CASE MANAGEMENT SERVICE STANDARDS

UTAH DEPARTMENT OF HEALTH

2021-2022
Ryan White Part B Program
Bureau of Epidemiology
Division of Disease Control and Prevention

TITLE: Medical/Non-Medical Case Management Service Standards **PROGRAM:** Ryan White Part B **SECTION:** Service Standards	UTAH DEPARTMENT OF HEALTH
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SECTION 1.0 INTRODUCTION

1.1 ACRONYMS

ART- Antiretroviral Therapy
BS- Benefits Specialist
CD4- Cluster of Differentiation 4
CM- Case Manager
DAP- Data, Assessment, Plan
DLA-20- Daily Living Activities 20
HRSA- Health Resources and Services Administration
MCM- Medical Case Management
NASTAD- National Alliance of State and Territorial AIDS Directors
NMCM- Non-Medical Case Management
PLWH- People Living with HIV
PSA- Psychosocial Assessment
ROI- Release of Information
RWB- Ryan White Part B
SMART- Specific, Measurable, Achievable, Realistic and Time-bound
SP- Service Plan
UDOH- Utah Department of Health

1.2 DEFINITIONS OF TERMS

Action Step: A plan with steps listed to achieve a specific goal in the SP. The purpose is to clarify required resources to reach the goal, formulate a timeline, and identify the responsible person to complete the task(s).
BS: Works in conjunction with MCMs and NMCMs to ensure clients receive and/or maintain eligibility for the Program. BSs also assist clients to access medical and support services and educate clients on Program benefits.
Case Management Agency: Agency contracted by the UDOH for the Program to provide CM services.
Client Record: Location where protected client information and documentation is located, this includes ClientTrack© and other as identified.
CM: A social worker, social service provider, nurse or health provider that focuses on MCM or NMCM. The CM is involved with a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet a client's needs based on their circumstances.
HRSA: The federal entity that administers Ryan White funding.
MCM: Medical CM includes all types of CM encounters (e.g. face-to-face, phone contact, and any other forms of communication). MCM provides a range of client-centered activities focused on improving health outcomes along the HIV Care Continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers.
NMCM: Non-medical CM provides client guidance and assistance to access medical, social, community, legal, financial, and other needed services.
Program: Utah Ryan White Part B Program.
Re-engagement: Clients who re-establish care through a CM agency or HIV provider after a period of not receiving HIV primary care.

Service Standards: Establish the minimal level of service or care that an RWB funded agency or provider may offer within a state, territory or jurisdiction. Each RWB funded service category has service standards.
Transition: a change in level or location of service.

1.3 Service Category Definition

CM activities consist of a collaborative process to assess, plan, facilitate, coordinate care, evaluate, and advocate for needed services based on client circumstances. CMs work with the client to identify appropriate resources and services to assist in meeting their medical, socioeconomic, and psychosocial needs. Service Standards established by the UDOH Program describe the minimum CM service delivery standards to ensure consistent, quality care is implemented by each contracted agency.

1.4 Acknowledgement

According to NASTAD, HIV/AIDS program Service Standards ensure high quality care and improve client and public health outcomes. NASTAD emphasizes Service Standards are essential to clients, service providers, grantees and quality management personnel. Service Standards establish minimum service provision expectations for the client, and define core components of each funded service category. The Program ensures benefits to the client and the service provider through:

- A consistent process to develop Service Standards
- Access to clearly defined CM service expectations for contracted service agencies
- A framework to measure performance, improve quality of care, client satisfaction and health outcomes
- Promoting high quality CM services

To ensure PLWH in Utah receive the highest quality of care, Service Standards are developed through collaboration with other States, HRSA, NASTAD, the UDOH Program and contracted agencies.

