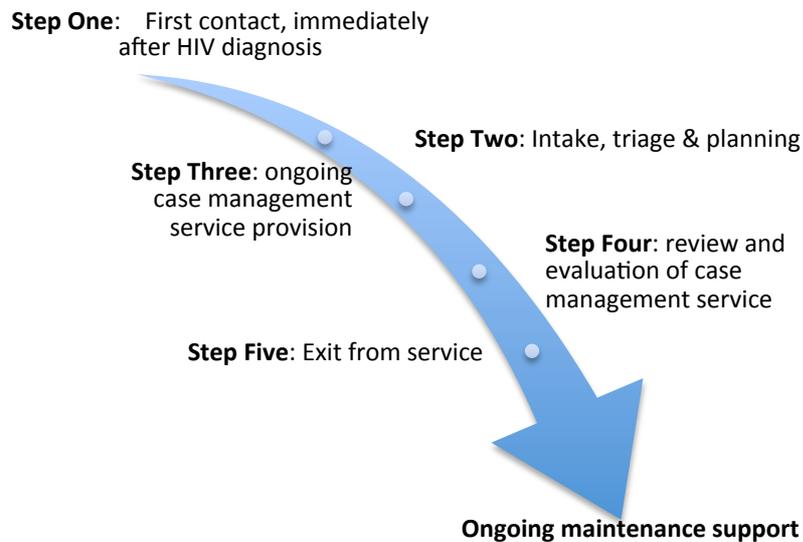


CLIENT-CENTERED HIV CASE MANAGEMENT MANUAL

QUEZON CITY HEALTH DEPARTMENT,
PHILIPPINES

A service guide to the delivery of client-centered support, case management and 'in-reach' services for people living with HIV





Note: STC logo and ASP

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARV/ART	Antiretroviral treatment
BCC	Behavior Change Communication
CBO	Community-Based Organization
DOH	Department of Health
HTC	HIV Testing and Counseling
HIV	Human Immunodeficiency Virus
KAP	Key Affected Population
LGU	Local Government Unit
MSM	Men who have Sex with Men
PLHIV	People living with HIV
QC	Quezon City
QCHD	Quezon City Health Department
SDN+	Service Delivery Network
SP	SangguniangPanlungsod
STI	Sexually Transmitted Infections
TG	Transgender woman
THF	The HIV Foundation
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development

Glossary

Case manager	Sometimes also called a “patient navigator” or “case worker”, a case manager describes an HIV service worker who takes responsibility for a limited number of MSM and TG clients (usually around 20) who are newly diagnosed with HIV and ensures that they are linked to and enrolled into antiretroviral treatment, ideally until virally suppressed. The case manager also links clients to other health and social support services they may require. Case managers find new cases either via referrals from outreach workers or via referrals by staff at HIV counselling and testing facilities or from other NGOs.
Comprehensive package	According to the SP-2504 (2016) AIDS ordinance, the comprehensive package of interventions for STI, HIV and AIDS is provided by all social hygiene clinics and sundown clinics, and consists of: comprehensive condom and lubricant programming, behavioural interventions, HIV testing and counselling, HIV treatment and care, prevention and management of co-infections and other co-morbidities, and sexual and reproductive health interventions. Referrals to services dealing with syndemic conditions, including mental health care services and legal support against stigma, discrimination and violence should eventually also be part of the comprehensive package.
Gay men/Gay community	‘Gay’ is a term used to describe men who have sex with men who view their homosexual orientation as an important part of their identity. They tend to be open about their sexuality towards family and friends and sometimes also to colleagues or less intimate members of their social network. Most gay men feel part of a ‘community’ of like-minded men, called the Gay Community. However, there are many men who have sex with men who prefer to keep their sexual preference secret, staying away from gay community activities and services.
HIV services cascade	Refers to a comprehensive set of HIV services for prevention, testing, diagnosis, treatment, care and support. In order to serve clients most effectively, ‘one-stop’ services are preferred, and QCHD is working to make this a reality, starting with Klinika Bernardo. Case management helps clients to move

from one HIV service to the next and prevents them from disappearing from the system.

Key populations	People who are at higher risk for HIV infection, such as people who engage in unprotected sex, unprotected sex in exchange for money, favours or goods (sex work) or people who engage in unsafe injecting-drug use.
Men who have sex with Men	Men who have sex with men (MSM) is an inclusive public health term used to define sexual behaviour between males, regardless of sexual orientation or preference, motivation for engaging in sex or identification with any or no particular community. The term include men of all ages (also adolescent males and transmen). The words “man” and “sex” are interpreted differently in diverse cultures and societies as well as by the individuals involved. As a result, the term MSM covers a large variety of settings and contexts in which male-to-male sex takes place. In this document, MSM does NOT include transgender women (see definition below).
Quezon City STI, HIV & AIDS Council	The Quezon City STI, HIV and AIDS Council (QCSAC) was created under the City Ordinance SP 838, S-99, as a multisectoral organization to unify the HIV response, supervising implementation of QC HIV related policies and ordinances, reviewing and approving planned HIV prevention activities and monitor the city’s peer education program.
Service Delivery Network (SDN, now SDN+)	Monthly coordination forum of HIV service providers in QC, soon to include all service providers across the HIV services cascade, including outreach service providers. SDN+ aims to reduce barriers clients face while navigating the HIV service cascade, to share the latest data on the HIV situation and response, to supervise the gradual adoption of the agreed standards of quality outlined in this MoP document by all SDN+ members, and improve linkages between HIV services and services addressing HIV syndemic factors, such as alcohol- and drugs addiction and mental health problems. The SDN+ will conduct a yearly program review and jointly plan an intensified and expanded response.
Social hygiene clinic	The primary implementers of HIV and STI control programs in local government.

Sundown clinic	This word refers to the Quezon City program of extending operational hours of certain clinics that cater to HIV and STI health care needs, extending up to 11 PM during weekdays.
Syndemic	A set of health problems or social conditions that strengthens in the presence of, and is linked to one another. HIV among MSM and TG is often linked to mental health problems and drug or alcohol abuse. Syndemics often occur under situations of poverty, stigma and discrimination or among populations with limited or no access to health or other essential services.
Transgender woman	A transgender woman (TG) is a person who was assigned the male sex at birth, but identifies as a woman. TG may or may not embark on a process to transform their normatively masculine bodies into more feminine ones; they can do this via an array of strategies ranging from ways of dress and hairdo, ways of speech, cosmetic measures, hormone therapy and different levels of gender reassignment surgery.
Treatment hub	Hospital or clinical facility with an organized HIV/AIDS Core Team (HACT) that provides prevention, treatment care, and support services to People Living with HIV (PLHIV) including but not limited to HCT, clinical management, patient monitoring, and other care and support services. Antiretroviral (ARV) treatment can only be accessed through these facilities.
Unique identifier code	A way to identify and track service users without recording their name or other identifying information.

SECTION ONE: BACKGROUND

1.1 The HIV Program in Quezon City

The HIV (Human Immunodeficiency Virus) program in Quezon City is fully supported by the City Government through the City Health Department, which has shown a high level of leadership. In 2013, there were three Social Hygiene Clinics providing STI and HIV testing; by 2016 the number of clinics had risen to six. Three of these clinics currently operate extended hours ('Sundown clinics') to cater specifically to men who have sex with men (MSM) and transgender women (TG). SHCs are supported by the LGU, with some support from the central government and Global Fund for AIDS, Tuberculosis and Malaria (GFATM).

Quezon City Health Department has pioneered a number of initiatives in the HIV response of the Philippines. With assistance from USAID/FHI360, it developed a local Service Delivery Network (SDN) for people living with HIV, which facilitates referrals across several hospitals and NGOs; it was the first local government unit (LGU) to hire peer educators to expedite HIV service delivery to MSM and TG (2010); and the first to set up clinic services specifically to meet the needs of MSM and TG (the Sundown Clinic, established in 2012). Klinika Bernardo has been officially recognized as a satellite treatment hub since late 2015.

The HIV services program in Quezon City has benefited from high-level political commitment of both the executive and legislative branches of the local government. This is demonstrated through their response to requests for funding; willingness to facilitate access to funding from a variety of sources; the issuance of local ordinances that directly or indirectly support the AIDS response; and the approval of innovative approaches such as the hiring of peer educators, the opening of a Sundown clinic for MSM and TG and allowing NGOs to use SHC facilities.

The LGU's willingness to engage civil society organisations as partners in the response may have been influenced by the strong tradition of student activism, NGOs and community mobilization in Quezon City. Other examples of the City's support include the use of Mayor's Funds to establish the Quezon City Pride Council, which is led by gays, lesbians, bisexuals and transgender people.

The 1998 AIDS Law stipulates that every LGU in the country should have an AIDS council, supported by contributions from each of the member departments. The Quezon City STD and AIDS Council (QCSAC), established in 1999 under city ordinance No. SP 838, S-99, is tasked with setting the direction of and coordinating AIDS and STD prevention programs in the city that are implemented by the LGU and non-government organizations. Alongside the Quezon City Health Department, the QCSAC formulates policies and guidelines, and coordinates activities and funding for the AIDS response. Members include all departments and offices of the city government, the Philippine Red Cross, CSOs (including organizations serving key affected populations) and others. It is

chaired by the Mayor, with the Head of the City Health Department as the co-chair.

The QCSAC has a defined budget from each department. The Council meets every quarter; minutes go to the Mayor, department heads, stakeholder organisations, et cetera. Many, if not all, of the NGO implementers/partners are invited to the quarterly QCSAC meetings, even if they are not members. All implementers and development partners are invited to an annual HIV/AIDS Program Implementation Review (PIR) to evaluate progress and plan for the next cycle.

Quezon City has issued a number of local ordinances in support of the AIDS response, the first of them predating the 1998 AIDS Law. The latest and most important ordinances are:

- **Ordinance SP-838, S-99 1999:** formed the Quezon City STD/AIDS Council (QCSAC), defined its functions and membership, as part of the City's response to the emerging threat of HIV, AIDS and other STD.
- **Ordinance SP 1053, S-2001,** or the Quezon City AIDS Prevention and Control Ordinance: strengthened the QCSAC by giving it a mandate to ensure the comprehensive implementation of five STD/HIV/AIDS Prevention Policies, including the availability of prophylactics and other information materials in all registered entertainment establishments.
- **Ordinance SP-2210, S-2013,** "an ordinance prohibiting all forms of discrimination of workers perceived or suspected or even found to be positively infected with HIV in workplaces within the territorial jurisdiction of Quezon City."
- **Ordinance SP-2504, S-2016,** amending ordinance SP 1053, S-2001, entitled the 'Quezon City STI, HIV and AIDS Prevention and Control Ordinance', which reinforced the role and commitment of QC to the HIV response, strengthened QCSAC, strengthened anti-discrimination legislation, recognizing the rights to care, treatment and dignity of all people living with HIV.
- **Mayoral executive order 5, 2016** was "an order institutionalizing "peer education" as a strategy for strengthening the city's STI-HIV/AIDS prevention and control program especially among key affected population" [sic] mentioning MSM and TG as the most-at-risk and most urgent target audience for peer education. It called for the following:
 - The appointment of a formal peer education coordinator
 - Establishing qualification standards for recruitment of peer educators
 - The definition of standards for their role and responsibilities
 - The institutionalization of continued training and skills-building of peer educators, rather than one-off training events;
 - The development of a supervision structure for peer educators
 - Better M&E of the results of peer education on the overall response to HIV of Quezon City.

Importantly, the mayoral order applies not only to QC’s social hygiene and sundown clinics, but to all private and NGO-implemented peer education programs in the city as well.

1.2 The HIV situation in Quezon City

In Quezon City, just like in nearly every other major Asian city, men who have sex with men and transgender women are disproportionately affected by HIV. A record 4,643 new HIV cases were reported to the Philippine Department of Health between January and June 2016 for the entire country, of whom 4,446 (95.8%) were male. Of these men, 86.0% reported sex with men. 40% of all new HIV cases reported from January to June 2016 were residents of the greater Manila region. In June 2016 alone, 841 new cases were reported nation-wide, an all-time record; of these, 82% were among MSM and TG and bisexual men¹.

Official HIV prevalence in MSM and TG in Quezon City stood at 5.5% in 2015 (N=600, 95% confidence interval: 2.9-10.3%), slightly down from 6.6% in 2013 but sharply up from 0.4% in 2007 and 1.5% in 2009².

Table³: HIV case reports by reporting clinic, Quezon City, January – December 2016

Location	# of tests conducted*	# of HIV positive test results	Sero-positivity rate**
Batasan	4,218	58	1.38
Bernardo	5,862	167	2.85
Project 7	3,978	61	1.53
KB sundown clinic	3,497	245	7.01
KN sundown clinic	4,283	100	2.33
K Proj. 7 sundown clinic***	3,978	77	1.94
	23,368	708	3.03

* These are the number of tests; some clients could have been tested twice.

** Sero-positivity rate is depressed due to possible double-counting of negative-testing clients, i.e. the denominator is # of tests, not # of people tested

*** K Proj 7 only opened in March 2016

The table above indicates that out of 23,368 HIV tests conducted in QC in the year 2016, 708 new cases were found to be reactive for the screening test; of those, 360 returned for the confirmatory test result (51%), 369 cases tested for CD4 (52%) and 282 have since enrolled for treatment at KB (40%). Although a loss-to-follow-up rate of 49% of those screening positive looks very worrisome, it is a big improvement from the situation in 2014, when up to 90% of clients testing positive would not return for their confirmatory test result. In addition,

¹Bureau of Epidemiology, DOH, Manila, 2016. See: http://www.doh.gov.ph/sites/default/files/statistics/EB_HIV_June-AIDSreg2016_0.pdf

²Bureau of Epidemiology, DOH, Manila, 2015. Pages 77-80. See: http://www.aidsdatahub.org/sites/default/files/highlight-reference/document/Philippines_2015_IHBSS_Factsheets.pdf

³Rolly Cruz, Quezon City Health Department, personal communication, 30 January 2017.

due to the lack of a well-functioning central reporting system, it is likely that a significant number of clients have sought confirmation tests results, baseline test results and eventual enrolment in ART elsewhere—either in another city or in the private sector⁴.

