

Community Based Programs

Standards of Care for HIV Case Management 2011



Ohio Department of Health
HIV Care Services Section

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RYAN WHITE PROGRAM: PURPOSE & HISTORY

The Ryan White HIV/AIDS Program is the largest Federal program focused exclusively on HIV/AIDS care. The program is for individuals living with HIV/AIDS who have no health insurance (public or private), have insufficient health insurance coverage, or lack financial resources to get the care they need for their HIV disease. As such, the Ryan White HIV/AIDS Program fills gaps in care not covered by other funding sources.

The legislation that maintains the Ryan White program is the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87, October 30, 2009). The legislation was first enacted in 1990 as the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. It has been amended and reauthorized four times: in 1996, 2000, 2006, and 2009. The Ryan White legislation has been adjusted with each reauthorization to accommodate new and emerging needs, such as an increased emphasis on funding of core medical services and changes in funding formulas.

The legislation authorizes programs called Parts. The purpose is to provide a flexible structure under which this national program can address HIV/AIDS care needs on the basis of:

- Different geographic areas (large metropolitan areas, States, and communities across the Nation)
- Varying populations hit hardest by the epidemic
- Types of HIV-AIDS-related services, and
- Service system needs (e.g., technical assistance for programs, training of clinicians, research on innovative models of care).

Legislative provisions, called Sections, address planning and decision-making, type of grants that are available, what funds may be used for, requirements for entities submitting applications for funding, and available technical assistance to help programs run more effectively.

The Ryan White HIV/AIDS Program is administered by the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB).

Highlights of the 2009 Ryan White Legislation

Following is a summary of select provisions in the 2009 legislation, with references to key changes from the 2006 legislation.

- The 2009 Ryan White legislation continues the Ryan White HIV/AIDS Program through fiscal year 2013. Authorization levels increase 5 percent for each fiscal year but are dependent on annual appropriations.
- Minority AIDS Initiative (MAI) funds under Parts A and B will be distributed according to a formula (based on the distribution of populations disproportionately impacted by

HIV/AIDS), a change from the former competitive process. Also, MAI awards now coincide with grant cycles under each Part.

- Under Part A, the law continues issuance of grant awards to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs). For TGAs that lose their eligibility status, the State in which the former TGA is located shall receive incremental transfers of funding for three years.
- In addition to existing Part A planning council responsibilities, the law adds a new requirement to determine not only the size and demographics of HIV/AIDS infected individuals but also those individuals who are unaware of their HIV status. One-third of Part A supplemental grants are to be based on the area's ability to demonstrate its success in identifying individuals with HIV/AIDS who are unaware of their status and bringing attention to their status.
- Part A and Part B grantees must develop comprehensive plans that include a strategy for identifying individuals with HIV/AIDS who do not know their status and helping them seek medical services. The strategy must focus on reducing barriers to routine testing and disparities in access to services for minorities and underserved communities.
- The law continues hold harmless protections for Part A and Part B grantees for fiscal years 2009-2013.
- Part A and B grantees currently using code-based data reporting will have three more years to convert to names-based data reporting. Penalties will remain for Part A and Part B areas that report code-based data in fiscal years 2009 through 2012. In fiscal year 2013, only name-based data reporting will be accepted.
- The law makes adjustments in Part A and Part B unobligated balances (UOB) provisions. It retains the three penalties, but with some changes. The trigger for the penalty provisions changed from 2% to 5% of unobligated formula funds. If triggered, grantees are subject, in a future year, to: an offset of the amount of UOB less the amount of approved carryover, a reduction of the amount of UOB less the amount of approved carryover, and ineligibility for a supplemental award. Implementation of the UOB provisions was simplified by providing the Secretary with the option to offset unobligated funds rather than cancel those funds.
- Part D funds are not required to be used for primary care services if payments for such services can be provided from other sources (including titles XVIII, XIX, and XXI of the Social Security Act). Public and nonprofit private entities funded under Part D can now provide care through memoranda of understanding in addition to contracts.

Source: <http://hab.hrsa.gov/law/leg.htm>

STANDARDS OF CARE: PURPOSE

The Ohio Department of Health's purpose in creating Standards of Care for HIV Case Management is to:

- To ensure that the quality of case management is high and is consistent for all clients;
- To ensure that HIV case management to clients is beneficial and cost effective;
- To ensure that clients receive the best possible service;
- To ensure that the goals of standards of care are met.

