention, decide how much information you have time to obtain and whether you want to have the client answer any questionnaires. Watch for defensiveness or other resistance, and avoid pushing too hard.

Providing Feedback

This component highlights certain aspects of the client's behavior using information gathered during screening. It involves an interactive dialog for discussing the assessment findings; it is not just case manager driven. Feedback should be given in small amounts. First, the case manager gives a specific piece of feedback, and then asks for a response from the client. Sometimes the feedback is a brief, single sentence; at other times it could last an hour or more.

Case management tips: Use active listening. Be aware of cultural, language, and literacy issues. Be nonjudgmental.

Talking About Change

Talking about change involves talking about the possibility of changing behavior. It is used with clients in all stages of change, but it differs profoundly depending on the stage the client has reached. For example, in pre-contemplation, clients are helped to recognize and change their view of consequences; in contemplation, they are helped to resolve ambivalence about change. In action, the focus is on planning, removing barriers, and avoiding risky situations; in maintenance, the emphasis is on establishing new long-term behaviors. It is important that the case manager assess the client's readiness to change if it is not already known. In talking about change, the case manager often suggests a course of action, then negotiates with the client to determine exactly what he is willing to do. Sometimes, talking about change is premature (i.e., before the assessment and feedback have happened). In that case, it should be postponed until later in the intervention.

Case management tips: Offer change options that match client's readiness for change. Be realistic: Recommend the ideal change, but accept less if the client is resistant.

Summarizing

This step involves a summary of the discussion and a review of the agreed-upon changes. If no agreement was reached, review the positive action the client took during the session. At this point, it is important to schedule a follow-up visit to talk about how the client is progressing. The follow-up could be another face-to-face meeting, a telephone call, or even a voice mail message. The goals of closing on good terms are to arrange another session, to leave the client feeling successful, and to instill confidence that will enable the client to follow through on what was agreed upon.

Case management tips: Tailor your closure to the client and the particular circumstance of this brief intervention; interpret any client resistance in a positive light leading to progress. Thus, if a client has been unwilling to commit to changes, thank him for his willingness to consider the issues and express the hope that he will continue to consider committing to changes.

DOCUMENTATION AND PROGRESS NOTES

Documentation is written proof or evidence of an encounter taking place. Case managers must document information for the purposes of coordinating client service, recording referrals and resources provided, and monitoring and evaluating services. In addition to documenting demographic information, the case manager documents the date, the type of encounter, and description of the encounter in the progress notes. The case manager's signature and credentials should be located at the end of each documented encounter in the progress notes. Any other information that will assist the case manager in remembering events should be documented in the progress notes or on a form designated for that purpose.

Documentation should be written in complete and succinct sentences. Remember, if it isn't written down, it didn't happen and you can't prove that it did. All Ryan White funded case managers are required to participate in case management training. Examples of case notes and proper documentation will be provided during the training session.

Client Records

- (a) Case managers should take reasonable steps to ensure that documentation in records is accurate and reflects the services provided.
- (b) Case managers 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) Case managers' 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.

MULTIDISCIPLINARY TEAM APPROACH

HIV is a complex illness that has ramifications for many aspects of an individual's health and life. An integrated, multidisciplinary approach to care can help identify issues that impact on a person's adherence. A multidisciplinary team, which may include physicians, nurses, social workers, therapists, pharmacists, health educators, nutritionists, peer educators, and drug treatment providers, can be used to provide coordinated services for each individual.

Regular team meetings can promote good communication among the various caregivers. However, it is important that a person is comfortable with such information sharing, and the team should remain aware of the possibility that a person may be less than willing to be open with a treatment team. Letting an individual know that his/her care team will discuss his/her care can mitigate issues of confidentiality.

Case conferencing is a formal, planned, and structured event separate from regular contacts. The goal of case conferencing is to provide holistic, coordinated, and integrated services across providers, and to reduce duplication. Case conferences are usually interdisciplinary, and include one or multiple internal and external providers and, if possible and appropriate, the client and family members/close supports.