The disproportionate burden of HIV in MSM and TG in comparison with the general population can be partly explained by the high probability of HIV transmission per sexual act through unprotected receptive anal intercourse, plus the fact that MSM often have both unprotected receptive and unprotected insertive anal intercourse, sometimes in different phases of their lives, further facilitating transmission. HIV can therefore spread through MSM and TG networks at great speed, with network size and density as well as structural factors having a large role in the severity of HIV epidemics.⁵ Despite this, efforts to contain HIV are more often than not delivered at the individual level, with network and structural factors not given due importance.⁶ What is also increasingly clear is that HIV is interlinked with a number of other social, psychological and health issues, many of which need to be tackled in tandem.⁷

Many MSM and TG avoid HIV testing services even when such services are available, mainly because of (actual or perceived) stigma by health care providers and inconvenient locations or opening hours, meaning they are unaware of their HIV status, cannot access life-saving antiretroviral treatment (ART), and may be continuing to spread infection to their partners, perpetuating the HIV epidemic. Another important problem is the moralism that many MSM and TG grew up with and apply to themselves, resulting in feelings of self-loathing, guilt and a sense that they 'deserve' HIV and should suffer the consequences⁸.

HIV peer outreach workers have for many years played a key role in disseminating HIV prevention information and commodities (condoms and lubricants), identifying undiagnosed HIV infection among MSM and TG and in facilitating access to HIV counseling and testing services. Peer outreach workers are often not well remunerated, poorly motivated, and poorly supported and supervised within the organizations where they work. In recent years, it has become clear that outreach should be 'professionalized', meaning that peer outreach workers need to be well-paid in exchange for clearly defined achievements⁹.

⁴MoP review workshop discussions with outreach workers, October 2016

⁵Beyrer C et al. Global epidemiology of HIV infection in men who have sex with men. *Lancet*. 2012;380.9839: 367-377.

⁶Beyrer C. Strategies to manage the HIV epidemic in gay, bisexual, and other men who have sex with men. *Curr Opin Infect Dis*. 2014;27.1: 1-8.

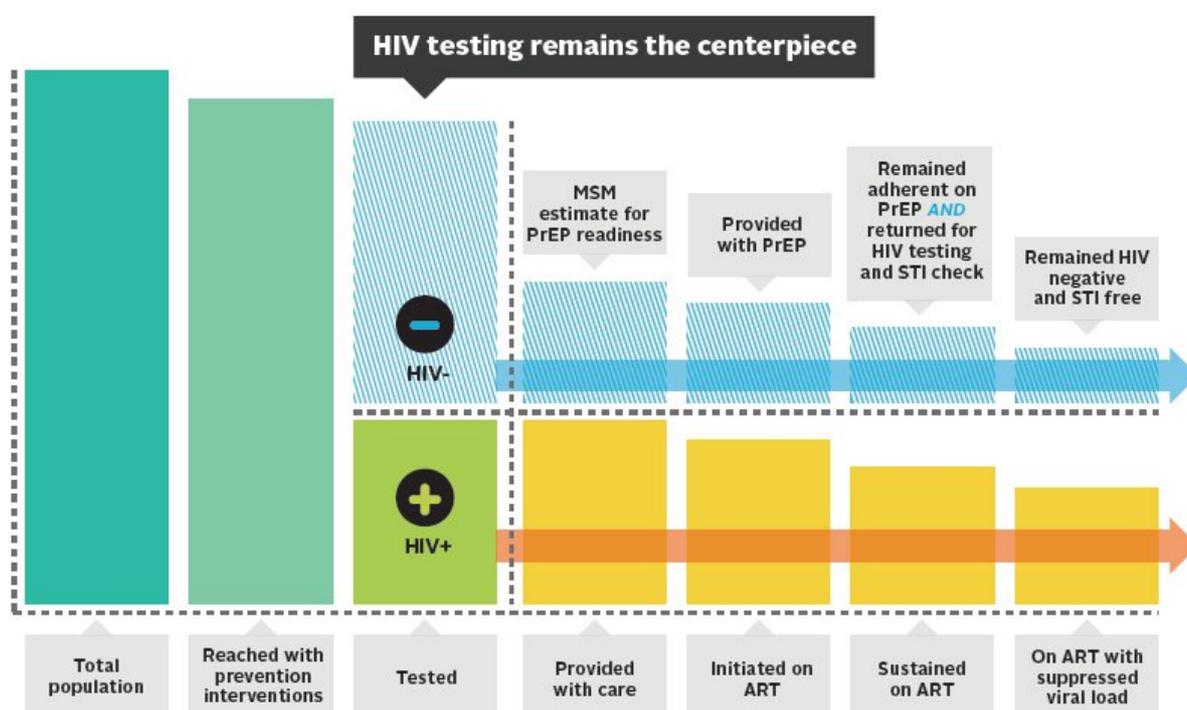
⁷Stall R et al. Association of co-occurring psychosocial health problems and increased vulnerability to HIV/AIDS among urban men who have sex with men." *Am J Public Health*. 2003;93.6: 939-942.

⁸De Lind van Wijngaarden JW, Ching AD and BelimacGJ, "*Barriers to the access of HIV services among MSM in Manila, Philippines*". Study conducted for DOH and UNDP in 2015, to be published in 2016.

⁹ See the UNAIDS/APCOM 'Changing Gears' Framework for Innovation in MSM and TG responses, 2016.

However, in recent years, a consensus has emerged that preventing HIV will require not only strong prevention services, but strong linkages across an entire continuum of HIV prevention, care and treatment services, as illustrated below. There is evidence from around the world showing that linkages between different HIV services and client flow through them have been woefully inadequate at every stage of the HIV services cascade. The Philippines has adopted the term ‘linked to care’ as a measurable indicator for success of its HIV program, based on WHO M&E guidelines¹⁰.

Figure: The HIV Service Cascade*



Source: USAID, FHI 360, PEPFAR and LINKAGES. HIV cascade framework for key populations. Arlington, VA: FHI 360; 2015.

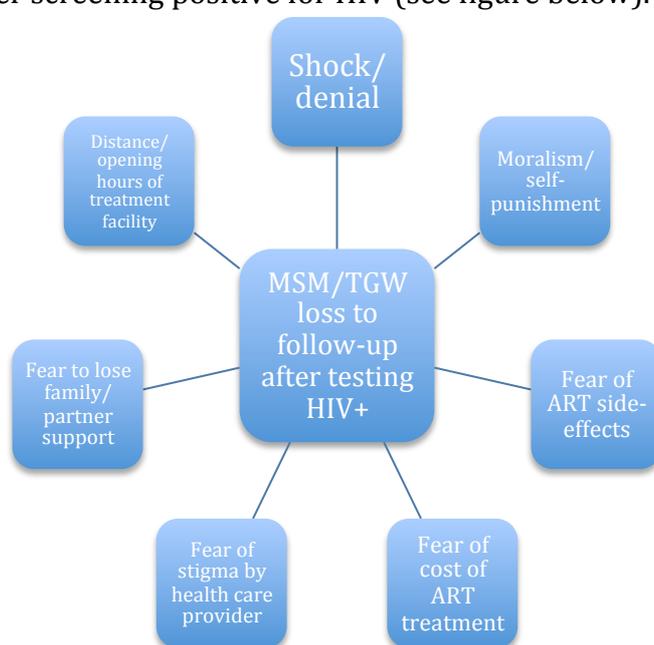
* Please note that PrEP is still being piloted in The Philippines, and that it is currently not yet part of the HIV prevention approach.

Peer outreach programs aim to reach people who are at risk for HIV (defined as those engaging in unprotected anal sex between men, unprotected sex in the context of sex work and/or unsafe injecting drug use) in order to refer them to HIV testing services. Despite ongoing efforts in the Philippines, surveillance data shows that only 54% of MSM reported to have used a condom at last anal intercourse, and only 20% of MSM were tested in the past 12 months and went back to get the result; an additional 3% had tested but had not returned for the result. 71% had never tested for HIV in their lifetime². Even if MSM or TGare

¹⁰WHO, 2016. “Metrics for monitoring the cascade of HIV testing, treatment and care services in Asia and the Pacific”. Available from: http://www.searo.who.int/entity/hiv/hiv_metrics.pdf

diagnosed HIV+ in their initial screening test, many did not come back to hear the result of their confirmatory test. This is partly caused by the requirement in The Philippines of a Western Blot confirmation test, which results in waiting times of up to 3-4 weeks. Out of 24 MSM and TG identified with HIV in the 2015 IHBSS in Quezon City, only 4 knew their HIV status, but only two clients were currently on antiretroviral treatment.

Clients do disappear after a reactive test for several reasons. **Many leave, often in shock or in denial, without the medical or social support to start early ART.** Many seek treatment very late, when they already have multiple health problems related to early symptoms of AIDS, as was recently confirmed in a qualitative study in Quezon and three other Metro Manila cities⁸, which listed eight key reasons why Metro Manila-based MSM and TG do not access follow-up HIV services after screening positive for HIV (see figure below).



In short, while perhaps not as bad as in other areas of Metro Manila, at above 50%, loss-to-follow-up is still too high among MSM and TG along the HIV service cascade in Quezon City.

HIV infection rates remain unacceptably high and access to ART for Key Affected Populations (KAP) living with HIV unacceptably low, which leads to unnecessary HIV-related deaths. Trained and well-supported outreach staff are working to identify and plug these “leaks” across the HIV cascade so that MSM and TG clients, once engaged, are effectively supported and retained within the system and access the services they need to safeguard their own health and to prevent the further spread of infection¹¹. For this, the initiation and strengthening of a ‘**case management approach**’ is essential.

¹¹ Caroline Francis and Stephen Mills, *HIV Cascade Framework for Key Populations*. FHI 360/Linkages/PEPFAR/ USAID, 2015. See: <http://www.fhi360.org/sites/default/files/media/documents/linkages-hiv-cascade-framework-oct15.pdf>

1.3 A short history of the Case Management Approach in Quezon City

Peer outreach is the 'bridge' between untested (and potentially positive) MSM and TG and the testing facilities that form the entry point into the HIV service cascade. After a client agrees to be tested, many of those who test positive currently do not proceed to the next level in the HIV service cascade in Quezon City. They do not come back for follow-up HIV tests and/or baseline/pre-ART tests after testing positive for HIV, although it is possible that a number of these cases seek care outside QC or in the private sector. A recent study⁸ in QC and other Metro Manila cities discovered that there are numerous reasons for this high level of drop-out, including a lack of effort by health care providers to ensure that newly diagnosed clients, who may be in a state of shock and confusion, continue a trajectory towards enrolling on ART. In the three other Metro Manila cities in a recent study⁸, it was found that there was a severe lack of coordination between different health services that make up the HIV service cascade, and 'pathways of care' were more often than not unclear to clients. Clients' own (often outdated) beliefs about HIV treatment also play a role in deterring them from accessing ART. Newly diagnosed clients also very often have unfounded fears about debilitating side-effects of HIV medicines. There are also frequently fears about losing the love and support of their family, concerns about stigma and discrimination by healthcare providers, friends, colleagues and family members, and many face structural barriers such as long working hours and poverty that made it difficult for them to access treatment at facilities that are often operating during formal office hours only.

Another key "leak" in the HIV service cascade is among clients who start ART but drop out, perhaps because they cannot follow their doctors' appointment schedule, or because they are having issues handling treatment side effects, or in some cases because they feel better and believe that treatment is no longer necessary. Of course, stopping treatment threatens not only the health of the client; a person living with HIV who is not adhering to treatment is also more likely to transmit HIV to others than a person who is sticking to their treatment. These are the two reasons why it is critical that we support HIV-positive clients to adhere to treatment.

In Quezon City, the Service Delivery Network (SDN) was established in 2012 in Quezon City and in Cebu, with technical support from FHI 360/USAID. The most important role of the SDN was initially for different service providers to share information and become aware of what each of them could contribute as part of the HIV service cascade.

Under the SDN umbrella, **case management teams** were established, consisting of a Team Leader (the medical officer of a testing / treatment facility), a nurse who supports clients in adhering to their therapy, who is called a "Case Management Coordinator, and a social worker. The Case Management Coordinator is in charge of every-day operations: he/she develops supportive relationships with case managers and clients, motivates them to make the right/best choices for their health and wellbeing, and helps case managers facilitate access to and use of available services. The Case Management

Coordinator is responsible for many essential tasks: s/he manages the client's file; reviews open case files and works with case managers to follow-up on clients who have gone missing. They conduct intake interviews, service referrals and scheduling of follow-up visits. Linkages with peer educators are also part of this model; peer educators are supposed to refer clients to the case management team and also help follow-up clients who are lost to follow up in their community networks. The case management team of three people meets two times a month, or more often if there were specific emergency situations among the client caseload.

As a result of the program, some clear improvements were seen in the number of newly diagnosed people who managed to enroll into antiretroviral treatment. However, as of 2015, around 54% of those newly diagnosed still became lost-to-follow-up in Quezon City. Although this was a big improvement on the situation before (when up to 90% were lost to follow-up)¹², it has become clear that an important component of case management is not yet in place in Quezon City. Whereas the system has lessened the gaps between different parts of the HIV service cascade by the ability to 'follow clients' through the system, creating closer working relationships between service providers, the focus of the effort has been on HIV service providers. **A focus on supporting individual clients in overcoming physical, psychological and knowledge-related barriers to HIV treatment** is still missing.