SECTION 2.0 UTAH CASE MANAGEMENT MODEL

The UDOH Program is currently funded to provide MCM and NMCM.
https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

MCM provides proactive, holistic, client-centered services to RWB clients. MCMs have knowledge and training to manage client medical needs, and to participate in interdisciplinary client case conferences to coordinate and provide specialized comprehensive intensive CM along the HIV continuum of care. Clients who have multiple barriers to adhere to treatment necessary to achieve or maintain viral suppression, with complex medical needs, and with comorbidities are appropriate for MCM services. The MCM works with the client to develop an appropriate SP and to coordinate care to ensure the client's needs are identified, interventions are implemented, and care is optimized to improve health outcomes.

NMCMs work with clients who are self-sufficient and have one-time/short-term needs to provide proactive, holistic, client-centered support and services. The focus is to improve health outcomes through access to support services, adherence-related needs, psychosocial services coordination, and referral/follow-up based on the client's unique needs and barriers.

MCM and NMCM follow Service Standards to coordinate access to appropriate levels of medical and support services. A client needs assessment will determine if services are provided in a community or clinic setting to support linkage to medical care and social services. Ongoing reassessment promotes continuity of care. MCMs and NMCMs practice culturally competent and linguistically appropriate service provision. Interactions with clients may be face-to-face (in an office and/or clinic setting or in the field such as in a client's home or other public space), via telephone, or other form of communication tailored to the client's circumstances.

CM can be provided on a long or short-term basis. Clients are evaluated during the assessment process to determine how much time is needed to enable and empower clients to manage and maintain their own health. The level of CM can be separated into three categories:

1. **Self-Management**
    - Competency in HIV disease, risk reduction, and how treatment impacts positive health outcomes
    - Engaged in care and is treatment adherent
    - Undetectable viral load
    - No major barriers to care
2. **NMCM**
    - Needs education regarding HIV disease, risk reduction, and how treatment impacts positive health outcomes
    - Viral load is less than 200 copies or undetectable
    - Identified barriers
3. **MCM**
    - History of non-adherence to ART treatment or on-going medical care
    - HIV new diagnosis
    - Needs education regarding HIV disease, risk reduction, and how treatment impacts positive health outcomes
    - Viral load unknown, or greater than 200 copies
    - Multiple co-morbidities and health conditions
    - Identified barriers

SECTION 3.0 EXPECTATIONS & REQUIREMENTS

3.1 POLICY AND PROCEDURE EXPECTATIONS

Each agency providing CM services develops written policies and procedures pertaining to RWB clients. Policies are reviewed and updated as needed annually. See the Universal Service Standards for more information on the following policies:

• Confidentiality and ROI • Client's Rights and Responsibilities • Interdisciplinary case review • Grievance • Linguistic Services • Transition • Broken Appointment	• Re-engagement to Care • Safety Plan • Home Visit Protocol • Employee Self-Care • Scheduling a regular appointment for client to meet with CM and BS • General Agency Operation

3.2 CASELOAD EXPECTATIONS

A caseload consists of a number of clients served under a professional provider (e.g., social worker, CM, nurse, teacher, etc.). A caseload does not account for the expanded roles that are needed to achieve positive outcomes. An appropriately sized caseload is essential to provide quality CM, create effective communication channels between clients, streamline service provision, meet client needs and prevent confusion.

An average caseload expectation for MCM is between 20-30 clients, and for NMCM is between 40-80 clients. The assigned caseload may vary depending on the setting, acuity, and holistic view of each client and the workload.

A workload refers to a continuum of activities (direct and indirect services) provided to and on behalf of the client to ensure compliance and quality of service. The activities include, but are not limited to: direct service delivery, travel, documentation, reports, research on resources, consultation and collaboration with interdisciplinary team, and family, etc.