Case conferences can be used to identify or clarify issues regarding a client or collateral's status, needs, and goals; to review activities including progress and barriers towards goals; to map roles and responsibilities; to resolve conflicts or strategize solutions; and to adjust current service plans.

A case conference form can help document the participants, topics discussed, and follow up needed as a result of a case conference. When distributed immediately to attendees, the form reminds each participant of the roles and activities they've agreed to perform.

WORKING WITH TARGET POPULATIONS

When providing case management services to clients, it is important to remember that certain populations of people have special circumstances that relate to that target group. Having the general knowledge associated with a specific group can help case managers in working with those target populations of individuals. Remember that the following are general tips about a given group of individuals that belong to a particular target group. Each individual client has their own specific needs. The following is an overview of a few target populations.

YOUTH

Adolescence is a time of intense transformation. No longer children but not yet adults, adolescents must navigate a multitude of emotional, cognitive, and physical changes, many of which can render them at risk for HIV infection. Youth require age-appropriate outreach and treatment services that address their unique needs.

Most people who become HIV infected during adolescence are not diagnosed until they are in their twenties or beyond. Time from HIV infection to progression to AIDS can exceed 10 years. Thus, it is certain that a large proportion of people with AIDS who are in their twenties became infected with HIV while in their teens; similarly, it is probable that a number of people with AIDS who are age 30 to 34 were infected during their teenage years.

It is estimated that one-fourth of all HIV infections occur in people under age 21—a segment of the population that is among the most medically underserved. Experts predict that only 11 percent of HIV-positive youth in the United States receive adequate medical care. Adolescents are also the most uninsured and underinsured group in the United States, and those at the highest risk for HIV are the least likely to be receiving office-based primary care services. One in 7 adolescents—and 1 in 2 minority adolescents—live in poverty, which can greatly impede access to health care. In addition, adolescents are often inexperienced and unfamiliar with the medical system and may distrust health care professionals.

Not only do many adolescents delay or forego HIV testing, but those who test positive often delay treatment for the disease. It may take several months for an HIV-positive youth to accept his or her diagnosis and return for treatment. Despite the efforts of HRSA, Ryan White Comprehensive AIDS Resources (CARE) Act providers, and organizations and individuals across the country, an enormous disparity remains between the numbers of youth who are HIV positive and the numbers who are enrolled in care.

Often the very psychosocial and socioeconomic factors that place young people at high risk for acquiring HIV are the same ones that leave them at the margins of disease prevention and health care systems. Infected youth who have been successfully linked to care still face substantial barriers that impede their effective utilization of, and adherence, to treatment. Growing evidence demonstrates that young people are less likely than adults to adhere to complex HIV drug regimens. In a study published in the *Archives of Pediatric and Adolescent Medicine*, only 28 percent of HIV-infected adolescents reported taking all of their prescribed antiretroviral medications in the previous month.

Many communities lack age-appropriate HIV services—and when those services are available, they are often difficult to locate and navigate. Simply treating the medical needs of youth is insufficient. HIV care must be part of a comprehensive, multidisciplinary approach that is coordinated through case management. The following are recommendations for programs intending to engage hard-to-reach youth populations:

- Provide age-appropriate care. Programs must address the unique developmental, cognitive, and emotional changes associated with adolescence. Service locations and hours of operation should accommodate school and social schedules, and care providers should be respectful of youth.
- Ensure seamlessly integrated and accessible services. Services are most effective when they are comprehensive and integrated and when they comprise multidisciplinary outreach, testing, and treatment, particularly for youth with co-occurring mental health

and substance abuse disorders. When co-located services are not feasible, case management and **interagency linkages** are crucial.