For those who test positive, the all-important immediate task is ensuring that clients do not disappear in a vacuum of despair, depression, guilt, loneliness and self-loathing. The client needs lots of emotional support, especially during the first days and weeks after diagnosis, and needs assistance in overcoming structural barriers to treatment. Especially, clients who have moved to Metro Manila from the provinces often need help to overcome confusing private insurance or PhilHealth- and clinic-related registration processes or regulatory issues, which can be cumbersome and time-consuming, and can seem like an impossible task, especially if one feels depressed and desperate as a result of one's recent HIV diagnosis. Under the current system, the case management coordinator cannot fulfill all these tasks, as the number of clients under his/her care is simply too large. They cannot spend much time with clients themselves, be it face-to-face or via social media, counseling and supporting them and accompanying them to their medical appointments. In order to move to a situation where 100% of MSM and TG clients diagnosed with HIV are successfully entering into ARV treatment (which THF successfully achieved in Bangkok), it is necessary to make the **client central to the case management program in Quezon City**. This can only be done if each case manager has a limited number of clients under his care—the experience of THF in Bangkok shows that 20 clients per case manager is pretty much the maximum.

In line with the recommendation made in FHI 360's Technical Brief on case management, it is recommended to give the responsibility of case management and support for newly-diagnosed clients to a group of specialized and fulltime client-centered HIV case managers who have personal experience in dealing with

¹²Rolly Cruz, Quezon City Health Department, personal communication.

HIV in the context of overall life as a gay man / man who has sex with men in The Philippines. The tasks of emotionally supporting newly-diagnosed people living with HIV and assisting them in accessing or remaining on life-saving HIV treatment are so time-intensive, all-encompassing and complex that peer outreach workers or existing clinic staff cannot be expected to fulfill properly.

Client-centered HIV case management is pivotal in order to achieve the desired drop in loss-to-follow-up along the HIV service cascade. Case management is defined as follows:

Client-centered case management provides a holistic service that offers social, mental, educational and logistical support to a client from the immediate moment after initial diagnosis with HIV until the achievement of viral repression as a result of successful HIV treatment and the tailored provision of other health- and social support services.

1.4 About this Manual

As was described above, the establishment of the SDN+ network has been an essential first step towards better-quality and better-coordinated case management services to people living with HIV in Quezon City. Building on this achievement, this Manual aims to provide the technical framework for the provision of a wider range of high quality health- and social support services by and for people living with HIV in local places in the context of the existing SDN+ network.

This manual has been developed from experiences with service delivery to newly HIV diagnosed MSM and transgender people in Thailand by APM Global Health (APMG) and The HIV Foundation, at that time supported by USAID. Best practices derived from experiences delivering peer support, case management and peer counseling in Central Asia, South East Asia and the Pacific have also been used in the development of this manual.

The current manual is meant to be used by Quezon City Health Department to strengthen its peer-outreach program further, by setting up, managing and delivering *client-centered* HIV case management support for people who are newly diagnosed with HIV. Client-centered case managers are most effective if they are themselves persons living with HIV and/or identify as coming from a Key Population for HIV. The manual procedures and policies have been developed from contexts in which both peers and non-peers deliver the support services. The core aim of the manual is to strengthen cross-sector collaboration between the medical, social welfare and community sectors and to facilitate multiple entry points to care for people living with HIV from key populations, which in Quezon City means especially men who have sex with men (MSM) and transgender women (TG).

The manual is a resource for grassroots- and local government organizations seeking the management and technical tools needed to run a support and case

management service for people living with HIV. The manual provides the basic information and resources needed to deliver services to people living with HIV. The core aim of client-centered HIV case management is to support people living with HIV to live successful and independent lives. The service achieves this by assisting people living with HIV to access the services they need.

This manual assists client-centered HIV case managers to provide 'in-reach' services. In-reach is a specialized form of service delivery in which case managers deliver services at hospitals and clinics and cooperate with clinical teams at these sites. The aim of the approach is to minimize loss to follow-up among people living with HIV accessing the health system.

Client-centered case management is a specialized form of support in which the range of health and welfare needs of an individual are identified and decisions made together with the individual about how best to meet those needs. In order to ensure that people living with HIV are well supported, case managers accompany them to health and welfare services. Case managers help people living with HIV solve the problems they experience within health and welfare service systems so they can live successful and independent lives with HIV.

In brief, the main aims of HIV case management services are:

- a) To build knowledge and skills in people living with HIV so they can make informed choices about their health,
- b) To work cooperatively with HIV service agencies to ensure service access with little difficulty as possible and
- c) To influence and change health service policy and implementation so that it better meets the needs of people living with HIV over time.

SECTION TWO: CASE MANAGEMENT BASICS

This Manual, in preparation for the planned Quezon City client-centered HIV case management program, gives an overview of the resources needed to deliver support and case management services to people living with HIV to help them access the services they need to live healthy and independent lives with HIV.

This section of the manual describes

- *Mission Statement*
- *Philosophy of Service*
- *Core Services in Client-centered HIV Case Management and Support*
- *Client Service Pathway*

2.1 Mission Statement & Philosophy of Service

The Quezon City client-centered HIV Case Management program assists people living with HIV to live well by supporting timely access to health services and by reducing the social isolation that can be associated with living with HIV.

It works to achieve this goal by cooperating with local service providers to deliver counseling and case management services to people living with HIV experiencing difficulties or crises in their lives. In Quezon City, HIV partners include local hospitals, social hygiene clinics and private clinics providing HIV services to people living with HIV as well as local community-based organizations and civil society organizations such as Love Yourself, REDx, HIV & AIDS Support House Inc. (HASH) and Family Planning Association of the Philippines (FPAP). A recent UNDP study among MSM with HIV in QC and other Metro Manila cities discovered that their difficulties include fear of losing family support or losing friendships, shame and guilt related to (Roman Catholic) morality and internalized homophobia, fear of or actual stigma by health care providers, misconceptions about the cost of HIV treatment, misconceptions about side effects of HIV treatment, lack of social support, problems accessing or understanding how to access treatment or health care services when in need (De Lind van Wijngaarden and Ching 2015, in press).

The **philosophy of service** emphasizes the right of people living with HIV to make their own decisions and to live successfully and independently.

The view of the person with HIV

People living with HIV are capable of living healthy and independent lives when they have the support and health service access they need. Even in the midst of crisis, illness (with or without symptoms) or other difficulties, people living with HIV can make their own choices about how to solve problems when they have a supportive environment for doing so.

Health Promotion

To best facilitate a supportive environment for healthy and independent living, the Quezon City client-centered HIV case management service operates within a health promotion framework by

- (a) Seeking to increase the knowledge and skills of our clients and support them to support each other in groups and communities;
- (b) Working closely and cooperatively with other service agencies and
- (c) Influencing health service policy and implementation at local and national levels.

No discrimination

Services are offered to people living with HIV regardless of ethnicity, class, age and religious or other beliefs, family background or their sexual orientation or gender identity and expression. Everyone with HIV is welcome—although this manual zooms in on MSM and TG, the populations most severely affected by HIV in the Philippines.

A role as family or friend

Some people living with HIV have little access to family or friends to whom they can disclose their HIV status—this is especially the case for MSM, who often have to keep their sexual orientation hidden from family and close friends. The proposed Quezon City client-centered HIV case management service aims to play a valuable role as substitute family or friends to people living with HIV in certain circumstances.

Case managers are not medical experts

Case managers are not medical experts and should NEVER play the role of substitute doctors, nutritionists or mental health professionals. They do not diagnose illnesses nor give medical, mental health or nutritional advice of any kind to clients. They defer to both their clients and their service providers for guidance on health, medication and monitoring.

Client-centered practice

The primary focus of service delivery is on the client's needs. Even in the crisis of initial HIV diagnosis, the client can assist in tailoring an individualized program of services and supports that can meet their unique and particular needs. The client and the case managers should use sessions to jointly identify needs, how needs should be responded to and how everyone will know that each need has been addressed.

However, client-centered practice is more than just focusing on clients. The core principles behind client-centered practice are

- **Unconditional positive regard** –valuing clients unconditionally and offering them high quality service no matter who they are,
- **Empathy** – “walking a mile in the client’s shoes”, trying to understand the world from the client’s perspective and
- **Anon-judgmental attitude** –making no judgments about the client’s life, opinions or behaviors.

Client-centered HIV case management should, as the phrase suggests, be led by the client. This can be difficult because case managers won't always agree with clients about what might be best for them. Also, when service involves others in meeting the client's needs, these others may disagree with the client and ask the case manager to side with them. Case managers focus on solving problems through supportive and diplomatic negotiation. Ultimately, attention is focused on the client and their needs with a desire to help them to best meet these—but this may take a long-and-slow approach.

Individual PLHIV bring skills and life experience to their situation and are capable of solving their own problems with assistance from case managers and other service partners—they are not helpless victims without a will or sense of direction. Clients are involved and considered as experts, as equal partners in the process of assessing and resolving their own situations.

Early Intervention and Prevention

Staff have a duty of care to ask questions about issues and problems that lie outside the experience of HIV. Early intervention in, or prevention of serious health problems can make a real difference to the lives of clients. Therefore, staff should look to identifying other needs beyond the client's presenting issues and to agreeing with clients on some action about those issues, where they are identified. For example, this could include identifying a client's drug or alcohol issues or that a client is in a violent relationship. Supporters are not experts on the various health and other issues, which might affect someone. Therefore, they should refer to their team leaders and to the clinical staff at the clinics and hospitals where they provide service when they have concerns and before taking further action.

Duty of care

There are some times when presenting issues are of such a serious nature that case managers have a 'duty of care' to respond. 'Duty of care' is defined as an obligation to ensure the safety or well-being of others. Case managers are not experts on duty of care issues and should always seek urgent advice from team leaders and clinical staff at the clinics and hospitals where they provide service in these cases. Some issues that might indicate the need for advice might include (but aren't restricted to):

- Mental health issues (e.g. the client or others claim to hear voices or have visions or appear to be bipolar or severely depressed)
- Statements indicating a risk of suicide or self-harm
- Threats to harm others
- Suspicions of violence or abuse (e.g. the client has unusual bruising, appears frightened and/or states they are being hurt or threatened)
- Homelessness, acute poverty

Case managers are obligated to act in these and other circumstances to ensure the safety of clients and other individuals in direct contact with clients.

2.2 Core Services: In-reach, counseling, case management support

The Quezon City client-centered HIV Case Management Team provides the following core services:

- **'In-reach'** – Facilitating linkages between services, including by having case managers working at each of the 6 HIV testing facilities so that no person with HIV is lost to follow-up or 'falls through the gaps' of service provision. This includes making sure case managers are nearby during outreach where HIV screening tests are provided.
- **Basic one-to-one counseling** – Listening to and supporting an individual client in relation to their emotional needs and fulfilling a client's request for information and advice, including about whether to disclose to sexual partners and/or the family.
- **Case management support** – Facilitating access to local health and welfare services, including support groups for people living with HIV, accompanying clients to medical appointments, supporting clients who are hospitalized or at home sick through hospital and home visits.

2.2.1 'In-reach' service provision

'In-reach' involves the delivery of support and case management in hospital and clinic settings, in partnership with clinical teams. 'In-reach' is based on the same management structures and systems used in community outreach programs for HIV prevention, but focuses instead on support for people living with HIV in bringing them into the health system for treatment and care. Instead of these teams working at venues and public places to distribute condoms, needles and other paraphernalia (as is done in outreach education), 'in-reach' teams attend clinics and hospitals and provide support and counseling to people living with HIV in partnership with clinical teams at those sites, ensuring that newly-diagnosed clients can find their way and access the services they need.

Whatever the role taken, case managers aim to take the opportunity to make a strong connection with each patient and to let them know they are available to help them with ongoing support should they need it.

When the relationship between casework teams and clinical teams is working well in the setting, nurses and doctors will refer patients that need follow up support to case managers. They may invite case managers into a consultation with a patient who needs case management help beyond the capacity of the nurse or doctor.

The main objectives of in-reach include:

- Develop **cooperative relationships** with hospitals and clinics, but also with providers of essential additional services that a client may need, including those provided by LGBTI or women's shelters and groups, faith-based organizations, PLHIV support groups, drug support services and other health (including mental health) and social welfare services to facilitate shared service provision and (cross-)referral of clients/patients.
- Develop **supportive relationships with newly-diagnosed people living with HIV** so they are not lost to follow-up by the health system and are not isolated and alone.

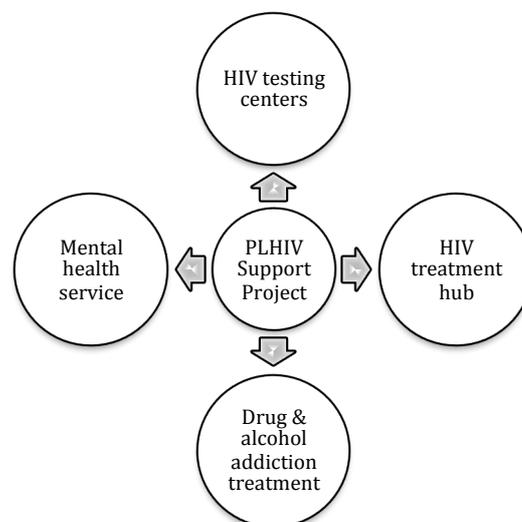
- Develop **supportive relationships with patients** who present with HIV-related symptoms at hospitals and clinics, and with people living with HIV-related illness in their homes and in the community, so they can access the range of health and welfare services they need in a timely manner; this includes dealing with the issue of disclosure to family or loved ones.
- Develop **supportive relationships with patients being hospitalized** with symptoms of HIV illness, so that support and assistance can be arranged for them while they are an inpatient and so that the transition from hospital-to-home can be managed smoothly; this includes dealing with issues of disclosure to family or loved ones. This means that clinics and hospitals providing care to people living with HIV are key partners in client-centered HIV case management, and should be part of the SDN+.

Maintaining service partnerships with health facilities

12 new case managers will soon be operational in Quezon City. Three will be based at Klinika Bernardo; two at Bernardo Social Hygiene Clinic; two at Project 7 social hygiene clinic; two at Klinika Project 7; two at Klinika Nova and one at Klinika Bataasan—these allocations were based on the number of new HIV cases that were diagnosed at each of these locations during 2016.

