

## 8. PREVENTION CASE MANAGEMENT<sup>1</sup> (Revised: April 2006)

### 8.0 Definition

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Prevention Case Management (PCM) is an intensive multi-session individual level intervention. It targets individuals who are at highest risk for HIV transmission because of multiple and complex needs.

PCM acknowledges the relationship between HIV risk and other issues (i.e., substance abuse, STD treatment, mental health, and social and cultural factors). It integrates the strategies of prevention counseling and service brokerage to assist clients in adopting and sustaining behaviors that reduce the risk for transmission of HIV.

PCM involves the identification of HIV risk behaviors and medical and psychosocial needs that influence HIV risk taking followed by the development of a client-centered prevention plan with specific behavioral objectives for HIV risk reduction. It is different from individual-level HIV prevention counseling in that PCM is longer term and intensive in nature and also involves brokerage to supportive services. PCM is different from care case management in that PCM involves negotiation of behavioral risk reduction plans and monitors progress toward achieving objectives included in these risk reduction plans.

Michigan's model for PCM includes the following three components:

- (1) Client recruitment
- (2) A maximum of four (4) sessions of individual-level prevention counseling, for the purpose of client screening, engagement, assessment and negotiation of a six session commitment
- (3) A minimum of six (6) sessions client-centered risk reduction counseling and service referral

### 8.1 Goal

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To assist those at highest risk of HIV transmission to identify, adopt, and maintain behaviors that reduce their risk of transmitting HIV infection or for becoming re-infected.

### 8.2 Standards

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**Targeted Services.** Prevention Case Management services are to be targeted to HIV-infected persons who have attempted without success to adopt and maintain behaviors to reduce their risk for transmission or re-infection with HIV **and** who experience situational factors which influence their HIV-related risk behaviors (e.g. chronic mental illness, homelessness).

**The Prevention Case Management Process.** All agencies providing Prevention Case Management services under contract with MDCH must use the HAPIS/DHWDC Model for PCM which incorporates the following critical elements:

*Client Recruitment.* A written client recruitment plan must be developed and implemented. The recruitment plan must describe how the agency will ensuring recruitment of clients enrolled in care case management that are appropriate be referred to PCM. If the agency does not provide care case management, Memorandum of Agreement (MOA) should be established with providers of such

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<sup>1</sup> These standards replace standards for prevention case management issued by HAPIS/DHWDC in May, 2003.

services in order to facilitate referral. The recruitment plan must also address relationships with substance abuse, mental health or other health/human service providers. These relationships must be documented with a MOA.

During the first four sessions of individual-level prevention counseling screening, engagement, assessment and negotiation of a six (6) session commitment are to occur:

*Screening for Eligibility.* The HAPIS/DHWDC developed “*PCM Eligibility Tool*” must be used to identify persons at highest risk for transmitting HIV, and to determine who is an appropriate and eligible client for PCM. All persons screened for PCM, including those who are not considered to be appropriate for PCM, must be offered counseling by the prevention case manager or other appropriate agency staff, and referrals relevant to their needs should be made. Eligibility screening procedures must be responsive to DHWDC “*Guidelines for Prevention Case Management (PCM) Eligibility and Engagement*”

*Client Engagement.* A HAPIS/DHWDC developed “*PCM Engagement/Pre-Test Tool*” measures the client’s willingness to engage in PCM services. This tool shall be utilized by the agencies providing PCM. This tool shall be administered during one of the first two counseling sessions and then again on the sixth PCM session. Incentives may be utilized to facilitate client engagement.

*Assessment.* All PCM clients must participate in a thorough assessment of their HIV, STD, and substance abuse risks and their medical, prevention and psychosocial needs. Agencies must use the HAPIS/DHWDC developed “*PCM Client Assessment*”. This tool addresses the following:

- Adherence to HIV-related treatment (if relevant)
- Sexually transmitted disease history
- Drug and alcohol use
- Mental health issues and treatment history
- Sexual history
- Social and environmental support
- Risk reduction skills
- Barriers to risk reduction
- Protective factors, strengths and competencies in the client’s life related to HIV risk reduction.

PCM staff must provide clients with an informed consent document for signature at the time of assessment. This document must assure the client of confidentiality, and must lay out the client and agency roles and responsibilities in Prevention Case Management (e.g., time commitment of client, services of the agency, guidelines for discharge and grounds for termination of service if appropriate.)

*Negotiated Six Session Commitment.* Each client shall be asked to commit to six PCM sessions to work on their Prevention Plan. These six sessions count as PCM sessions, and begin after the client has agreed to participate in the program. Clients may negotiate more than six sessions, as needed and appropriate, in order to finish working on their prevention goals. Additional PCM sessions beyond the sixth should be negotiated between the client and prevention case manager, as needed to achieve prevention goals. Sessions should be held as frequently as necessary and appropriate to achieve client prevention goals. PCM sessions should be held no less frequently than once per month. Incentives may be utilized to ensure client retention.