3.3 EDUCATION REQUIREMENTS

Role	Minimum Requirements
MCM NMCM	One year of paid employment/professional experience providing CM services, excluding internships **AND** one of the following: • Bachelor of Social Work • Social Service Worker Certification (SSW) • Bachelor of Science in Nursing • Bachelor degree in Health or Human Services **OR** Five years of paid employment/professional experience providing CM services, excluding internships
CM Supervisor	One year of paid employment/professional experience providing CM services, or other comparable experience in a Health or Social Services associated field working with PLWH or persons with history of mental illness, homelessness, or chemical dependence, excluding internships (preferably with one year of supervisory or clinical experience) **AND** one of the following: • Licensed Clinical Social Worker (LCSW) • Master of Social Work (MSW) • Master of Science in Nursing (MSN)

3.4 TRAINING REQUIREMENTS

MCM and NMCM Training Requirements

- Agencies awarded Program funding for MCM and/or NMCM complete training within six months of hire, then annually, unless specified otherwise.
- Potential training opportunities are approved through the UDOH, Ryan White Part B Administrator.
- Agency supervisors monitor compliance with training requirements.

MCM and NMCM Training

Training Topic	Frequency	Responsibility
PSA, DLA-20, SP, and Transition	One-time or as needed	• The Program trains all current CMs with new updates • CM Agency trains all new and current CMs
HIV 101	One-time or as needed	CM Agency
QPR (Question, Persuade, Refer) - Suicidal Prevention	One-time or as needed	CM Agency
RWB CM Service Standards, all other service standards, clinical quality management plan, and policy manual	Annually	• The Program provides the CM agency all updated service standards, policy manual, and clinical quality management plan • CM Agency trains all new and current CMs
ClientTrack©	Annually	• The Program trains all current CMs • CM Agency trains all new and current CMs
HIV Medication 101	Annually	CM Agency
Harm Reduction	Based on expiration date	CM Agency

MCM Training

Training Topic	Frequency	Responsibility
ART Medications	Annual or as needed	CM Agency
HIV Counseling	Based on expiration date	CM Agency

Measure

Documentation of completed training within the service standards timeframe. This can be demonstrated through certification and attendance sign-in sheets, and is available in the employee personnel file.

SECTION 4.0 SERVICE DELIVERY

4.1 SUMMARY OF FUNCTIONAL ROLES

4.1.1 DAILY LIVING ACTIVITIES-20 (DLA-20)

The DLA-20 is a validated functional assessment tool used to assist planning and coordination of services for PLWH. It reliably assesses a client's functioning in 20 different areas of daily living. It guides prioritization of client needs and determines the appropriate level of support and service. This information is used when establishing the SP.

Standard
• The DLA-20 assessment is completed for clients enrolled in a CM service. • The initial DLA-20 is completed within 30 business days after intake and eligibility determination. • An updated DLA-20 is completed every three months or as needed after the initial DLA-20.
Expectation
• Complete assessment face-to-face, with the client present, or through telehealth. • Ensure appropriate ROI is obtained and in client record. • Gather information from client self-report and a variety of sources, including providers serving the client and the client's collaterals. • Complete the DLA-20 to determine the level of CM and client interaction (see the DLA-20 assessment for the level of interaction). • Use the DLA-20 to determine case assignment and to ensure even work load distribution. • Use the DLA-20 as a guide to assist clients in creating a SP.
Measure
• Documentation of completed initial/updated DLA-20 in client record within the Service Standard timeframes. • Documentation of all interactions and correspondence related to DLA-20 in the client record within the Service Standard timeframes.

4.1.2 PSYCHOSOCIAL ASSESSMENT (PSA)

The PSA is used to conduct a comprehensive assessment of current and past events of client's medical, physical, mental, psychosocial and emotional health, to determine needs and the ability of the client to function within the community. The PSA provides a framework to guide discussion with the client to identify and understand the client's situation in order to provide appropriate interventions and referrals. The PSA collects the information needed for the CM to create a SP with the client.