This section provides suggestions on how to establish or maintain good working relationships with the existing case management teams. The goal of the initial period is to ensure there is sufficient capacity to deliver regular services within hospitals and clinics in the local area on a daily or weekly basis. Five general points of advice are proposed:

1. **Identify relevant support facilities:** This has already been completed under the umbrella of the SDN+, however, there are still areas for improvement, for example on referral for clients who are drug-dependent, depressed or otherwise afflicted by mental health problems, clients who are addicted to alcohol or who are homeless.
2. **Approach clinical staff at health facilities that need to be part of the network of support:** The concept of client-centered case management should be explained, especially from how it differs from the case management that is already happening.
3. **Determine with staff the best way to support clinical staff at each site:** This means understanding the way the clinical team works in each site and agreeing together how the case manager(s) can best support their work. In case the case manager is not at the premises when a client is newly diagnosed, the



staff may collect contact details and arrange for a 'live' telephone call between the newly-diagnosed client and the case manager to arrange for the intake/development of the Plan of Action (Step 2 – see below).

4. **Formally approach facility administration:** This is already happening as part of the monthly SDN+ meetings.
5. **Establish a focal point at each facility.** This is someone, usually a nurse, who will act as a liaison for the partnership and help to solve problems in the settings if and as they emerge; this is already in place.
6. **Trial a pilot period** of around 3-6 months of shared service delivery and then organize a joint evaluation meeting, so that initial problems are anticipated and can be resolved quickly and easily.

TIPS to maintain good relationships with partners in the network

1. **Resolve problems** in the partnership quickly and cooperatively.
2. **Write to the directors/managers/administrators of each partner organisation at least every three months** to update them on the services you have been providing and to thank them for their cooperation; possibly this can be done in the form of a Quarterly Newsletter.
3. **Include service delivery data** in your communication with your partners so they can see their role in the success and share in your achievements.
4. Whenever staff present to forums or conferences they should **acknowledge the partnerships** and name each facility that is working with the program.

2.2.2 One-to-one counseling

One-to-one counseling involves creating the space and making time to listen to a person living with HIV, i.e. being a 'friend who listens'. The person with HIV should feel they have time to explore their feelings and thoughts about what is happening in their life right now. Counseling is about establishing a relationship where the individual being supported understands they have the opportunity to talk openly and that it is safe to express feelings without the fear of being judged by their case manager. The client is given the opportunity to bring up and discuss issues of concern, including how to live with HIV in everyday life; who to disclose to and who not to disclose to; and how to ensure continued access to treatment, care and support. Non-HIV related health- and support-needs are also important to explore during counseling sessions. Not all case managers will be equally qualified to provide counseling services: it is important that case managers know their strengths and limitations, and if issues come up that are too complicated or require a better-trained mental health professional, it is important that the case manager suggests to the client that he/she be referred.

The easiest way to establish a counseling-based relationship with a person living with HIV is for the case manager to focus on listening more than talking, keeping the attention on the person with HIV. This can be hard to do - especially when the client keeps asking questions or is asking for the case manager's own experiences. A couple of strategies can help:

- If you are talking more than your client most of the time, this is a sign that you are taking too much attention away from the client.
- Answer questions clearly and directly – taking the time you need to do so – but always be sure that if you are speaking about yourself, it is only so that you can clearly answer a direct question or need of the client.
- Allow for silence. This can be uncomfortable but it helps to signal to the client that you are giving them the space and time to talk about themselves – leaving some silences in the conversation sometimes leaves room for the client to say what is really on their mind.

2.2.3 Case management

The case management approach aims to assist people living with HIV to identify and resolve problems and barriers that prevent them living with the highest possible quality of life. This is done by developing a supportive, non-judgmental relationship with the client and by working with them to develop an Action Plan in which the client and the case manager both have tasks to complete. In case management, the case manager will accompany clients to medical and other service appointments and be available to help to solve problems in the service delivery as they arise. In this way the case manager becomes a central part of the support available to the person with HIV as they strive to adjust their lives to living well with HIV.

A key feature of this case management approach is that it promotes cooperative connections between people living with HIV and their service providers, partners, families, friends and communities. Client-centered HIV Case Management and Support attempts to work with all possible parties to increase the support available to people living with HIV.

2.3 Client service pathway

The service pathway involves four steps of service delivery with the client. The diagram below demonstrates the client service pathway:

- **Step 1:** The point of first contact with a Client-centered HIV Case Management Team (initiated either by a client themselves or another service provider). This step involves trust-building, reducing feelings of anxiety and panic, and some initial information- and support, especially if CD4 results are not immediately available (which are necessary for Step 2).
- **Step 2:** Obtaining consent, assessing resilience and ‘triage’ of client needs, and drafting a plan of action for case management service delivery.
- **Step 3:** Service delivery to the client includes meeting and talking regularly and acting on the plan of action agreed together.
- **Step 4:** Review of services provided and whether agreed goals were met.
- **Step 5:** Exit of the client from the service.

In the next section, the management of case management services is discussed, followed by a section on delivering case management in practice.

SECTION THREE: MANAGING CASE MANAGEMENT SERVICES

*A team providing client-centered HIV case management needs to have its own management and supervision arrangements in place for its staff. One case management team needs to be established at each of the six testing clinics in Quezon City, each composed of 1-3 case managers with one team coordinator (the nurse), and supervised by the team leader (the doctor). The six case management teams work together to deliver a unique set of services in different locations across Quezon City. This section focuses on the **management aspects** for the coordinator and team leader.*

This section of the manual describes:

- *Structure and roles of the case management operation*
- *Ethical behavior for staff*
- *Supervision and support*
- *Weekly Case Management meetings*
- *Case Allocation and Case Load Management*

3.1 Structure and roles of the case management operation

3.1.1 Case management teams

A 'Case management team' is a team of up to five people that is made up of one team leader, one team coordinator and up to three case managers (depending on the clinic). The coordinator is responsible for managing all day-to-day aspects of the team, starting with recruitment of case managers, supervision of case managers and resolving emergencies and dealing with difficult clients. As discussed in the first section, case management services could deal with in-reach, one-on-one counseling or case management.

3.1.1 Case Management Team Leaders

The team leader of the case management team is the doctor who is responsible for clinical operations in the 6 centers from where case management is organized. They supervise the case management coordinator (see below) and other staff supporting the case management operation.

3.1.2 Case Management Team Coordinators

Team coordinators are nurses, and it is desirable if they also have experience in counseling, social work or education. They may have formal qualifications in these areas, but that is not essential. They should be good with people, able to work independently and be able to resolve problems quickly and easily. As discussed above, the coordinator manages a team of up to 3 people. The coordinator will resolve any site-related problems as they occur, including emergency situations.

The coordinator, if they are highly experienced, will often themselves be the ones to support clients with the most complex needs or personalities, or work closely with experienced case managers to work with these clients. Weekly or fortnightly case management meetings are facilitated by the coordinator and involve talking with the team case-by-case and deciding together how to best support each client.

General Job Description for the Team Coordinator:

- Ongoing recruitment of case managers.
- Ongoing training, supervision and support to case managers.
- Supervising case management of clients by case managers.
- Ensuring service data is collected and reported on.
- Liaison with staff at hospitals/clinics or other services where 'in-reach' takes place.
- Meeting with other coordinators to coordinate support to people living with HIV, as part of the SDN+.

A detailed job description is provided in the Appendices or [click here](#).

3.1.3 Client-centered case managers

Case managers should ideally have experience in counseling, social work or education, but if they do not have formal training, their personal experiences living with HIV and/or seeking HIV treatment and care may be equally or even more valuable. They do need to either be people living with HIV, and/or from a population affected by HIV. They should have experiences within mutual support networks or groups of people living with HIV or affected populations. Case managers work to deliver 'in-reach' services at local hospitals and clinics, and/or to deliver support services at the host organization, and/or to facilitate groups or other kinds of support in the community.

General Job Description for the Case managers:

- Providing 'in-reach' services at hospitals and clinics or counseling services at local organizational premises.
- Providing active case management and support for around 20 clients, including initial intake and assessment, counseling sessions, providing moral/social support via social media or phone, accompanying to hospital, clinic and other appointments, actively resolving service and related problems as requested by the client, and referral of client to other services as needed.
- Completing and submitting client forms and service statistics related to service delivery and case management.
- Participating in case management meetings and other meetings as required.
- Participating in support and clinical supervision sessions as required.

A detailed job description for case managers is provided in the Appendices or [here](#).

3.2 Staff rights and responsibilities

Case coordinators and client-centered HIV case managers have both **rights** and **responsibilities**. The rights and responsibilities described here will be read out and discussed during orientation with all new staff.

3.2.1 Rights

The LGU or CBO/NGO organization providing case management services commits to:

- Maintain the privacy and confidentiality of its staff, especially in relation to sensitive, personal information.
- Value and respect staff equally and treat all staff as important co-workers.
- Provide orientation to all new staff in the program.
- Provide a supportive environment with regular one-to-one supervision, team meetings, and support and case meetings.
- Inform staff about what is happening with the program.
- Provide input into planning and evaluation of the program.
- Be clear about the roles of all staff, including providing written job descriptions for all roles.
- Provide a work environment free of intimidation, bullying or discrimination.
- Respond to complaints by staff in a timely, sensitive and respectful way.
- Inform staff clearly and respectfully when there are concerns about work performance and provide a 'right of reply'.

3.2.2 Responsibilities

Staff in LGU/CBO/NGO organizations providing case management are responsible to:

- Commit to at least 6 months of service to the program.
- Attend supervision, support and case meetings.
- Abide by the Code of Conduct Confidentiality and Work Practices Agreement (see below).
- Keep the coordinator and other relevant staff informed about what is happening with clients.
- Be reliable, honest and considerate in all dealings with clients, their friends and families, service providers and staff of this program.
- Keep the program informed about changes in address or phone numbers.
- Be punctual when attending work shifts.
- Deliver services according to the guidance provided in this Client-centered HIV Case Management and Support Manual.

3.3 Ethical behavior for staff

All staff delivering client-centered HIV Case Management Teams, including coordinators, must comply with confidentiality and other ethical work practices to ensure that services they provide to people living with HIV will do no harm.

Ethical conduct is particularly important because professional conduct will help to maintain a good reputation and relationship of the service with local hospitals,

clinics and HTC centers. Unethical conduct will undermine the trust and respect needed to ensure that local service providers cooperate with the service and refer their patients/clients.

The following ethical principles/behavioral rules are particularly important:

- **No sex with clients** under any circumstances.
- **No gossiping** about clients during or after service provision.
- **No drug taking or drinking alcohol** with clients under any circumstances.
- **No financial transactions**, lending to or borrowing money from clients.
- **No engagement in illegal activity** of any kind during service provision or with clients during or after service provision.

Engaging in these behaviors can result in **immediate dismissal, subject to due process, of staff or volunteers in every case**, as this is the only way to ensure and retain cooperative and trustful relationships with other service providers.

At the start of a new staff member or volunteer's time with the service, an orientation must be undertaken. In this orientation the team coordinator should read out loud the [Code of Conduct](#) for staff and the [Confidentiality and Work Practices Agreement](#) for staff. At the end of reading each document, the coordinator should engage in discussion about the document to ensure the staff fully understand all clauses and principles, and allow for questions and concerns to be raised.

3.4 Supervision, support and case meetings

Regular supervision, regular support sessions and case meetings are at the basis of a supportive internal working environment for the provision of high quality support services to people living with HIV. Regular supervision ensures that team coordinators are up-to-date with the experiences of case managers, case managers know of each others' work experiences and can provide advice and support to each other. Regular staff support meetings ensure that the host organization is meeting a 'duty of care' to its own staff. Regular case meetings ensure that all active clients are discussed in a timely manner and allows for case managers to share their knowledge and experiences with one another.

The Team Coordinator provides individual supervision to staff in their case management team. Supervision is a supportive space for case managers to talk about their experiences, successes and difficulties in delivering services to people living with HIV. Supervision with case managers should occur at least every two weeks or more often if so requested by the case manager. The supervision session can last from 30 minutes to one hour depending on the number of issues needing to be discussed and/or the support needs of the case managers.

The supervision session should provide time for the case manager to:

- Talk about their recent experiences delivering services.
- Raise problems and seek solutions in the delivery of services.
- Talk about their personal responses and feelings about doing the support work with the supervisor, if appropriate.

Burnout is a common phenomenon among case managers engaged in HIV service delivery. Burnout happens when case managers become emotionally exhausted by the support work. Symptoms can include increased irritability or sadness in a case manager that is uncharacteristic. Increased non-attendance at work can also be a symptom, as can a dramatic slowdown in performing key activities and deliverables without a reasonable excuse. Burnout occurs for many reasons, but it can be delayed and even avoided if a supportive work environment is maintained.

The provision of emotional support for case managers themselves is viewed as a key method for delaying or avoiding burnout. In providing emotional support to case managers, the host organization can avoid the increased financial and human resource expenses caused by high staff and volunteer turnover. The service should meet its duty of care to staff by providing an external psychologist or counselor for the provision of clinical support to the case manager team on a monthly basis. The psychologist or counselor should be an individual with no ties to the program. They should have no personal relationships with any people in the program. The person should **not be someone intimately involved in the work** of the service. The support relationship established between the external practitioner and the support team members should allow for discussion about their personal feelings and responses to undertaking the support service delivery. Support of this kind can be provided in a group counseling session for the case managers. However, it is recommended that one-to-one sessions for case managers are the main mechanism of support.

Using a practitioner external to the program aims to ensure that the discussion of personal feelings by case managers has no negative consequences. The team coordinator or the host organization should not normally require report back from the external practitioner. However, there are some situations where report back is required. Where issues are raised in the support sessions that suggest

- A breach of the Code of Conduct or Work Practices Agreement.
- A case manager raises an issue that suggests the worker or a client is in danger, for example, where there is a threat of harm to themselves or others, including children.