STANDARDS OF CARE: GOALS

The Ohio Department of Health's goal in releasing funds for HIV Case Management is to:

- Provide accessible, and culturally competent case management services to a highly diverse population of individuals living with HIV;
- Assure that case management services are available to people with HIV and their families in every county of the State of Ohio through either a subgrantee office, satellite office, or in-home client visits;
- Assure that all individuals living with HIV have access to medical care and medications per the guidelines developed by the US Public Health Service;
- Provide information and education to people living with HIV regarding horizontal or vertical transmission, secondary infection, and resistance;
- Make individuals aware of, and assist them in, accessing healthcare related resources for which they may be eligible in order to improve the quality of their lives; and as a last resort approve the use of Ryan White Emergency financial assistance funds and/or refer individuals to other Ryan White programs;
- Provide access to quality case management services, based on the National Association of Social Work (NASW) model of case management, to as many individuals with HIV as may be interested in such services regardless of their residence location.
- Provide specialized case management to populations in service areas as identified in "Specialized Case Management Descriptions"

* Goals as stated in the ODH/HCS Federal HIV Care RFP, 2010

MEDICAL CASE MANAGEMENT

Medical Case Management services are a range of client-centered services that link clients with health 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.

Key activities include:

- initial assessment of service needs;
- development of a comprehensive, individualized service plan;
- coordination of services required to implement of plan;
- client monitoring to assess the efficacy of the plan;
- periodic re-evaluation and adaptation of the plan as necessary over the life of the client.

It 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 other forms of communication.

*As defined by HRSA

NATIONAL ASSOCIATION OF SOCIAL WORKERS

QUALIFICATIONS FOR CASE MANAGERS*

Case managers should maintain competence in their area(s) of practice by having one of the following:

- a) Current, active, and unrestricted licensure or certification in a health or human services discipline that allows the professional to conduct an assessment independently as permitted within the scope of practice of the discipline; and/or
- b) Baccalaureate or graduate degree in social work, nursing, or another health or human services field that promotes the physical, psychosocial, and/or vocational well-being of the persons being served. The degree must be from an institution that is fully accredited by a nationally recognized educational accreditation organization, and the individual must have completed a supervised field experience in case management, health, or behavioral health as part of the degree requirements.

How Demonstrated:

- Possession of the education, experience, and expertise required for the case manager's area(s) of practice.
- Compliance with national and/or local laws and regulations that apply to the jurisdictions(s) and discipline(s) in which the case manager practices.
- Maintenance of competence through relevant and ongoing continuing education, study, and consultation.
- Practicing within the case manager's area(s) of expertise, making timely and appropriate referrals to, and seeking consultation with, others when needed.

*As outlined in the CMSA Standards of Practice for Case Management, adopted by NASW 2010

CULTURAL COMPETENCY

The case manager should be aware of, and responsive to, cultural and demographic diversity of the population and specific client profiles.

How Demonstrated:

- Documentation demonstrating:
 - Case manager understands relevant cultural information and communicates effectively, respectfully, and sensitively within the client's cultural context
 - Assessment of client linguistic needs and identifying resources to enhance proper communication. This may include use of interpreters and material in different languages and formats, as necessary, and understanding of cultural communication patterns of speech volume, context, tone, kinetics, space, and other similar verbal/nonverbal communication patterns
 - Evidence of pursuit of education in cultural competence to enhance the case manager's effectiveness in working with multicultural populations.

*As outlined in the CMSA Standards of Practice for Case Management, adopted by NASW 2010

*Please refer also the "Indicators for the Achievement of the NASW Standards for Cultural Competence in Social Work Practice"

<http://www.socialworkers.org/practice/standards/NASWCulturalStandardsIndicators2006.pdf>

SUPERVISION

Supervision is a way to assist case managers in the development of their social work skills. As required by the Ryan White Part B program, an L.I.S.W. must provide on-site supervision on two hours per week average for each full time case manager and one hour per week average for each part time case manager.