Standard
• The PSA is completed if the client is enrolled and ready to participate in CM services. • The initial PSA is completed within 30 business days after intake and eligibility determination. • An updated PSA is completed annually or when there is significant change in a client's status.
Expectation
• Complete assessment face-to-face, with the client present, or through telehealth. • Ensure appropriate ROI is obtained and in client record • Gather information from client self-report and a variety of sources, including providers serving the client and the client's collaterals. • Use the PSA as a guide to assess client resources and strengths, including family and other support when creating a SP.
Measure
• Documentation of completed initial/updated PSA in client record within the Service Standard timeframes. • Documentation of all interactions and correspondence related to PSA in the client record within the Service Standard timeframes.

4.1.3 SERVICE PLAN (SP)

The SP directs services provided based on prioritization of needs identified in the DLA-20 and the PSA. This process supports the client's self-determination and empowers them to actively participate in the planning and delivery of services.

Standard
• The initial SP is completed within 30 business days after initial PSA completion. • An updated SP is completed at minimum every six months after initial SP completion, or more often as needed.
Expectation
CM collaborates with client to: • Identify and prioritize needs based on results of the DLA-20 and the PSA. • Strategize optimal adherence e.g., medication management, medical appointments, CD4, and viral suppression (if applicable). • Create goals and action steps that are SMART. • Provide support services and referrals consistent with the goals outlined in the SP. • Engage through close monitoring, and modify SP until goals are met. • Monitor through ongoing data gathering and frequent observation. SP documentation includes: • Identified DLA-20 and PSA needs. • Plans for communication with the client's primary medical team and mechanism of feedback to ensure adherence (if applicable). • SMART goals and action steps. • Client's education on relevant topics (e.g. medication, side effects, general health literacy, and risk reduction). • Linkage to other community services. • Progress summary of the overall SP at a minimum of every six months.
Measure
• Documentation of completed initial/updated SP in client record within the Service Standard timeframes. • Documentation of all interactions and correspondence related to SP in the client record within the Service Standard timeframes.

4.1.4 TREATMENT ADHERENCE

A client may have difficulty with the demands of treatment adherence. Reasons for poor HIV treatment adherence are varied and may include, but are not limited to: client's challenges related to new diagnosis, trauma, age, health education, psychosocial, neurocognitive issues, mental health, and substance use.

Standard
• The client receiving MCM services has goal(s) based on medication/treatment adherence needs identified in the DLA-20 and PSA documented in the SP. • An interdisciplinary team meeting is held for the client receiving MCM services at a minimum of every six months or more often as needed.
Expectation

• Assess and identify client needs, barriers, and readiness to engage in treatment.
• Work with client to develop SP based on client's lifestyle, this may include scheduling appointments with providers and appointment reminders.
• Provide client education on:
  ○ HIV and risk reduction.
  ○ Disease management and treatment adherence including information and expectations for medications, lab results (CD4, viral load), medical appointments, and how to access appropriate support services.
  ○ Medication and side effects challenges, barriers, and importance of medication adherence, and consequence of missing doses.
• Identify and offer available tools to support adherence. These include pillboxes, pocket-sized medication records, reminder sheets, text reminder systems, etc.
• Establish linkages, relationships, and appointments with medical providers for treatment adherence.
• Report to medical provider for follow up (with appropriate ROI).
• Interdisciplinary team meeting documentation for the client includes:
  ○ Date
  ○ Participating interdisciplinary representation
  ○ Issues and concerns
  ○ Follow-up plan and verification of implementation

Measure
• Documentation of treatment adherence goal(s) as part of the SP in client record within Service Standard timeframes. • Documentation of interdisciplinary team meeting(s) in client record within the Service Standard timeframes. • Documentation of all interactions, correspondence and overall progress summary related to treatment adherence in the client record within Service Standard timeframes.

4.1.5 REFERRAL AND FOLLOW UP

Referral and follow up may be indicated to meet client-specific needs and eliminate barriers.

Standard
• A current and comprehensive list of internal and external providers and community services to support clients is maintained by the CM agency. • Appropriate, timely referral, and follow up based on client's needs and barriers. • Documentation of referral follow-up within 14 business days.
Expectation
• Referral is appropriate to client situation, lifestyle, and need. • Facilitate client access to referrals. • Referrals initiated at the time of identified need. • Follow-up to monitor completion and outcome of referral.
Measure
Documentation of all interactions and correspondence related to referral(s) and follow up in the client record within the Service Standard timeframes.