- Establish and maintain trust. Programs must establish an atmosphere of trust, confidentiality, and respect. Peer-based outreach and counseling are effective strategies. Research suggests that HIV-positive youth who develop trusting relationships with their providers are more likely to be tested, return for test results, and transition into treatment.
- Provide comprehensive care that addresses youth's non-medical needs. HIV-positive youth often require help with housing, transportation, financial assistance, job training and placement, and child care. Primary care for HIV-positive youth must be integrated with services that address factors such as mental health problems, sexual health, and substance abuse.

WOMEN

Poverty fuels the spread of the AIDS epidemic, and the epidemic in turn fuels poverty. In the United States, people living with HIV/AIDS are poorer than the general population, and women with HIV/AIDS are more likely to be poor, to be unemployed, and to have less education than their male counterparts. HIV-positive women are also less likely than men to have private health insurance and are more likely to face barriers to health care services. Low-income women are more likely to report negative experiences with the health care system, higher rates of dissatisfaction with providers, lower use of preventive services, and limited access to primary care. Access for low-income women is also complicated by their caregiving responsibilities, and lack of child care and transportation are often barriers to care.

When women living with HIV disease in the United States are diagnosed early and given appropriate treatment, they survive as long as men with HIV/AIDS. Yet as a group, women with HIV/AIDS report worse health outcomes and physical functioning because they are less likely than men to receive appropriate care. Not only do HIV-positive women still tend to be diagnosed later than infected men, but after diagnosis, 35 percent postpone medical care due to various psychosocial and financial barriers. In other words, the factors that increase risk for HIV infection among women do not go away after seroconversion. And other factors, such as discrimination, begin to play a more insidious role. In one study, 71 percent of participants (men and women) reported having experienced race-based discrimination when receiving treatment for HIV. Those reporting discrimination had a greater severity of AIDS-related symptoms, lower perceived general health, and less health care satisfaction.

HIV/AIDS affects women in almost every facet of their lives. Given the extremely high rates of poverty and its attendant problems among HIV-positive women in America, engaging underserved women and helping them adjust to their illness requires that providers address a multitude of issues. What is the impact on the HIV-positive woman's family? How can the family's housing be stabilized? What mental health and support services are needed so that entry into care is viable and that the life of the family can be safeguarded?

Women's vulnerability to HIV/AIDS must be examined in the context of the social and economic factors that shape our world. Women tend to become infected with HIV at younger

ages than men do, a pattern reflecting that the risk they face is partly related to the vulnerability intrinsic to being young.

Refusing sex is simply not an option for many women, particularly for sex workers, victims of sex trafficking, women forced into marriage, and young women who have relationships with much older men. But the problem is not limited to those situations. Research suggests that at least 1 in 5 women worldwide have been physically or sexually abused as either adults or children. An estimated 10 to 15 percent of all females, many of whom are younger than 15, report being forced to have sex.

Even when the sexual encounter is consensual, negotiating condom use—if, indeed, condoms are available at all—is often difficult or even dangerous. Several studies have found that women commonly cite their partner’s unwillingness as the primary reason for infrequent condom use. Moreover, unprotected sex is often considered a sign of intimacy, commitment, and trust between a couple. Maintaining intimacy and securing male approval may be especially important to adolescent girls, who also may lack the communication skills to negotiate condom use.

Violence against women is “both a cause and a consequence of HIV/AIDS” and is a fact of life for too many women in every country. In the United States, women who suffer frequent abuse often become trapped in a cycle of “violence, drug abuse and unwanted sex which leaves them at a very high risk of becoming infected with HIV.” Women threatened by violence may be afraid to ask their partners to use condoms and may submit to coerced sex for fear that their refusal will spur abuse. Similarly, a study of HIV-positive women enrolled in a Johns Hopkins clinic, most of whom reported either physical (68 percent) or sexual abuse (32 percent) as adults, found that nearly one-third of the women reported being afraid of disclosing their HIV status for fear of violence.

Violence is more than an occasional problem among women living with HIV/AIDS, particularly for women in poor urban communities. Traumatic life experiences, such as violent victimization, have been found to be associated with high rates of psychiatric problems, substance abuse, and treatment non-adherence.