3.5 Case Management Meetings

Client-centered HIV case management meetings should occur on a weekly or fortnightly basis. The goal of these regular meetings is to ensure that no client is ever lost to follow-up or forgotten by the program. All case managers need to participate; the team coordinator usually leads case meetings. Basic guidance on case meetings includes:

- **All active case files must be brought** in to the meeting room.
- **Each case file must be opened, read and discussed at each meeting.**
- The participants of the meeting should decide whether clients are to be **moved between the different triage colours**, depending on the progress or development in providing case management services.
- The team coordinator should **assess the standard of note taking** in each file – do the file notes provide a comprehensive and accurate

understanding of what has been done for this client? Remember, case notes are the only way of knowing whether a case manager is providing high quality services. If note taking is poor and inconsistent this suggests that service delivery is poor and inconsistent.

- **Decisions should be made about what to do next for each individual client** and these **decisions should be noted on the file**.
- The decision to **close a client's case** is made at case meetings by the entire team after the case manager of that client has placed this on the agenda.

3.6 Case allocation and caseload management

Each case manager may manage a caseload of up to around 20 clients. The number of clients managed per case manager depends upon a number of factors:

- **The capacity and experience of the case manager** - a case manager with less experience should have fewer clients until they gain more experience.
- **The skills and preferences of the case manager** – one case manager may have skills and/or prefer to work with newly-diagnosed PLHIV while another may have skills and/or prefer to work with people living with HIV-related symptoms or with adherence problems. This can affect where case managers are deployed, i.e. how much time he/she needs to spend on each client.
- **The number of very high needs clients in a case manager's caseload** - for those with very high need clients the number of clients they hold in their caseload should be fewer because they have to devote more to each of them (see below, *triage*, Step Two).

Case allocation is determined by the case management team during their team meetings. A case manager who meets a new client for the first time undertakes intake with the client, but if he is unsure whether he has space / time to take the client himself, he may inform the client that they may be assigned to another case manager who will call them later, and who may or may not be the case manager who did the intake. It is then determined in a case managers team meeting who is the best 'fit' for that client and their particular needs.

The client's own preference for a case manager must always be considered. For example, a transgender person with HIV may prefer a transgender case manager, or a gay Muslim man with HIV may prefer a case manager who is Muslim as well. Also, a client may trust the case manager he just met, and may not want his case to be known to another person.

Moving clients between case managers may be necessary when a case manager stops working for the program or to readjust and balance a particular case manager's caseload. In some circumstances, where a relationship between the client and a case manager is not working well, another case manager may need to replace him/her. Passing the client to a new case manager needs careful consideration and discussion and should involve a shared meeting between the client and both case managers.

The **case management coordinator** facilitates the allocation and reallocation process, supervised by the **case management team leader**.

Managing patient case loads

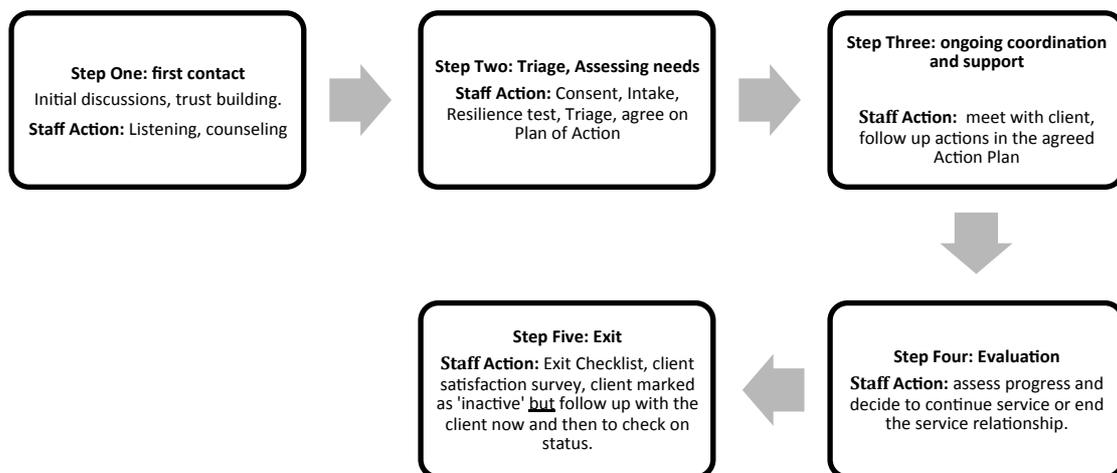
If one considers that a case manager should handle at most around 20 clients at a time, and assuming that clients are under a case manager's care for an average of 3-6 months, one case manager can support a maximum of 40-80 newly diagnosed clients per year. Since there are 2 new cases of HIV diagnosed every day among MSM and TG in Quezon City, 180 cases emerge on average in three months. Assuming that each of them needs/accepts case management services, there is a need for at least **12 case managers** in Quezon City.

While overall, it has been found that case managers can handle a maximum of around 20 cases at the same time, this is dependent on the number of high-need clients in the case manager's caseload. For case management coordinators, in order to assess which case manager is available to take on more work or who is about to be overloaded, it is suggested to pilot a 'points system'. In this experimental system, which has not been used in practice so far, it is proposed that each case manager needs to 'carry' a load of 30 client-support-units (CSU). For the sake of assessing work-load, a high-need client is considered to be equivalent to 3 CSU; a medium-need client is equivalent to 2 CSU and a low-need client 1 CSU. This means that a case manager could be fully employed caring for 10 high-need-clients, 15 medium-need clients, or 30 low-need-clients, or any combination of these numbers. It should be noted that not every high-need client is the same, and the level of need may also vary over a period of time; this system should therefore be used as a guideline/for planning purposes only, and not be rigidly enforced.

SECTION FOUR: CONDUCTING CLIENT-CENTERED HIV CASE MANAGEMENT IN PRACTICE

This section of the manual provides information and resources needed for the case managers to deliver client-centered HIV Case Management in practice; its primary audience is case managers themselves. The service delivery pathway is described as a five-step process in which forms are required for each step and activities required to be completed at each step.

Five steps for service delivery to clients are proposed for client-centered HIV case management and support in Quezon City. At each step, case managers are required to use a set of forms and engage in a series of service activities for and with the client. At the fifth step, which is the client's exit from service, an ongoing maintenance support relationship is established using online social networking tools. This allows ongoing contact with clients and the opportunity to ensure that health concerns and questions can be followed up quickly and easily. The diagram below visually describes the five-step service delivery process:



In the below, the steps are described in detail.

4.1 Client Service Pathway Step One: First Meeting

During the first meeting, the key objective is to gain the client's trust and to avoid losing the newly diagnosed client to follow-up. The first contact usually occurs at an HIV testing and counseling service site when a person has just received their diagnosis of HIV or at a hospital HIV clinic where a person living with HIV is attending for a confirmatory or other blood test and/or to receive HIV treatment. Alternatively, referrals of clients may be received by the host organization from a range of other services in the city or locality in which the service is being provided. At first contact, a case manager mostly listens to the client and allows

them to tell their story of being diagnosed with or living with HIV. Contact information is exchanged, and a date is set up for the second meeting (when CD4 test results are available).

4.2 Client Service Pathway Step Two: Intake, consent, Resilience Scale, triage, and Plan of Action

Step Two occurs at the meeting (or, if there is limited time, two or more meetings) after Step One. After the medical service provider has analysed the CD4 and other pertinent laboratory results, and other contextual aspects of the client's situation are assessed. A number of forms and procedures need to be completed during Step Two. Meanwhile, the case manager should keep notes and ensure that continued counseling and moral support is provided to the client.

4.2.1 Client consent form

The [Client Consent Form](#) (see Annex) should be completed at the beginning of the second contact, once and if the client has decided to enroll in the case management service. The case manager should talk through each paragraph of the form and ask whether the client understands and agrees. Should the client agree they tick ✓ the 'Yes' column on the right hand side. Should the client disagree to any aspect of the consent they should tick ✓ 'No' on the right hand side of the form. Where a client ticks 'No' the case manager should discuss and seek agreement about how to manage information or provide more information.

4.2.2 Client Intake Information Form

The [Client Intake Information Form](#) (see Annex) should be completed for every new client of the Quezon City client-centered HIV Case Management Team after the consent form has been filled out and the client has agreed to receive case management services. Information on the ethnicity, age, sexual identity and living situation and which contextual problems/burdens the client faces can help the team to understand better what the client's needs are; overall, it can also help highlight gaps in service delivery to particular sub-populations.

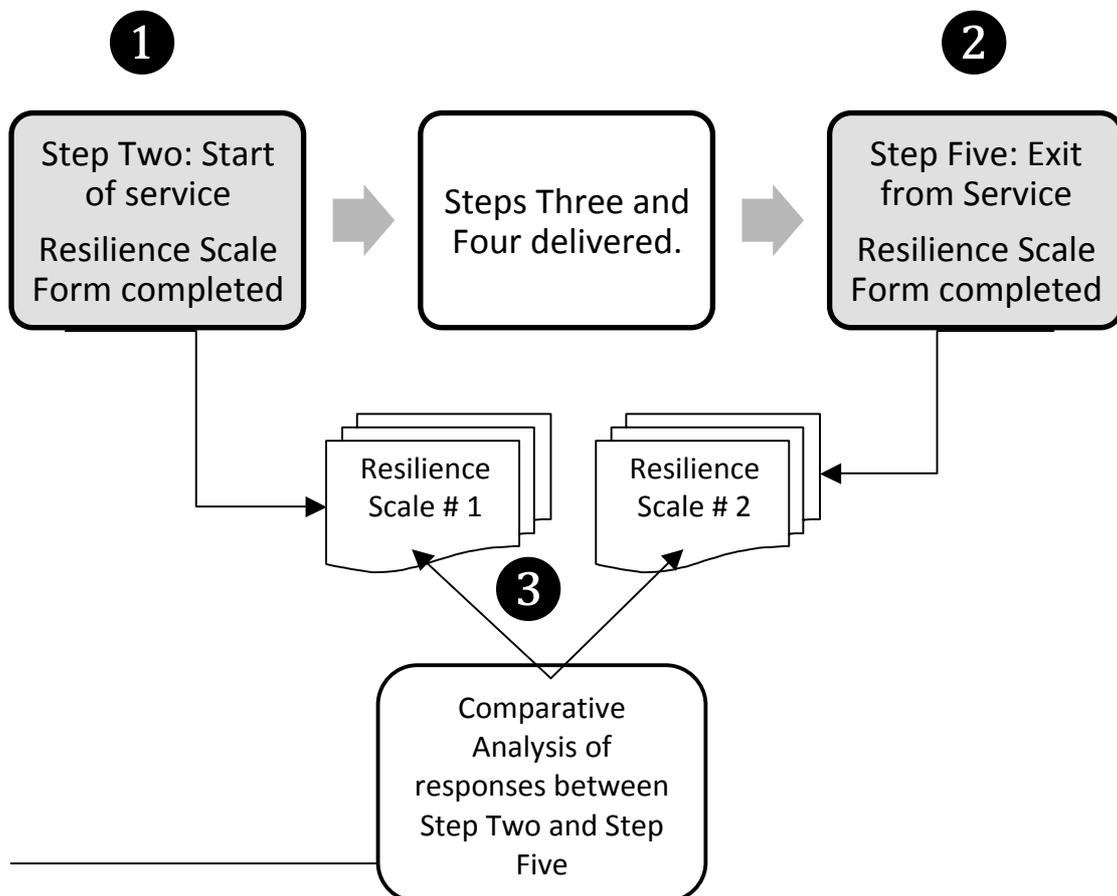
The client information form also ensures the structured collection of clinical information and other information about the client as it becomes available. This includes CD4 count, viral load, AIDS-related conditions and any presenting symptoms of illness at first contact; it also reflects on signs of depression, anxiety, family problems and other social concerns. **Case managers have to embed clinical information into a wider 'portrait' of the client's situation, which goes far beyond clinical and health issues.** All this is important information that helps to decide how to respond to the client's needs. It also allows for reporting to donors and government on clinical markers on entry into the Quezon City client-centered HIV case management service system.

Finally, it is important to document a summary of the story each client tells about their experience with HIV during the first few contacts. It is recommended that notes say something about (a) what was **said** (b) what was **observed** about

the client (a) what was **assessed** about the client’s presenting needs and (d) what was **planned** to do in the future.

4.2.3 The HIV Resilience Scale

The [HIV Resilience Scale](#) (see Annex) is a pre-and-post-service evaluation scale that helps to assess the psychological and emotional state at entry into the service, and the impact of the support services provided by in Client-centered HIV Case Management and Support¹³. It can help assess the level of the client’s need (*triage*, see below). The same form is completed twice by the client: First it is completed at Step Two (see ① below). Service is provided to the client over several weeks/months through Steps Three. The form is completed once again at Step Five: Exit from Service (see ② below). Responses are then compared between Step Two and Step Five (see ③ below) to assess whether the psychological and emotional wellbeing of the clients has improved over the course of service delivery through the Quezon City client-centered HIV case management service.



¹³The HIV Resilience Scale has been developed from the Mental Adjustment to HIV Scale which is a modified version of the Mental Adjustment to Cancer Scale produced by the University of Queensland and the New South Wales Department of Health in Australia. It was tested in a formal study in 2000 to assess its relevance to HIV among homosexual and bisexual men in three Australian Projects. That study applied the scale to 164 homosexual and bisexual men living with HIV. (Reference: *Measuring Psychological Adjustment to HIV Infection*, Authors: Kelly B, Raphael E, Burrows G, Judd F, Kemutt G, Burnett P, Perdices M and Dunne M. In *The International Journal of Psychiatry in Medicine* Vol 30, No. 1, 2000.

The scale utilizes five sub-scales that focus on the level of hopelessness, fighting spirit, personal control, minimization and hopefulness in the client. A six-point Likert scale is used with '1' representing a 'definite no' and '6' representing a 'definite yes'.