Definition of social work supervision:

(Per the Ohio Revised Code, Chapter 4757-23-01)

(1) “Clinical supervision” of social workers performing social psychotherapy and social workers employed in a private practice, partnership, or group practice means the quantitative and qualitative evaluation of the supervisee’s performance; professional guidance to the supervisee; approval of the supervisee’s intervention plans and their implementation; the assumption of responsibility for the welfare of the supervisee’s clients; and assurance that the supervisee functions within the limits of their license. The assessment, diagnosis, treatment plan, revisions to the treatment plan and transfer or termination shall be cosigned by the supervisor and shall be available to the board upon request.

(2) “Training supervision” means supervision for the purposes of obtaining a license and/or development of new areas of proficiency while providing services to clients. Training supervision may be individual supervision or group supervision.

(a) “Individual supervision” means face-to-face contact between a supervisor and an individual supervisee in a private session wherein the supervisor and supervisee deal with problems unique to the practice of that supervisee.

(b) “Group supervision” means face-to-face contact between a supervisor and a small group (not to exceed six supervisees) in a private session

Purpose of Supervision

The purpose is to provide clinically-based, social work supervision for those who are not independently licensed. If an agency does not have an L.I.S.W. on staff, it should contract out for this service.

Clinical supervision should address the following:

- Clinical skill development
- Use of theories/interventions
- The helping relationship and delivery of clinical services to clients
- Case presentation
- Understanding and identification of transference/counter transference
- Continuing education
- Identification and referral to community resources
- Emotional support of case manager with regard to client-related issues
- Crisis interventions

- Clinical Documentation

Administrative supervision should address the following:

- Documentation
- Punctuality
- Relationships with colleagues
- Job performance
- Reliability
- Continuing education/ professional growth opportunities
- Emotional support to case manager in relation to job performance, organizational issues

ODH-FUNDED LISW/CASE MANAGER CLINICAL SUPERVISION TIME SHEET

Please complete this form and submit it to ODH HIV Care Services with each quarterly report. LISWs and Case Managers are encouraged to keep copies of this form for their own records. On-site supervision by an LISW on a two-hour per week average for a full-time social worker and one-hour per week average for a part-time social worker is **required** per ODH HCS funded HIV Case Management Grants.

LISW/Case Manager's Name: _____

LISW Supervisor's Name: _____

DATE	TIME	LSW INITIALS	LISW INITIALS
LSW Signature:		Date:	
LISW Signature:		Date:	

DOCUMENTATION

Importance

Documentation is needed in order to show any interactions between the client and case manager. It contributes to the client's continuity of care and ensures the most up to date information on the client is available in the client file. In addition, it verifies that proper procedures have been followed, including rules, regulations and necessary guidelines. Remember, if it is not documented, it never happened.

It is essential that there are no gaps in service for the client. By documenting every time there is contact with a client, a case manager is able to track what services are needed or have been provided as well as when a client needs to be contacted.

Basics

- Use black ink at all times.
- Write legibly.
- Fill in all of the blanks on forms. If there is nothing to document, enter N/A or put a line through the area.
- Sign off on all of your documentation.
- Be objective in your documentation.
- Ensure that your documentation is clear. When someone else reads it, will they understand what you are stating?
- Include the client name, case number and date of documentation as well as the date of contact (and differentiate between the two).
- Document chronologically.
- Do not make any entries in advance.
- Do not use correction fluid. Place a line through the error and initial it.
- Focus on goals of service plan.
- Reflect all activity or contact with client in progress notes and daily service logs.

CONFIDENTIALITY

One of the most important responsibilities of a case manager is to protect the confidentiality of a client. Confidentiality is defined as one's responsibility of not disclosing privileged information. If confidentiality is broken, the case manager can be held liable.

Guidelines

The case manager is required to have a Release of Information form completed and signed by the client or an authorized representative before information can be shared with designated service providers.

Clinical Records

- Records must be kept in a locked, secure place.
- Records must be stored and accessible for a period of seven years after the closing of the case. After the seventh year, records can be destroyed in a way that will maintain confidentiality.
- Documentation in the record should only include information significant to the client's situation, circumstance and presenting problem.
- All forms and documentation must be completed in a factual and objective manner.
- Records must include a release of information form completed by the client to show verification that information can be shared with other agencies if needed.