4.2 TRANSITION

See Universal Service Standards for transitions in care and case closure expectations.

4.3 RE-ENGAGEMENT

In addition to the Universal Service Standards expectations, specific CM expectations related to re-engagement are outlined below.

Standard
• The agency follows the policy and procedure for client re-engagement. • Assessments are completed for client re-engagement in CM services.
Expectation

• If client transitioned out of the Program for less than one year, the CM will:
  ○ Update the PSA
  ○ Complete a new DLA-20
  ○ Complete a new SP
• If client transitioned out of the Program for more than one year, the CM will complete a new:
  ○ PSA
  ○ DLA-20
  ○ SP

Measure
• Documentation of new/updated client re-engagement assessments in client record within the Service Standard timeframes. • Documentation of all interactions and correspondence related to re-engagement in the client record within the Service Standard timeframes.

4.4 DOCUMENTATION

See Universal Service Standards for general documentation guidelines and expectations. The standard below is specific to CM.

Standard

Appropriate documentation in the client record within 24 business hours of client related interactions or activities. The types of activities to document include:

- Assessment
- Problem
- Pertinent social, economic, and health factors
- Prognosis
- Interventions
- Application / Recertification
- SP
- Treatment progress
- Interdisciplinary case review
- Referrals and follow up
- Case transfer, closure and termination (or transitions of care)

Expectation

- Document interactions with client, providers, or community agencies that pertain to the client via face-to-face, emails, or phone conversation.
- Data, Assessment, and Plan (DAP) documentation are all in each progress note.

D
- What did the client say?
- What did you observe?
- Include both non-verbal and verbal communication.

A
- What is the presenting situation?
- What is the client's mental/physical state?
- Include CM educational conclusion about the client situation.

P
- Intervention to the overall client situation.
- Identify next visit date (any topic to be covered by next visit).
- What is your plan of action?
- What are your and/or the client's responsibilities?
- What is your follow up plan with the client?

Measure

Documentation of appropriate information regarding client interactions and correspondence in client record using the DAP format within the Service Standard timeframes.

SECTION 5.0 APPENDIX

5.1 WHAT IS HOLISTIC CASE MANAGEMENT

CM uses a multi-step holistic approach to focus on mental, psychosocial, and physical aspects of health. This approach ensures timely access to services and resources needed to alleviate barriers.

CMs may be social workers, social service providers, nurses, health providers, or other professionals who work with clients to support them accessing care, removing barriers and bridging gaps to meet client needs. CM core emphases consist of:

Service: CM applies knowledge and skills to support bio-psychosocial well-being, and to address challenges faced by clients. CM prioritizes services to clients beyond professional or personal self-interest.

Social Justice: CM pursues change to decrease poverty, discrimination, oppression, and other forms of social injustice experienced by clients. CM provides services in a culturally and linguistically appropriate manner and acts on client and systemic levels to ensure client participation in decision-making to access needed information, services, and resources.

Human Dignity and Worth: CM works with clients in a caring manner, respecting their self-determination, and valuing their strengths. CM strives to increase client capacity to improve situations and accomplish goals.

Integrity: CM acts in accordance with the mission and values of the organization and practices ethical principles and standards. They use the power inherent in the professional role responsibly. CM embarks on all actions with respect for clients' goals, exercising judicious use of self, avoiding conflicts of interest, and applying professional judgment in presenting resource options and providing services to clients.

Competence: CM practices within area of competence and persistently strives to develop knowledge and skills related to CM and the population served. CM recognizes self-care is essential to being present for clients and attends to self-care accordingly.

5.2 SELF-CARE

Working in a stressful environment can create burnout for CMs. It is important for the CM to practice physical, emotional, and social self-care. Recognizing stress and implementing effective coping mechanisms improve self-care. Below are coping mechanisms from Substance Abuse and Mental Health Services Administration (SAMHSA) to consider when experiencing burnout.