The questions about hopelessness refer to the level of despondency of the individual about HIV and their lives. This sub-scale is comparative to the fighting spirit sub-scale and is predicted to return high scores in those with depressive and other psychological complications as well as those newly diagnosed or with HIV symptoms.

Fighting spirit questions refers to the capacity of the individual to feel they have personal agency over their own health and life. This sub-scale is in opposition to the hopelessness sub-scale.

Personal control question refers to the intention to take action and learn more about HIV both from others living with HIV and from medical services.

Minimization questions refer to the capacity of the individual to develop strategies which minimize the negative psychological states associated with an HIV diagnosis.

Hopefulness refers to the capacity of the individual to incorporate strategies that defend against negative psychological states associated with an HIV diagnosis.

4.2.4 Triage of client needs

After the initial counseling and trust-building session(s), CD4 test results and other clinical data are available, the post-diagnosis intake form and the Resilience Test are completed, **an assessment is made of the client's needs** to determine how urgent these needs are. In clinical services this is called *triage* and it aims to ensure that clients with the highest and most urgent needs get service first. A traffic light system has been proposed by THF to categorize client need as either high, medium or low. Caseworkers assess *with the client* their level of need, under supervision of medical staff. A colored sticker is placed on the client's file to indicate the category of need. Caseworkers take advice from medical professionals when necessary.



Red is high need – a client with high needs has a CD4 result of 200 or below and CD4 percentages of 15% or lower but is not yet taking ART. These clients may present with HIV-related illnesses but are not yet taking prophylactic medication. Many require hospitalization or intensive outpatient support. A series of presentations are always high need, regardless of other presentations: (a) a client who discloses recent gender-based violence, (b) is kicked out of his home or otherwise homeless, (c) problematic drug or alcohol use/addiction (d) severe depression with suicide risk or other untreated mental health issues and (e) pregnant women with HIV not yet taking ART.

High need clients receive intensive support including accompanying to hospitals, linking to services and 'listening sessions'.



Amber is medium need – a client categorized as having not urgent but significant need is someone with a CD4 test result of between 499 and 201 and CD4 percentages between 16-24% but is not yet taking ART. Psychosocial presentations such as mental health issues, migration, social isolation, violence and poverty are all part of a medium need assessment. Medium need clients receive semi-intensive support that includes accompanying to hospital appointments, online and face-to-face workshops and group support.

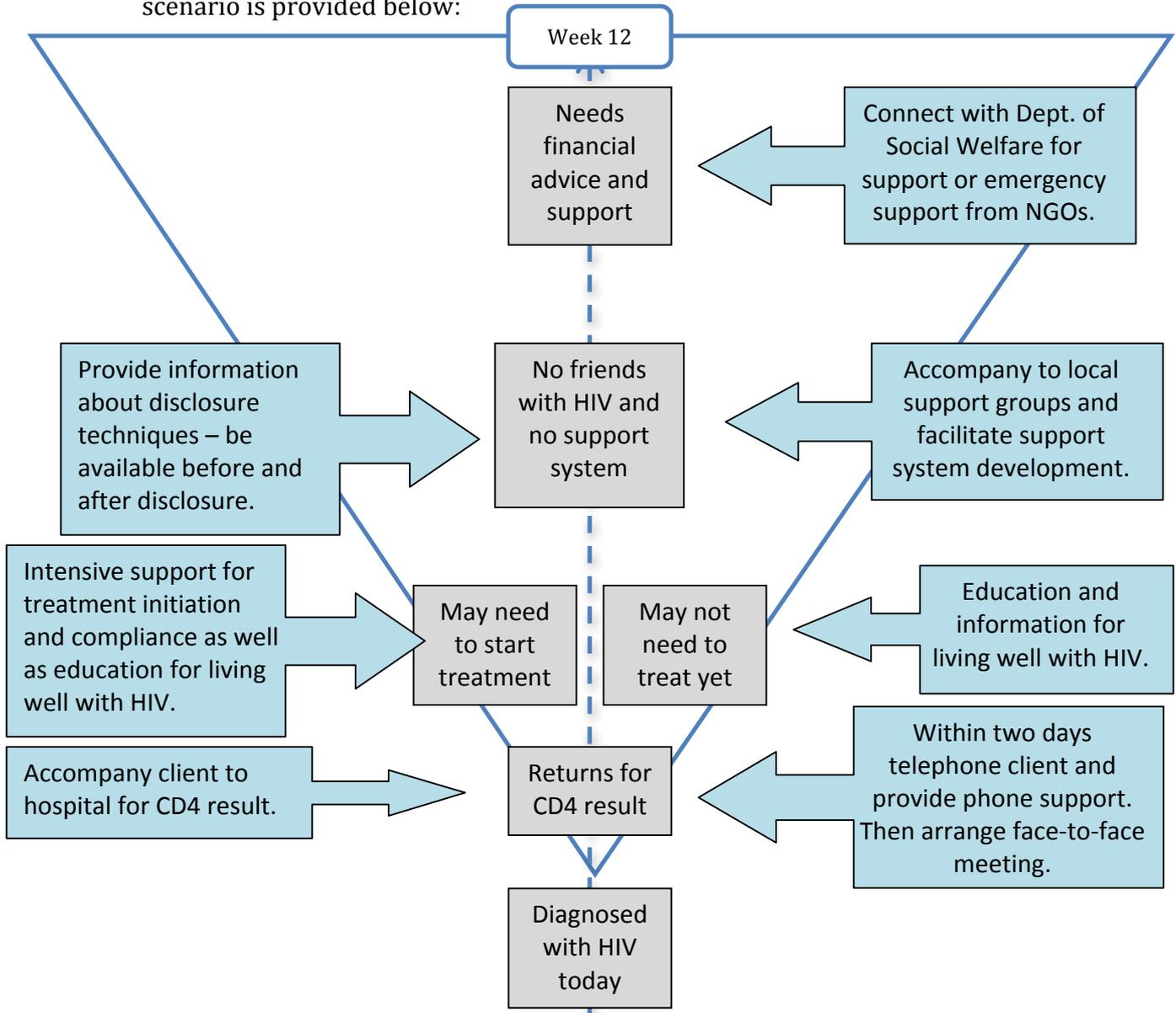


Green is low need – a client categorized as having non-urgent need is someone with a CD4 test result of 500 or more and CD4 percentages above 24%. These are often newly diagnosed clients who have considerable psychosocial adjustments to the news they are living with HIV. They may be emotionally distressed and, although they may have partners, friends and family nearby, may not disclose their HIV status to them. Low need clients receive initial intensive support to ensure baseline CD4 results and ART initiation where possible. Low need clients are connected to other people with HIV through online and face-to-face workshops and groups and are, once stable, supported by phone or social media.

Casework and case allocation meetings are the settings in which client need is finally confirmed. This underlines that discussion with the entire team and the guidance of the team coordinator is essential to determining both the initial category of client need and also changing the category of need over time - as the client's needs are resolved and urgency reduces.

4.2.5 Map of Clients Life Pathway

The diagram in this section of the Client Information Form aims to assist case managers focusing upon what they will do to improve the health of a client over a 12-week period. Along the dotted line (in the middle of the triangle below) the case manager lists the presenting issues and concerns described by the client and assessed by the case manager. Along the outside lines of the triangle list the support that will be provided to the client to address their concerns. An example scenario is provided below:



After this, the activities agreed upon with the client can now be listed as a [Plan of Action](#), which can be found in the Annex section. This document, drawn up together with the client, contains case management service activities based on the problems identified, with deadlines and responsibilities assigned. The majority of these will be the responsibility of the case manager. However, it can be helpful to assign some of these activities to the client so they are taking responsibility for health seeking and managing their own support.

4.2.6 The Client Information Pack

It is important to ensure that all clients are fully informed of their rights and responsibilities. The [Client Information Pack](#) is meant to facilitate this by providing information about rights, privacy and complaints at **the end of Step Two**. The reason this is not done earlier is because at first contact the client may be very emotional. They may not be able to consider this information at that time and they may need a case manager to simply listen to them and help to address urgent needs for information and for alleviating fears and anxieties related to the recent diagnosis with HIV. It is therefore considered more humane to provide the information pack and read through each information sheet at the second face-to-face contact with the client.

The Client Information Pack includes three Information Sheets for Clients that cover Client Rights and Responsibilities, Privacy and Confidentiality and Making a Complaint about services provided by the Quezon City client-centered HIV case management service. Summarizing or reading through the information pack is important because not all clients are literate and those who are literate may not always easily understand everything they read.

Client Information Sheet #1 –Charter of Client Rights and Responsibilities

The case manager reads through this charter or summarizes the key points of the charter with the client. The case manager asks whether the client understands their rights and responsibilities once they have read through the charter. This can help the case manager to keep rights and responsibilities in their mind and it helps the client feel they are informed and aware of both their rights and their obligations in the provision of services.

Client Information Sheet #2 – Our Privacy and Confidentiality Policy

The case manager reads through this policy on privacy and confidentiality or summarizes its key points with the client. Again, the worker asks whether the client understands and whether they have any questions about the policy.

Client Information Sheet #3 – Complaints Resolution Policy

The case manager reads through this policy or summarizes its key points with the client. It can be helpful to explain that knowing how complaints are resolved and discussing potential reasons for complaints before there is a problem can help to prevent problems and/or to resolve problems easily should they occur.

At the end of this process, provide the client with the Client Information Pack so they can take it home and refer to it should they need to do so.

4.3 Client Service Pathway Step Three: Provide continued case management services

Step Three: Ongoing service usually lasts for a period of 3 to 6 months – mostly around 12 weeks of service provision. It involves accompanying a client to sort out his PhilHealth papers, to enroll in the treatment hub, connecting them to other services, such as mental health services, social/PLHIV support groups, and regular meetings with the client one-on-one to discuss and resolve other issues of importance in their lives, for example related to the issue of disclosure to romantic / sexual partner(s) and the family. An [Activity Plan](#), developed during Step Two, guides the service and the client to agree on the key activities needed to address problems in their lives. During this step, case managers attend weekly case discussion meetings with the team and present the issues and activities of the client in this case discussion meeting to receive guidance and support from the supervisor and from others in the team.

While providing services and having contact with your client, it is important to document, either on paper or e-mail/online, a summary of each of the contacts you have with the client, be it online or face-to-face. Note taking is an important discipline for case managers because it allows them to regularly reflect on what is happening in the interaction between themselves and a client. As well as this, note taking is important because (a) it allows others to easily understand what is happening with a particular client if for example a case manager is absent or the client needs support when their case manager is not available; (b) it assists the case manager to remember important details affecting the client; (c) it helps with the collection of data that can inform donors, government and partners about the work of the program and (d) it is often the only way for the host organization to determine whether good, professional service is being provided to clients.

A simple [form](#) can be found in the annex section. This can help the case manager to remember what has happened in the past but can also be a useful way to reflect on what has occurred and what else might need to be done to support the client. Again, it is recommended that notes document (a) what was **said** (b) what you **observed** about the client (c) what you **assessed** about the client's presenting needs and (d) what you **planned** to do in the future.

Guidance on online, internet-based support to clients

Establishing an online, internet-based system for the support of existing and exited clients is a useful and inexpensive way to ensure ongoing maintenance support to people living with HIV. Case managers can carry a small, online caseload of people living with HIV connected to the case manager through Facebook, WhatsApp or LINE and can answer questions or engage directly with a client who messages them with a problem. If clients agree, the case manager can decide to add them to small or larger anonymous groups on FB or LINE where people can also consult each other or answer each other's questions.

At any time in delivery of the four-step peer support service process, a case manager can assist a client to 'friend' them on Facebook or connect via other social networking sites online.

- Case managers are encouraged (but not required) to establish a new identity on Facebook, LINE, WhatsApp or another social media channel specifically for clients of the Quezon City client-centered HIV case management service.
- Case managers work with their casework team to develop standard, short messages about health and wellbeing, treatment adherence, connecting to others, seeking support when needed.
- Pictures posted on social media should never include pictures of clients.

Online Privacy and Confidentiality

Case managers always explain to clients that they are not required to engage with the case manager through Facebook or any other internet-based networking system. This always remains the client's own choice and should be addressed in the confidentiality agreement/service pathway.

It is important to ensure that the client understands how to protect their privacy online. Case managers can assist the client with this if needed.

- The case manager should set up their Facebook options to ensure that information of what they post is not automatically available to others, including setting the privacy setting of one's friends list to be visible to 'only me'.
- Clients should be encouraged to reconfigure their Facebook privacy settings to ensure that others who are not friends cannot read their personal information or who they have befriended from their home page.

Supervision of online activity

Coordinators should 'friend' all case managers online and monitor the case worker and client activity online. Where necessary, the coordinator steps in to resolve difficulties or set boundaries if needed.

4.4 Client Service Pathway Step Four: Evaluation and reviewing the service

Step Four: Review of service involves a discussion with the client toward the end of Step Three. At this point the case manager has been accompanying the client to appointments and actively engaged in resolving health and welfare concerns for the client. The goal of this step is to evaluate with the client whether significant issues have been resolved and if the client is connected to appropriate services and to a community of others living with HIV. If the client feels that all issues have been resolved, it is appropriate to close their case. If the client does not feel that issues have been resolved, then this should be brought to the case discussion meeting for discussion. Service can continue should there be significant outstanding issues unresolved for the client.

Comparative Analysis of Resilience Scale Responses

If the client feels ready to leave, the Resilience Scale, filled in during Step Two, is repeated to see if there have been changes in the way the client feels about his life with HIV. Care should be taken when drawing conclusions about the impact of services on clients' psychological and emotional health. It will be hard to prove that Client-centered HIV Case Management and Support has directly caused an improvement in psychological wellbeing, but it is possible to collect information from clients that describes what the support has done for them. Where psychological and emotional health has not improved, it can be argued that services provided need to be adjusted to address this. Where psychological and emotional health has improved, it is at best possible to conclude that the combination of time passing with service provided has contributed to this improvement. Responses by clients in the [Client Satisfaction Form](#), conducted in Step Five and provided in the annex can help to substantiate such an argument.