Women must receive support immediately following diagnosis so that they can “find acceptance” with themselves and their illness. “The most pressing need for most women, is the reassurance that they are not alone—that support is available.” In addition to providing linkages to the medical care necessary for ensuring good health, agencies must address needs that can be placed in the broadly defined categories, as outlined below.

- **Psychological and sociocultural needs, including substance abuse and mental health problems.** Women living with HIV have a high incidence of mental health problems and report greater levels of psychological distress than their male counterparts. Psychosocial distress not only impedes the quality of one’s social and emotional life but also is associated with poorer physical functioning: AIDS-related death, for example, is more common among HIV-positive women who report chronic depressive symptoms.

Incorporating gender-specific and culturally specific interventions into HIV/AIDS care can reduce substance use among women. A growing number of women are dually diagnosed with HIV infection and substance use problems. Effective diagnosis and treatment are critical to help women cope with HIV disease and adhere to their medications.

- **Financial stressors, including lack of health insurance, loss of employment, and competing subsistence needs.** In the United States, most women with HIV disease are poor and were living in poverty even prior to learning of their HIV status. HIV infection can wreak havoc on tenuous family finances, which often depend on the caregiving and wage-earning contributions of women. By compromising a woman's ability to generate income and complete household and caregiving tasks, AIDS diminishes economic resources, reduces food security, and further disempowers women. Most successful HIV/AIDS service providers help women take financial control over their lives by providing linkages to job training and education programs.
- **Transportation, child care, and similar basic living issues.** Lack of transportation is a major barrier to care. Aside from the expense, which is often considerable for women in poverty, accessing available transportation services is often extremely time consuming. A trip across a major American city can require numerous bus transfers and hours of lost time—and a trip to the other side of a smaller community may not be possible because of poor public transportation options. How does an hourly wage earner living on the brink cope with the loss of wages she will incur just to see the doctor? How does she explain her absence to an employer who, she fears, will fire her if she discloses her status?

Lack of child care presents a major barrier as well: Who watches a woman's children while she is seeing her doctor or attending the support group that will give her the psychological strength to fight her disease? According to the Kaiser Family Foundation, women in the HIV care system are more likely than men to have children under age 18 (76 percent of women compared with 34 percent of men). Of those parents, women are more than twice as likely to be living with their children. **Other research suggests that HIV-infected people with a child in the household are nearly twice as likely to delay seeking care as those without children.** Successful care providers adopt a family-centered approach that recognizes the importance of family bonds. Women often define themselves in terms of their caregiving relationships and may delay seeking needed medical treatment if they feel that doing so may compromise their ability to meet their caregiving responsibilities.

- **Stigma and discrimination.** People living with HIV/AIDS face considerable stigma, which can be especially severe among low-income African American women. Women who experience stigma are less likely than those in supportive environments to undergo HIV testing, to disclose their HIV status, and to seek out necessary medical care. Moreover, stigma or discrimination may hinder retention in care and adherence.

It is far beyond the reach of local service providers to mitigate all the effects of stigma in the world today. But providers can offer a safe place for women to explore their lives and

address their needs. And they must help clients develop strategies for countering the stigma, discrimination, and violence they encounter at home and in their daily lives.

HOMELESS AND MARGINALLY HOUSED POPULATIONS

Inadequate housing poses special adherence challenges for individuals. Since the need for shelter predominates over other needs, attention to health care and HIV treatment suffers. In addition, lack of stable housing makes storage of medications and adherence tools problematic. Without a permanent residence, individuals find it difficult to establish a fixed source of health care since they are residing in temporary domiciles at different locations. Inadequate transportation, thus, also becomes a barrier to accessing services.