Time Management:

- Make a daily plan of tasks.
- Prioritize the list. Identify tasks that have to be done today (A's), from those which could be done tomorrow (B's), and tasks which are not that important (C's). You may need to adjust and revise your list. There may be times when reviewing your list with your supervisor is beneficial.
- Be sure to do your "A" tasks first.
- Keep list simple and realistic.

- Carry your list with you – consult it often.
- Let your list be your guide.
- Set appointments with clients to provide CM services and stick with it. If they are not there for the appointment, reschedule. They will learn they can rely on you and they are responsible to be there on time.
- Be on time. Treat clients the way you want to be treated.
- Always ask "what is the best use of my time right now?"
- Do not always work on other people's "A" tasks at the expense of your own.

Stress Management:

- Talk with staff and your supervisor about your experience and feelings. Sharing with others helps to reduce the tension and find humor in difficult situations.
- Learn how to use relaxation exercises.
- Use humor appropriately.

Recognize the Stages of Burnout:

- Stage I – Early Warning Signs: vague anxiety, constant fatigue, feelings of depression, boredom with one's job apathy.
- Stage II – Initial Burnout: Lowered emotional control, increasing anxiety, sleep disturbances, headaches, diffuse back and muscle aches, loss of energy, hyperactivity, excessive fatigue, and moderate withdrawal from social contact.
- Stage III – Burnout: skin rashes, generalized physical weakness, strong feelings of depression, increased alcohol intake, increased smoking, high blood pressure, ulcers, migraines, severe withdrawal, loss of appetite for food, loss of sexual appetite, excessive irritability, emotional outbursts, irrational fears (phobias), rigid thinking.
- Stage IV – Burnout: asthma, coronary artery disease, diabetes, cancer, heart attacks, severe depression, lowered self-esteem, inability to function on the job and personally, severe withdrawal, uncontrolled crying spells, suicidal thoughts, muscle tremors, severe fatigue, over-reaction to emotional stimuli, agitation, constant tension, accident proneness, and carelessness, feelings of hostility.
- Act to deal with your burnout if you recognize it.
- Talk to your supervisor for assistance.
- Take time-outs. These can be mini time-outs, such as taking the afternoon off, or longer vacations.
- It is okay to say you are having a difficult time. We all do at times. It is not okay to ignore the stress symptoms and do nothing about them.
- Cultivate pleasurable activities and hobbies that will offer you balance and peace.
- Develop a positive, nurturing support system.
- Set limits with yourself and others. Know your own boundaries.
- Exercise regularly.

5.3 WHY IS CASE MANAGEMENT IMPORTANT FOR PEOPLE LIVING WITH HIV

Current treatment has changed HIV significantly from what was once a perilous, terminal condition to a chronic, manageable disease. PLWH have the potential to live long, productive, fulfilling lives; however, many people experience significant barriers, which prevent them from accessing or receiving the benefits of available treatment options. The barriers and challenges present in the lives of many PLWH indicate that optimum HIV care requires a comprehensive approach in which CM services are of significant importance, as the CM links clients to services and treatment, and monitors delivery of care.

Not all PLWH need CM or on-going services to manage and maintain medical care. The focus of CM is to advocate, support, educate and assist the client in accessing community resources to meet current needs, decrease barriers to care and move towards self-sufficiency.