All agency employees and volunteers who have access to client records are encouraged to sign a statement adhering to the practice of confidentiality set forth by the agency and HCS.

Electronic Records

- Do not share your password with anyone.
- Exit the computer system when you leave your workstation.

Telephone

- Leave a greeting on your voicemail that does not identify you as an HIV Case Manager. This will prevent a third party from obtaining knowledge of a client's status if they call you.
- When a message is left for a client (if the client permits you to do so), leave only your name and your phone number.

Faxes

- If possible, the fax machine should be located in a locked, secure place, away from unauthorized personnel;
- Released confidential information should not be left unattended

- Before sending a fax, the case manager should contact the professional who is to receive the fax so that the professional is waiting for it. The professional should then contact the case manager to ensure that it was received.

Transporting Client Records and Information

Client records which are transported outside the HIV case management provider agency should be handled in a manner which ensures absolute security and confidentiality

- never left unattended
- transported in a container (envelope, file, briefcase, etc.) which does not disclose client-specific information
- handled only by authorized personnel

CASE TRANSFERS AND TERMINATIONS

Case managed clients should be assigned to a new case manager, if appropriate, after implementing the agency transfer/discharge policy and procedure process and exhausting all other options.

Transfer

A case transfer request can be initiated by:

- client request
- case manager request
- case management supervisor when he or she determines that a transfer is appropriate through routine supervision
- a client moving out of the service area
- a case manager leaving employment

The case manager should appropriately terminate case management services based upon established case closure guidelines. These guidelines may differ in various case management practice settings.

How Demonstrated:

- Identification of reasons for case management termination, such as:
 - Achievement of targeted outcomes or maximum benefit reached
 - Change of health setting
 - Loss or change in benefits (i.e., client no longer meets program or benefit eligibility requirements)
 - Client refuses further medical/psychosocial services
 - Client refuses further case management services
 - Determination by the case manager that he/she is no longer able to provide appropriate case management services (e.g., non-adherence of client to plan of care)
 - Death of the client
- Evidence of agreement of termination of case management services by the client, family or caregiver, payer, case manager, and/or other appropriate parties.
- Documentation of reasonable notice of termination of case management services that is based upon the facts and circumstances of each individual case.
- Documentation of both verbal and/or written notice of termination of case management services to the client and to all treating and direct service providers.
- With permission, communication of client information to transition providers to maximize positive outcomes.

Corrective actions should be considered when clients are not fulfilling their responsibilities. Conditions can be applied to financial assistance and/or case management. Specifically, a client can be required to attend mental health or substance abuse counseling; if specified conditions are not met, case management can be terminated until they are met. In addition, limitations on what types of financial assistance provided (e.g., only medical appointments will be paid for) can be enacted. *

NOTE: case management can still be provided; even if financial assistance is limited or suspended.

*As outlined in the CMSA Standards of Practice for Case Management, adopted by NASW 2010

QUALITY MANAGEMENT

Client Satisfaction Survey

Ohio Department of Health/HIV Care Services Section (ODH / HCS) requires a Client Satisfaction survey be distributed to clients every other year during the months of October through March. The survey will be used to provide the agency and ODH/HCS with feedback regarding the performance of an agency. The survey will assist agencies and case managers in becoming more aware of client and community needs, and will provide feedback regarding an agency's performance in helping clients achieve their goals. The agency will summarize the results of the survey utilizing the standardized spreadsheet provided by ODH/HCS. The summarized results will be due at the time of the first quarterly report of the grant year (July 15).

Quality Management

Every Ryan White Part B provider agency should have a quality management program in place, which evaluates HIV case management services based on established case management standards. Quality assurance may include peer review, independent chart audits, and/or other measures of program performance which assess the quality, quantity, and outcome/impact of case management services. These measures are used to examine the case management process and not individual case manager performance.

Program Reports and Reporting Requirements

The administrative staff of HIV case management agencies should complete a quarterly case management program report which documents progress on the work plan objectives, major program activities, accomplishments achieved during the previous quarter and areas requiring additional resources or program improvements. Program evaluation should be conducted on an ongoing basis. Case management data collected as part of grant reporting requirements should be utilized in evaluating case management services throughout the year.