Homeless and marginally housed individuals are more likely than others to be mentally ill and/or chemically addicted. Their many unmet needs hinder their abilities to become ready for treatment and should be addressed before initiation of therapy so that the success of HAART may be maximized. Some tips for those working with homeless or marginally housed individuals include:

- Establish solid lines of communication within the provider team. Case managers are especially important team members for addressing social and medical needs, which can present major hurdles to individuals in need of care
- Bring program services to people. Outreach to shelters, single room occupancy (SRO) hotels, hospital emergency rooms, and other sites where homeless individuals regularly visit can help increase their access to health care systems, which is a necessary first step to adherence
- Educate providers of services to marginally housed populations about adherence and adherence programs as they will be access points for initiation of contact and valuable members of the adherence team
- Stress adherence as a broad concept of concern about one's health and health care at each encounter

INCARCERATED/POST-INCARCERATED

Over the past three decades, the United States has experienced remarkable growth in incarceration rates. There are now more than a million people serving time in local jails, state and federal prisons—a fourfold increase since the early 1970's. Nearly all of these people will return home to their families and communities after completing their sentences. This population of Americans is at high risk on a number of fronts due to high rates of infectious disease, substance use, mental illness, homelessness and unemployment.

More prisoners are leaving California's prisons and jails than ever before, beginning a difficult transition that many will fail. It is estimated that sixty-two percent of them will be arrested at least once within the next three years, and 41 percent will wind up back in jail or prison. Supporting people during the critical period just after release is critical because it is at that point when inmates face many challenges at once.

In addition to a rate of HIV infection that is triple that of the general population, people entering corrections facilities today do so with a host of problems. **When they return to the community, those problems aren't necessarily left at the gates of those facilities.** Instead, leaving incarceration can mean entering a frightening world of uncertainty from which there is little retreat—except to the way of life that led to incarceration in the first place.

Thus, as we open the doors of incarceration to release the HIV-positive ex-offender, we must be certain to open other doors, too. Many inmates' first adult encounter with the health care system occurs during incarceration, and many more struggle to find and access health care upon release. Case Management programs can help people cement a relationship with a health care provider prior to release. Typical components of such case management programs include building a relationship with the prisoner prior to release through HIV education and prevention classes and, sometimes, one-on-one HIV counseling and discharge planning.

After inmates are released from incarceration, case managers have the task of assisting these clients with services or referrals for many of the following needs:

- Housing
- Comprehensive health care that includes specialty care for diagnoses such as hepatitis C, substance abuse, and mental health disorders
- Life skills training
- Legal and parole support.

Along with housing, perhaps the biggest stressor for some of the PLWHA coming out of corrections facilities today is not living with HIV; it's making a living. The stigma of incarceration, coupled with low education levels (less than 50 percent of prisoners have a high school diploma), exacerbates the barriers to employment that underserved PLWHA face.

Equally important are efforts to prepare inmates for the challenges ahead:

- Finding a job
- Re-establishing family ties and support
- Resisting the pull of drugs and alcohol
- Addressing physical and mental health problems
- Avoiding old habits linked with previous criminal behavior.

Inmates have always been released from prisons and jails, and corrections officials have struggled with how to facilitate successful transitions.

ETHICAL CONSIDERATIONS FOR CASE MANAGERS

Cultural Competence and Social Diversity

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

(b) Case managers 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) Case managers 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.

Conflicts of Interest

(a) Case managers should be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. Case managers 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.

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

(c) Case managers 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, case managers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries. (Dual or multiple relationships occur when case managers relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively.)

Sexual Relationships

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

(b) Case managers 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 case manager and client to maintain appropriate professional boundaries. Case managers--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) Case managers should not engage in sexual activities or sexual contact with former clients because of the potential for harm to the client. If case managers engage in conduct contrary to this prohibition or claim that an exception to this prohibition is warranted because of extraordinary circumstances, it is case managers--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) Case managers should not provide services to individuals with whom they have had a prior sexual relationship. Providing services to a former sexual partner has the potential to be harmful to the individual and is likely to make it difficult for the case manager and individual to maintain appropriate professional boundaries.

Sexual Harassment

Case managers 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.

Discrimination

Case managers 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.

(Revised May 2008)