Regardless of educational background, CMs can provide effective CM to PLWH. This is enhanced through training in the following areas:

- CM process (intake, assessment, SP development and implementation, service coordination, monitoring, evaluation and documentation)
- Motivational interviewing
- Oral, written, and general communication skills
- Professional rapport and maintaining relationships
- Program services
- Community organization/resources
- Basic working knowledge of HIV/AIDS
- Basic understanding of ART
- Record keeping and documentation
- Knowledge of current HIV/AIDS standards of care
- Setting boundaries
- Cultural competency
- Self-care
- Trauma informed approach

5.4 CHRONIC DISEASE MANAGEMENT

Chronic disease management is an approach to health care which supports clients in maintaining independence and optimum health through early detection and effective management of chronic conditions. This approach prevents deterioration, reduces risk of complications, prevents associated illnesses, and enables people living with chronic conditions to have the best possible quality of life. A client's ability to follow medical advice, accommodate lifestyle changes, and access appropriate support are all factors that influence successful management of an ongoing illness. PLWH need support and information to become effective managers of their own health. Chronic conditions require both medical and behavioral interventions. Clients play a large role in managing chronic conditions such as HIV. Each client is unique, and appropriate interventions are customized to influence the client's desired outcomes. The following are essential to meet the needs of the client:

- Early access to and maintenance of comprehensive health care and social service,
- Involvement in and optimal use of the health and social service systems
- Integration of services provided across a variety of settings
- Enhanced continuity of care
- Agreement on medical treatment goals for effective adherence
- Basic information about HIV and treatment
- Prevention of HIV transmission
- Understanding of medication adherence to control HIV and sustain viral suppression
- Understanding of, and assistance with, self-management skill building
- Ongoing support from members of the health care/CM team, family, friends, and the community
- Personal empowerment

5.5 CLIENT-CENTERED APPROACH TO HIV CASE MANAGEMENT

Carl Rogers is considered the founder of the client-centered approach, which he developed in the 1940s and 50s. Three elements are key to effectively practicing a client-centered approach:

1. Be unconditionally positive.
2. Be genuine.
3. Practice empathetic understanding.

The essential principle of the approach is that all people have an innate inclination to strive toward growth, self-actualization, and self-direction. Comprehending how the client identifies resources and priorities for utilizing services to meet their needs is crucial for a client-centered CM relationship. One of the most difficult challenges for a CM is to see a client make a choice which may result in negative outcomes, and which are in conflict with the CM's best guidance. In these situations, the CM continues to nurture and encourage as the client experiences the consequences of their choices. This builds a trusting relationship between client and CM and provides a non-judgmental environment where the client feels safe to return when support is needed.

It is the CM's responsibility to:

- Offer accurate information to the client
- Assist the client in understanding the implications of the issues facing them and of possible outcomes and consequences of decisions
- Present options to clients from which they select a course of action or inaction
- Offer direction when it is asked for, or when withholding it would place the client or someone else at risk for harm
- Set appropriate boundaries and expectations
- Advocate for the client
- Show respect and dignity
- Promote self-efficacy and self-sufficiency
- Value and follow guidelines of privacy and confidentiality

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Revise Date	Title of Reviewer	Change Description or Location
2021.04.06	Quality Coordinator	Aligned verbiage across DLA-20, PSA, SP, Treatment Adherence, Referral & Follow-up, Re-Engagement and Documentation sections. Page and section header formatting.
2021.04.01	RWB Administrator	Finalized the changed on 1.1, 1.2, 3.2, 3.3, 3.4, 4.1.2, 4.4
2021.03.19	Quality Coordinator	Formatting, grammar and punctuation throughout. Alphabetized references. Other recommendations for improvement provided to RWB Administrator for consideration.
2021.03.18	RN Quality Consultant	Spelling, consolidation and removal of duplicated information throughout document, moved forms and SS contact to appendices
2021.03.15	RWB Administrator	Update the date of review, table of content, definition, formatting and grammar throughout the service standards, education requirement, training requirement, section 4.0, 4.4, and 5, and reference page.

Approval Group	Review Date
RWB Administrator: Seyha Ros	2021.04.01
Quality Coordinator: Marcee Mortensen	2021.04.06
Senior RN Quality Consultant: Vinnie Watkins	2021.03.24
RWB Program Manager: Tyler Fisher	2021.04.07
Director, Bureau of Epidemiology: Sam LeFevre	2021.04.08