If the client and case manager agree to let the client 'graduate' to a situation where they take their own care and treatment into their own hands, the case manager will bring this for discussion at the weekly or biweekly Case Management Meeting; the decision to let a client leave should be agreed upon by the entire team.

Checklist before moving to Step Five:

1. Client is adherent to ARV treatment, no significant side effects and/or CD4 is stable or rising
2. Issues in Plan of Action are all addressed
3. Resilience scale has improved since intake
4. Most important: Client agrees/is ready to leave the service

4.5 Client Service Pathway Step Five: Exiting

Once the case management team agree, at the weekly/biweekly meeting, with the assessment by the case manager that the client is ready to leave the service, during **step Five: Exit from service** a final face-to-face meeting is held with the client. The purpose is to say goodbye, to finalize the Activity Plan and service contract between the case manager and the client. A final [Exiting Checklist](#) is filled out by the client and the case manager, and signed by both, indicating the beginning of a new phase in the client's treatment trajectory. After this, the client is asked to fill in the [Client Satisfaction Survey](#), which should be passed on by the case manager to the Case Management Coordinator in a closed envelope. Explain to the client that the survey will not be opened or read by the case manager.

At this point, offering to continue a connection between the client to the case manager through Facebook or other local social networking sites is helpful. This can help to ensure the client stays connected to the service and to others with HIV who are using the service.

Ongoing maintenance support is a necessary component of Client-centered HIV Case Management and Support. This ongoing contact is less costly and less time intensive. Contact is provided through online social networking sites such as Facebook or other local social networking sites used by the host organization. Ongoing maintenance allows for regular contact between the case manager and

also between clients. This can include telephone contact between the case manager and a client where an issue emerges that needs follow-up.

4.6 Summary: List of forms, actions and outcomes

The table below provides a quick and convenient way to understand the forms needed, actions to be completed and outcomes required for each of the steps.

SERVICE STEPS	FORMS AND ACTIONS	OUTCOME
<p>STEP ONE: First contact with the client.</p>	<p>Contact information is exchanged, CCCM makes notes about first meeting, mainly listens</p> <p>Provide the client with:</p> <ol style="list-style-type: none"> 1. Your name card. 	<p>Client agrees to meet again when CD4 results, other lab tests are in and treatment regimen is available. Information on how to get in contact with you and your organization if the client is having difficulties.</p> <p>Client Contact information.</p>
<p>STEP TWO: Triage, Plan of Action, consent form signed</p>	<p>Client signs consent form and agree to have info about them recorded and used.</p> <p>CCM completes the Client Information Form.</p> <p>Client completes the HIV Resilience Survey form.</p> <p>Determine level of need (Red, Amber, Green)</p> <p>Plan of Action form completed</p> <p>Provide the client with:</p> <p>Client information pack</p>	<p>Client agrees/gives consent to receive Case Management Services.</p> <p>A picture of the presenting issues of the client, and Plan of Action is completed.</p> <p>Agreement to meet again and date set for meeting.</p>
<p>STEP THREE: Ongoing delivery of service (approx. 6-10 weeks).</p>	<p>Accompany or refer the client to services they need.</p> <p>Complete Sessional Form for each session you have with the client.</p> <p>Continue to meet and communicate with client.</p>	<p>Agreement on actions to improve the client's life.</p> <p>Act to meet the needs and improve circumstances by both the client and the Case managers.</p> <p>Connect the client with yours and other services.</p>
<p>STEP FOUR: Review of service provided.</p>	<p>Discuss with client</p> <p>Ask the client to complete:</p> <p>Client Resilience Scale (2nd)</p>	<p>Comparison of client resilience scales.</p>
<p>STEP FIVE: Exit the client from service and refer.</p>	<p>Ensure the client is ready to complete service (Exit Form).</p> <p>Connect the client to a case manager through Facebook or other social networking facility if they wish to and ensure client is engaged with other services.</p> <p>Client completes the Client Satisfaction Form.</p>	<p>Agreement to finish service</p> <p>Client is connected to services and able to access.</p> <p>Client is connected to a Case manager for maintenance support through Facebook.</p> <p>Client knows how to reconnect with you.</p>

SECTION FIVE: APPENDICES

JOB STATEMENT –COORDINATOR, HIV CASE MANAGEMENT TEAM

Office Use Only:

Job Title: Coordinator, HIV Case management team	Job Status: Full time
Department: [add]	Job Grade: Coordinator 1
Review date: [add]	Supervisor: Program Manager

Overview

The coordinator of a Case management team is responsible for recruitment, administration, supervision and overall coordination of a team of case managers who deliver counseling and case management to people living with HIV. The coordinator supervises up to six case managers at the places they provide services.

About The Quezon City client-centered HIV case management service

The Quezon City Client-centered HIV Case Management Team provides support and case management services to people living with HIV to help them access the services they need to live healthy and independent lives with HIV. The Quezon City client-centered HIV case management service provides ‘in-reach’ services to hospitals and clinics in local places, program workers accompany people living with HIV to medical appointments to help them solve problems they experience in the health system and they provide one-to-one and group peer support and counseling to people living with HIV. The Program is a health promotion service that aims to (a) build knowledge and skills in people living with HIV so they can make informed choices about their health, (b) work cooperatively with HIV service agencies to provide seamless services and (c) influence and change health service policy and implementation so that it better meets the needs of people living with HIV over time.

Key responsibilities of this position

The coordinator of a Case management team is responsible to supervise and coordinate a team of six case managers who travel across Bangkok working in clinics and hospitals delivering case management within HIV testing and counseling services provided by these hospitals and clinics. The Coordinator works from the host organization but travels to the clinic and hospital sites where the Centre delivers the service. The Coordinator is responsible to manage relationships with clinical staff at these sites and ensures the smooth running of service at these sites. The Coordinator also manages all logistical, administration, service, staff and financial needs of their Case management team.

Salary and Conditions

Salary: [add salary] per month dependent upon experience.

Conditions: Permanent Government position

Probationary Period: According to Government guidelines

Hours of work: 40 hours per week.

Roles and Responsibilities

General roles and responsibilities:

- Facilitate the provision of in-house clinic services (e.g. HIV Counseling and testing, sexually transmitted infections diagnosis and treatment) including baseline laboratory workups and prophylaxis to newly diagnosed HIV clients;
- Prepare the necessary referral to members of the Service Delivery Network in consultation with the case management team leader, if necessary;
- Ensure that the family, and if available, designate a facility-based MSM Peer Educator to accompany referred clients to needed services in identified Service Delivery Network member agencies;
- Follow-up status of referred clients;
- File Individual Client Record (ICR) for safekeeping against unauthorized access, attaching the client's behavior or treatment plan generated from the Motiv8 session;
- Encode data to the client database;
- Update the database of clients for succeeding Motiv8 sessions;
- Suggest "problematic" cases for discussion in the Case Management Committee in consultation with the facility-based MSMPEs;
- Act as Secretariat of the Case Management Committee Meetings;
- Coordinate and organize committee meetings twice a month;
- Facilitate the meeting with the chairperson of the committee;
- Regularly update and prepare documentation of cases for the meetings; and
- Keep record of the minutes and documentations of the meeting.

Detailed, case-management roles and responsibilities of the coordinator:

Supervision

- Daily individual and group supervision with case managers.
- Coordinate individual work planning and work plan review with the case manager team.
- Advise and guide case managers in relation to their day-to-day responsibilities.
- Coordinate team building with case managers.
- Coordinate individual annual performance review of case managers.
- Explore and develop professional development opportunities for case managers.

Administration

- Coordinate and ensure that support staff has the forms they need and follow them.
- Coordinate service data reporting.
- Oversee management of office space, equipment and logistics with the case managers
- Ensure that case managers follow protocols and procedures for office administration, rostering, etc.

Leadership

- Represent the Quezon City client-centered HIV case management service at local clinic and hospital sites ensuring that the team has the office space and resources it needs to deliver a high quality service.
- Meet regularly and work cooperatively with the clinical teams at these sites to ensure smooth integration of services in to clinical teams.
- Explore and coordinate with mobile HIV testing and counseling services to offer this service if relevant.

Contribute to a welcoming workplace

- Work to ensure the workplace is free from bullying, harassment and all forms of discrimination.
- Work to ensure that program is a welcoming service program for all marginalized people including ethnic minorities and migrants.
- Ensure the workplace is a welcoming environment for people living with HIV, including women and girls, people who use drugs, men who have sex with men and transgender people.
- Help to eliminate social and service barriers for clients.

Organizational responsibilities

- Participate in supervision with the Case Management Team Leader and follow all reasonable instructions.
- Read and utilize the host organization's policies and procedures when representing the organization in service delivery.
- Organise, lead and actively participate in team meetings and team building exercises conducted by the host organization.
- Ensure yearly individual performance reviews of individual case managers.
- Engage in professional development to build your skills.

Selection Criteria

- Bachelor's or Masters degree in Nursing, Social Work or Social Science
- The candidate must have training on HIV counseling and testing, behavioral change communication, ART and adherence, and motivational interviewing.
- Experience in the supervision of staff or volunteers.
- Experience providing support, counseling or welfare services to clients.
- Demonstrated experience working within or with clinics and hospitals.
- Demonstrated understanding and commitment to people living with HIV, and sensitivity to key populations for HIV.
- Demonstrated ability to work independently.
- Be highly organized with the ability to meet deadlines and organizational expectations on time and without prompting.
- Ability to communicate cooperatively and diplomatically with people at all levels.

JOB STATEMENT –CASE MANAGER

Office Use Only:

Job Title: Case manager	Job Status: Casual
Department: [add]	Job Grade: Casual 1
Review Date: [add date]	Supervisor: Coordinator

Background

The Quezon City Client-Centered HIV Case Management Team is responsible for providing case coordination and peer support services to people living with HIV. Case managers operate in teams and travel across the city to provide case coordination and support services at clinic and hospital sites. Case managers usually carry a caseload of 20 clients at the time and engage in assessment, referral and short-term (3-6 months, depending on client need) peer support to these clients. Case managers are responsible for administration, evaluation of the service provided and liaison with local clinical teams where they provide services and are supported by a Coordinator.

The Quezon City Client-Centered HIV Case Management Team provides support and case coordination services to people living with HIV to help them access the services they need to live healthy and independent lives with HIV. It provides 'in-reach' services to hospitals and clinics in local places; program workers accompany people living with HIV to medical appointments to help them solve problems they experience in the health system, and they provide one-to-one and group peer support and counseling to people living with HIV. The Program is a health promotion service that aims to (a) build knowledge and skills in people living with HIV so they can make informed choices about their health, (b) work cooperatively with HIV service agencies to provide seamless services and (c) influence and change health service policy and implementation so that it better meets the needs of people living with HIV over time.

Salary and expectations

Stipend: _____ per day of work plus _____ per day for mobile phone and transportation costs. Expected times of work: Flexible working hours from Monday to Friday for a maximum of 40 hours per week, must be willing to work during weekends and holidays if the situation requires this.

Roles and Responsibilities

Case Management and Counseling

- Engage in initial intake and assessment of people living with HIV who are referred to the case worker from the Outreach Team or from HIV testing sites in the city.
- Accompany clients to clinics and hospital sites where service is delivered, depending on client need.
- Provide basic counseling and support to people living with HIV over a three to six month period, depending on client need.
- Conduct referral and follow up of referrals to other services.

Administration

- Use the forms provided and complete them in delivering client services.
- Collect client data after every contact and ensure that records are added to the client file for review by the coordinator.
- Follow general protocols and procedures for office administration.

Liaison

- Represent the Quezon City Client-Centered HIV Case Management Team at local clinics and hospital sites and work cooperatively with clinical teams at these sites.
- Attend local places/events where people living with HIV gather to promote the service at these sites.

Contribute to a welcoming work environment

- Work to ensure the workplace is free from bullying, harassment and all forms of discrimination.
- Work to ensure that the Quezon City Client-Centered HIV Case Management Team is a welcoming environment for all marginalized people including ethnic minorities and migrants.
- Ensure the workplace is a welcoming environment for people living with HIV, men who have sex with men, transgender people and women.
- Help to eliminate social and service barriers for clients.

Organizational responsibilities

- Participate in supervision meetings and joint weekly planning exercises, including those on 'real-time evaluation' with the Coordinator (or other members of the management team as directed) and follow all reasonable instructions.
- Read and utilize the Quezon City Client-Centered HIV Case Management Team policies and procedures when representing the organization in service delivery.
- Actively participate in team meetings and team building exercises conducted by the team.
- Actively participate in individual annual performance review conducted by the team.
- Engage in professional development to build your skills.

Selection Criteria

- Experience in the provision of support, education or care services to people living with HIV.
- Demonstrated skills and experience in counseling or peer support.
- Personal and/or professional experience with clinics and hospitals.
- Demonstrated understanding of or commitment to people living with HIV, especially men who have sex with men and transgender women.
- Ability to work independently but cooperatively with others.
- Be highly organized, outgoing and have excellent social skills.
- Demonstrate a high level of integrity, compassion for others and a high degree of honesty.

CODE OF CONDUCT for Staff

The Quezon City Client-Centered HIV Case Management Team has an obligation to work with care and skill and to act in a way that promotes the Quezon City client-centered HIV case management service and protects our clients. You agree to:

Personally:

- Treat everyone fairly, with respect, courtesy, compassion and sensitivity.
- Do not engage in discrimination or verbal or physical bullying.
- Do not ever engage in romantic or sexual relationships with clients.
- Do not use illegal substances and/or alcohol in the course of duty.