The six sessions of prevention case management are to encompass:

*Development of a Prevention Plan.* For each client, a written client-centered prevention plan must be developed with client participation. The plan must define HIV risk-reduction behavioral objectives and strategies for change that are time-phased and achievable.

Each prevention plan must be client-specific and responsive to the individual client's needs and circumstances. Both the client and the PCM staff must sign the prevention plan. The prevention plan should specify **who** is responsible for **what** and by **when**. The plan should specify when counseling to support adherence to treatment should be provided, if appropriate. The prevention plan should describe specific referral needs and priorities.

*Monitoring and Reassessment of Client's Needs and Progress.* PCM staff must meet with clients at least six times once the client has agreed to participate in the PCM program in order to monitor their changing needs and their progress in meeting behavioral objectives. Progress must be documented in the client's confidential file.

A protocol must be established defining minimum, active efforts to retain clients. The protocol should specify when clients are to be made "inactive," according to guidance provided in "Prevention Case Management: Client Status Definitions." Inactive status should be noted in the client file using the "PCM Client Status Form."

All attempts/efforts to retain clients in the PCM program must be documented in the client file.

*Discharge from PCM.* A protocol for client discharge must be established. This protocol should include an after care plan and "relapse protocol" so that the client understands that PCM is available as needed. Client status should be documented in the client file using the "PCM Client Status Form."

**Case Load.** The case load of an individual prevention case manager is not to exceed 20 active clients.

**Coordination of Services/Referrals.** Coordination of services and completion of referrals are essential to the success of PCM. To that end:

- Memoranda of Agreement must be established with relevant service providers to ensure availability and access to key service referrals.
- Communication about a client with other providers must not occur without first obtaining signed, informed consent from the client. Consent must be specific to each provider with whom communication occurs.

PCM must not duplicate care case management for persons living with HIV, but PCM may be integrated into these services.

**Record Keeping.** Accurate and complete record keeping is essential to quality assured services. Client files are to be maintained for each client participating in Prevention Case Management. Client files must contain the following:

- A copy of the signed informed consent document
- The negotiated prevention plan with the client's signature
- Documentation of progress toward meeting behavioral objectives
- Documentation of referrals made and the status of referrals
- Documentation of discharge plans
- Copies of referral documents
- A copy of the check-off sheet for chart documents
- A copy of the HIV Event System record for each session

**Risk Reduction Tools.** Provision of risk reduction tools appropriate to a client's behavioral risk are a critical element of PCM effectiveness. Condoms must be made easily available to all clients at risk for sexual transmission/acquisition of HIV.

### **8.3 Staff Training and Development**

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In addition to the standards associated with staff training and development described in Section 1 of this document<sup>2</sup>, staff providing Prevention Case Management must:

- Successfully complete the MDCH HIV Counselor Certification Course (six days).
- Successfully complete a HAPIS/DHWDC-approved PCM training.
- Participate in MDCH-endorsed updates related to the scientific and public health aspects of HIV, counseling techniques and special topics at least every two years.

**NOTE:** Staff may **NOT** begin providing PCM prior to successfully completing the MDCH HIV Counselor Certification Course and a HAPIS/DHWDC approved training in prevention case management.

### **8.4 Supervision**

Clinical supervision of prevention case managers and PCM activities must be provided. The individual providing clinical supervision must possess appropriate credentials (e.g., MSW) and experience. It is expected that clinical supervisors will meet with prevention case managers on a monthly basis, at minimum and will conduct regular review of client charts.

### **8.5 Agency Quality Assurance Protocol**

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Each agency must develop a written protocol which addresses quality assurance in their PCM program. In addition to the standard components of quality assurance described in Section 1<sup>2</sup> of this document the protocol must address:

**Recruitment.** The protocol must describe methods that will be used to recruit clients for PCM services. This protocol must also address how the agency plans to collaborate with the care case management programs located in their area.

**Engagement.** The protocol must describe the frequency, number and time frame of contacts associated with client engagement.

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<sup>2</sup> Please refer to HIV Prevention Program Quality Assurance Standards (May 2003)

**Confidentiality and Privacy.** The protocol must describe the strategies used to ensure that client confidentiality is maintained.

**Referral.** The protocol must describe the methods to:

- Assist clients to access referrals to needed services
- Ensure coordination with relevant service providers
- Assess and document referrals

**Record Keeping.** The protocol must describe record keeping policies and procedures, including documentation of risk reduction plans, referrals and client progress toward meeting prevention goals and objectives.

**Coordination with Care Case Management.** A protocol for structuring relationships with care case management providers must be developed, that describes how to transfer and/or share clients.

## **8.6 Evaluation and Data Collection**

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Standards associated with evaluation and data collection are described in Section 1<sup>2</sup> of this document. In addition,

- Outcome monitoring is to be conducted, using HAPIS/DHWDC tools and pursuant to protocol and procedures issued by HAPIS/DHWDC.
- A system to measure client progress toward achievement of HIV prevention related goals and objectives must be developed, implemented and maintained to demonstrate program effectiveness.
- A system must be developed, implemented and maintained to monitor client utilization and satisfaction with referrals.