Case Management Outcomes Measures

The purpose of the Case Management Outcome Measures is to assess the impact that case management has on Ryan White Part B case management clients. The results of case management are examined to see what services and information are being provided and if they are being utilized. Improvements to life situations, access to community resources, the reduction of barriers in one's life, and one's knowledge of their environment are examples of what is evaluated. The measures are completed in the CMIS system.

CASE MANAGEMENT CLINICAL AUDIT STANDARDS

The purpose of Case Management audits is to ensure that the program standards and guidelines for Ryan White Part B HIV Case Management funding are met. The goal of the HIV Care Services Section auditing process is to provide assurance that optimal quality HIV case management services are being provided to consumers throughout the State of Ohio.

A clinical audit tool was developed to incorporate the Standards of Care. The Standards were derived from the National Association of Social Workers (NASW) Standards of Social Work Case Management and the NASW Code of Ethics. This audit tool is used to evaluate the timely completion of forms, how Ryan White Emergency Assistance funds are administered, how case managers incorporate assessments and interventions while collaborating with the clients and the overall social work practice is demonstrated. At the conclusion of the audit, preliminary results are provided to the agency's Executive Director. In addition, a narrative summary highlighting the case managers' strengths and areas for growth is mailed to the agency. The audit may also include an audit checklist. Only the areas that can be reasonably corrected will be included on the checklist. The ODH/ HCS audit checklist must be completed and returned to ODH/ HCS with original signatures (LSW and LISW signatures) by the date requested. The clinical audits occur on an annual basis. Each agency is given a 30-day advance notice of the audit date.

Should an agency fail to meet acceptable standards (75%) for any standard, the HIV Case Management Coordinator will follow up with the agency to schedule a plan of correction meeting and to discuss the re-audit process. Per the 2011 RFP, any agency which scores between 75% and 80% overall or on any standard will be required to submit a written plan of correction to address the deficient areas. The plan must include training with Jennifer Landau, ODH/HCS trainer. The plan will then be monitored during targeted trainings and technical assistance, as well as routine site visits.

Completion of Forms

FORM OR CONTACT	EXPECTED COMPLETION	UPDATED
Client Data Intake Report (CDIR)	Within 30 days of intake (completed in CMIS)	Annually and as changes are known, including transfers to a new case manager
Written documentation of HIV Status* Documentation of current Ohio Residency* Income verification *All forms should be obtained prior to providing RWEA.	At intake At intake At intake	N/A Annually and as changes are known Annually and as changes are known
Release of Information (ROI) form for all coordinated services and the primary case and/or ID physician	Prior to communication with designated service provider(s)	180 days
Psychosocial Assessment (PSA) -signed, dated & credentialed on the last page and each page initialed by the case manager	Within 30 days of intake	Annually
Individual Service Plan (ISP) – signed and dated by both the client and case manager, including case manager’s credentials	Within 30 days of intake	Every 6 months
Case Management Outcome Measures (CMOM)	Within 30 days of intake (completed in CMIS)	Every 6 months

Fiscal Accountability

The case manager and agency must adhere to Ohio Department of Health and HRSA guidelines when administering RWEA funds:

- Prior to authorizing RWEA, income verification must be obtained. Income verification should also be updated on an annual basis. If Medicaid eligible, the client must utilize Medicaid prior to requesting RWEA assistance.
- Case managers must ensure that Ryan White funds are used as a last resort for an emergency need and are noted as such in the case notes.
- Pre-approvals for core medical services must be documented in the file.
- Agencies must follow ODH policies and procedures when submitting exceptions to the guidelines. All exceptions submitted to ODH must be placed in the file with the ODH response.
- Funds are only fronted for allowable services as indicated on the Service Category Code List.
- ODH imposed caps on services are not exceeded.

Assessments/Interventions

Psychosocial Assessment (PSA)

The Psychosocial Assessment is inclusive of the following:

- Insurance status
- Medical information (including medical history and medications)
- Legal assistance needs
- Legal history
- Sources of social/emotional support
- Alcohol/drug use history
- Mental health treatment history
- Housing status
- Ability to care for self/level of care
- Employment information
- Financial information (income vs. expenses)
- Services offered/requested

Individual Service Plan (ISP)

The Individual Service Plan is inclusive of the following:

- The goals are outlined and match the assessed problems/needs specific to the client.
- The actions documented on the ISP are measurable and identify the specific steps the client or case manager will perform to achieve outcome indicated on the ISP.
- Agencies or professionals that are referenced in case notes or the PSA are also indicated on the ISP.
- For those goals identified, the action steps on the ISP specify the responsibilities of both the client and case manager.
- For those goals identified, referrals have been identified in the plan.
- Specific target dates or dates of reassessment are documented on the ISP.

Case Management Notes

The case notes are inclusive of the following:

- Are descriptive of client's psychosocial, medical and socio-economic status.
- Reasons that any services were denied or unavailable are document in the case notes.
- Show contact with the client/support system at least every 6 months.
- Documentation reflects that clients have been informed of purpose of service and limitations.
- The documentation demonstrates the case manager advocated to obtain services as needed and/or advocated for the client to follow-up on a referral.
- Follow-up regarding missed appointments with case manger or other service providers.

- Follow-up regarding client usage of services.
- Crisis intervention provided is documented.
- Copies of correspondence are in the file.
- Case Notes document communication with the client regarding case transfer(s) within the agency.
- If the case was closed: is it justified and appropriate? Are referral documented?

Case note do not:

- Contain inconsistencies, contradictions or ambiguous statements.
- Leave unexplained gaps in services (i.e., case notes show appropriate interventions/referral are made).
- Contain unsubstantiated “impressions.”
- Contain personal information about the case manager or other staff.

Quality of Care

As a result of case management, and dependent upon the client’s level of functioning, it appears there was impact in terms of:

- Improved/maintained self-sufficiency
- Improved/maintained access to services

Social Work Practice

The case manager demonstrates adherence to the NASW Case Management Standards and Code of Ethics based on the following evidence:

- Chart documentation demonstrates that no conflict of interest exists, which includes no dual/multiple relationships with clients (or former clients).
- The documented assessments and interventions do not exhibit insensitivity to ethnicity, age, sex, sexual orientation or cultural issues.
- The case notes and other forms demonstrate expertise of HIV intervention issues/concerns through documented assessment and interventions.
- Chart documentation demonstrates the case manager provides information/education to people living with HIV regarding transmission, secondary infection and resistance.
- Chart documentation demonstrates that the case manager refers the client to the appropriate professional for medical or other clinical issues for which social workers are not trained.

The case notes demonstrate adherence to the NASW Code of Ethics by including evidence of:

- **Self Determination (1.02)**
The respect and promotion of the rights of clients to self-determination and assistance to clients in efforts to identify and clarify their goals (exceptions include instances in which harm to self or others is assessed).
- **Informed Consent (1.03)**
HCS requires all community-based agencies providing Part B Case Management and allocation of RWEA funds to have a completed Informed Consent for Services form on file.
- **Privacy and Confidentiality (1.07)**
Confidential information will only be disclosed with appropriate, valid consent from a client or person legally authorized to consent on the behalf of a client is obtained. HCS suggests long-term coordination of, or communication regarding services, be in the format of a written release. Short-term/one time only coordination or communication of services may be documented as verbal permission by the client (or legally authorized person) if congruent with interagency policies. An emergency telephone authorization with another professional on the line may be acceptable if there is no other alternative and is congruent with interagency policies, except information regarding HIV status, mental health, and/or substance abuse information. This information must have a written

release.

- **Respect (2.01)**
There is no negative criticism of colleagues and/or other professional (specifically demeaning comments regarding other professionals' levels of competence).
- **Client Records (3.04)**
Reasonable steps are taken to ensure accurate, sufficient, and timely documentation to facilitate the delivery of services and ensure continuity of services.

The case notes demonstrate the Standards of NASW Case Management are being practiced, and documentation specifically reflects:

- **Standard #3**
Clients are involved in all phases of case management practice to the greatest extent possible (specifically indicated through case note entries and Individualized Service Plans).
- **Standard #5**
Intervention documented is at the client level to provide and/or coordinate the delivery of direct services to clients and their families (the definition of families is inclusive of others significant to the client). This entails: a Biopsychosocial Assessment, development of a service plan, implementation of a service plan, coordination/monitoring of a service plan, advocacy for the client/client resources, reassessment (as needed) and termination (as appropriate).

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