Ethically:

- Use the facilities and resources of the Quezon City Client-Centered HIV Case Management Team effectively, economically, appropriately and not for personal gain.
- Do not accept money or solicit gifts from clients or our partners.
- Avoid or appropriately resolve any conflict of interest between your private interests and the Quezon City Client-Centered HIV Case Management Team.
- Report immediately to management any unethical, corrupt or criminal conduct by yourself, by fellow case managers, outreach workers or by clients.

Legally:

- Follow lawful and work-related directions given by supervisors.
- Comply with all policies and procedures of the Quezon City Client-Centered HIV Case Management Team outlined in this manual.
- Do not disclose any confidential information during or after work conducted for the Quezon City Client-Centered HIV Case Management Team.
- Comply with all privacy policies and requirements for collection notification.

Professionally:

- Be committed to team building principles.
- Abide by program guidelines and principles.
- Observe all Quezon City Client-Centered HIV Case Management Team Service goals, rules and procedures as specified in this manual.
- Meet the standards and policies of the Quezon City Client-Centered HIV Case Management Team.
- Represent the Quezon City Client-Centered HIV Case Management Team in a positive and professional way.

NOT ADHERING TO THIS CODE CAN RESULT IN IMMEDIATE DISMISSAL.

I, _____ have read and understood this Code of Conduct and I agree to abide by the personal, ethical, legal and professional practices outlined above.

Signed _____ Date _____

CONFIDENTIALITY and WORK PRACTICE AGREEMENT

This agreement should be signed by everybody working for the Quezon City Client-Centered HIV Case Management Team. Please complete this form and agree to the confidentiality and work practices requirements.

I, _____ (FULL NAME)

Accept that as an employee/volunteer of the Quezon City Client-Centered HIV Case Management Team, I may learn certain facts and have access to records that are of a personal, sensitive and confidential nature.

I understand that information of a personal and confidential nature includes:

- Medical conditions and treatments;
- Relations with family members;
- Sexual relations, HIV status of individuals and engagement in sex work or drug use by individuals;
- Names and addresses of people living with HIV;
- Other personal and sensitive information;
- Other records pertaining to volunteer workers, staff and clients.

I undertake that I will not reveal to any other person any confidential information about:

- The business of the Quezon City Client-Centered HIV Case Management Team;
- The Quezon City Client-Centered HIV Case Management Team employees or volunteers; and
- Clients of the Quezon City Client-Centered HIV Case Management Team that come to my knowledge during the course of my employment, and which has not been authorized by the Team Leader for release and/or specifically authorized by the client to whom the information pertains.

I further understand that this obligation:

- is subject to any legal obligation to disclose the information; and
- Applies to me both while an employee/volunteer of the Quezon City Client-Centered HIV Case Management Team and after I cease to be an employee/volunteer of the Quezon City Client-Centered HIV Case Management Team.

I understand that if I breach an individual's confidentiality, I may be subject to administrative sanctions by the Quezon City Health Department and/or subject to prosecution under Philippine law. In such a case, the Quezon City Client-Centered HIV Case Management Team will not indemnify me for damages. I accept that a breach of these conditions may result in instant dismissal, and civil and/or criminal proceedings.

I have read and accept the Quezon City Client-Centered HIV Case Management Team, Code of Conduct as the rules and guidelines by which I am required to work. I also accept that my colleagues are working to the same Code of Conduct.

Signed _____ Date _____

This document will be retained on your personnel file.

INFORMATION PACK FOR CLIENTS: Charter of Client Rights & Responsibilities, Confidentiality & Privacy Policy and Complaints Resolution Policy

At the Quezon City Client-Centered HIV Case Management Team we want you, as a new or potentially new client of our service, to understand your rights and responsibilities when you receive services from us. Below you'll find a list of basic rights and responsibilities that we hope you'll agree with.

Your Rights

As a person using the Quezon City Client-Centered HIV Case Management Team you have a number of important rights, as follows.

You have the right to:

- Be treated with respect and courtesy
- Have your needs assessed
- Be informed and be part of decision making about the services we provide you
- Receive quality services
- Have the right to make a complaint without retribution – in other words, services will not be refused to you or the quality reduced because you make a complaint about us
- Have someone represent you (an advocate)
- Have your privacy and confidentiality respected and to access all personal information kept about you by us
- Accurate information about our Program and the services we can provide you
- Non-discriminatory care – in other words, receive services which do not discriminate on the basis of age, race, religion, sexuality or gender
- Ask for a different service provider and have that request met wherever it's possible

Your Responsibilities

As a person using the Quezon City Client-Centered HIV Case Management Team services, you have a number of important responsibilities that we want to inform you of.

You have the responsibility to:

- Treat staff, volunteers and other clients with respect and courtesy – for example, letting us know as soon as possible if you cannot keep an appointment
- Provide a safe environment for staff, volunteers and clients and help us to provide you with services safely – for example, by not smoking while staff are present
- Avoid placing our staff in situations that are illegal or that compromise our integrity and reputation
- Inform us if you change your address or contact details
- Inform us if you no longer require or desire our assistance

- Take responsibility for the results of any decisions you make with us
- ## **INFORMATION FOR CLIENTS #2 Our Privacy and Confidentiality Policy**

This information leaflet tells you about the steps that the Quezon City Client-Centered HIV Case Management Team takes to protect your privacy and confidentiality.

Our commitment to you

At the Quezon City Client-Centered HIV Case Management Team we are strongly committed to protecting your personal information and to ensuring that information about you is not given or shared with others without permission. Our staff have been trained in protecting your privacy and given clear instructions about how to do so. They have signed an agreement saying that they will protect your personal information carefully. We will do everything in our power to protect your personal and private information.

Aim of our privacy and confidentiality policy

The aim of our privacy and confidentiality policy is to protect the personal and sensitive information of all our clients by providing clear and unequivocal direction to the Quezon City Client-Centered HIV Case Management Teamstaff about their obligations to protect the personal and sensitive information of clients.

Our client privacy and confidentiality policy aims to provide staff with clear and practical guidance that assists them in their day-to-day work to ensure the highest quality standard of confidentiality and privacy protection possible. This policy applies to all paid staff, casuals and contractors of the Quezon City Client-Centered HIV Case Management Team.

Getting your consent

At the second meeting between you and the case manager of the Quezon City Client-Centered HIV Case Management Team, you are asked to sign the *Client Consent Form* stating you are consenting to the collection and storage of information about you and that you consent to the sharing of information about your situation in an anonymous format to government, to our donors and in reports or journals.

Any transmission of information outside this code is deemed to be a breach of your confidentiality. The boundaries of confidentiality are outlined in the Quezon City Client-Centered HIV Case Management Team Confidentiality and Privacy Agreement that all staff sign when they first start working with us. All client-centered HIV Case Management and Support staff and contractors are under an obligation not to convey directly or indirectly, to any source, any private or personal information about a client that they are given or may obtain during the provision of their services. Breaches to this obligation shall be deemed to be a breach of confidentiality.

How we store and transmit information about you

We store information about our clients in a locked filing cabinet in an office that is staffed or locked when no one is present. We instruct our staff that information about clients should be stored in a locked filing cabinet or on a computer with a saved password. Information about clients is not left unattended on desks or at photocopiers or other places in the office.

As well, we provide clear advice and direction to our staff about how information about clients should be stored and transmitted. Client identifying details are NOT included in any emails or other written communications.

What to do if you believe your privacy has been breached

Our staff have been trained and are committed to preventing breaches of your confidentiality. Nevertheless, you may believe your privacy has been breached and, if so, we want to hear from you. Contact [NAME, POSITION, TELEPHONE NUMBER, EMAIL ADDRESS]. When dealing with your complaint we will:

- Treat you with respect and take your complaint seriously.
- Investigate the complaint within one week and call to explain our findings.
- Provide you with a new staff member or volunteer.

INFORMATION FOR CLIENT #3 Complaints Resolution Policy

About this policy

The policy describes the resolution process that we follow where a complaint is received from a client or stakeholder regarding the behavior or service delivery provided by a staff member, volunteer or contractor of the Quezon City Client-Centered HIV Case Management Team. It outlines the steps to be taken in the event of a written complaint or grievance and who is responsible to lead and resolve these complaints.

Aim of this policy

The aim of this policy is:

- To foster an atmosphere within the Quezon City Client-Centered HIV Case Management Team in which complaints are viewed positively as a mechanism of quality service improvement and enhancing the reputation of the Program.
- To provide for the resolution of complaints about staff, volunteers and contractors quickly and efficiently.
- To provide transparent and accessible mechanisms for the resolution of complaints and review of the Quezon City Client-Centered HIV Case Management Team decisions in relation to grievances and complaints.

Scope of the policy

The scope of this policy includes the activities, responsibilities and reporting relationships of staff, volunteers and contractors of the Quezon City Client-Centered HIV Case Management Team.

Promoting the policy

All stakeholders of the Quezon City Client-Centered HIV Case Management Team are entitled to be informed of their right to resolve grievances that they may have from time-to-time with staff, volunteers or contractors and with service delivery provided by the Program. In order to assist in promoting awareness of this right, the Quezon City Client-Centered HIV Case Management Team will ensure that:

1. All clients are provided with a Client Rights Information Pack at the point of initial assessment and an explanation of how to complain is provided by a staff member or volunteer.
2. The Quezon City Client-Centered HIV Case Management Team website will include information about how to complain on its website.

Complaints Resolution

General Principles

1. Genuine grievances are welcomed by the Program and its staff as an opportunity to improve the processes and reputation of the Program.
2. The Program holds the view that all stakeholders of The Quezon City client-centered HIV case management service have the right to seek resolution of grievances against staff, volunteers or services.
3. Complainants will therefore be treated with respect and care and there will be no recriminations by any other persons connected to the Program against any complainant.

Making a complaint

1. Enquiries about how to make a complaint about the service received can be directed to [NAME OF PERSON, TELEPHONE NUMBER, EMAIL ADDRESS].
2. The Program will welcome verbal complaints and will document the details on the complainants' behalf.
3. Complaints can be received by post, marked 'confidential' and directed to [NAME, POSITAL ADDRESS].
4. Alternatively, email complaints can be forward to [NAME, EMAIL ADDRESS].
5. Where the complaint relates to the Program Manager, those complaints can be received by post, marked 'confidential' and directed to the Director.
6. Alternatively, email complaints relating to the President can be forward to [NAME, EMAIL ADDRESS].
7. Complaints can be anonymous. However, communication to the complainant about deliberations will not be possible.

Resolution of complaints

1. Complaints will be considered carefully by the Program.
2. The management team will consider and discuss the complaint, documenting the discussion and all decisions made in relation to the complaint.
3. Action to be taken:
 - **Issue 1: the grievance relates to deficiencies in policy, procedure or systems**
A resolution is made to alter policy, procedure and systems and monitor improvements.

- **Issue 2: a grievance against an individual is found to be justified**
Provide support and counseling to the specific staff member or volunteer aimed to assist them understanding the deficiency and improving behavior and performance. The Program Manager must monitor performance improvements.
- **Issue 3: the individual's behavior continues**
A clear directive to cease behavior in writing and dismissal of a particular staff member or volunteer where the grievance is serious, proven true and the behavior continues.
- **Issue 4: the behavior is illegal or dishonest**
This may be cause for instant dismissal of a particular staff member where they act dishonestly or illegally.
- **Issue 5: there is no grievance to answer from managements' perspective**
The Director of the host organization may decide to take no action and make no agreements where they believe there is no grievance to answer.

Communicating the results

1. Communication in regard to the Quezon City Client-Centered HIV Case Management Team deliberations will occur by telephone or face-to-face in the first instance where possible.
2. A follow-up letter/email (where the complainant has identified themselves) will then occur.
3. Where resolution has resulted in Issue 5 above the host organization must outline its reasoning in the written reply.

Unresolved grievances

In the event that a complainant remains dissatisfied with the Quezon City Client-Centered HIV Case Management Team decision about their concerns a further process of mediation can be established to assist resolution. In these instances:

1. The complainant must indicate in writing (as outlined above) that they remain dissatisfied and request external mediation.
2. The host organization enters in to an agreement with a third party to assist and mediate resolution. This third party may be a local service provider at a clinic or hospital familiar to the client.

Vexatious Complainants

In some cases where the above processes have been exhausted it may be necessary for the Quezon City Client-Centered HIV Case Management Team to decide a particular individual is a vexatious complainant.

A vexatious complainant would be someone where there is evidence of a previous relationship with a staff member and the complainant is using the resolution process to abuse and psychologically injure that individual. In these cases, the Quezon City Client-Centered HIV Case Management Team has an obligation to protect the individual being victimized.

In other circumstances, a vexatious complainant may have complained repeatedly about the same or differing issues; The Quezon City Client-Centered HIV Case Management Team may have completed the above processes only to receive further complaints. In this case the Program is entitled to determine the complainant a vexatious complainant and no longer consider complaints received by this individual.

The Program will write to an individual determined to be a vexatious complainant informing them of their decision and that they will no longer consider complaints received by them in future.

CLIENT CONSENT FORM

In order to provide you with service I need to ask for your permission to collect, store and use information about you. The Quezon City client-centered HIV Case Management Team keeps files on each client it supports. These files are kept in a locked storage cabinet in our office. Personal and contact information on clients is not released to others without your permission. If we report on you as part of progress report to the Government or to donor organizations, no names, no addresses, no information that could identify you are provided.

Do you agree? Yes No

I have: Yes No

- Been informed about why and how information is kept about me
- Participated in determining the support that will be provided to me
- Been informed where and how this information will be stored

Sometimes it can be helpful to coordinate your support with other services such as hospitals and clinics or welfare agencies. After discussion with your case manager, you can nominate here the agencies that you agree we can talk to on your behalf:

1. _____
2. _____
3. _____
4. _____
5. _____

Signed: _____
(Client's Signature)

Date: ___/___/___

Name: _____
(Client's Name)

Case manager: _____

Initials

CLIENT INTAKE INFORMATION FORM

CM name: _____ Place of intake: _____ Date: _____

Client Name: _____ UIC Code: _____

Address: _____

Mobile: _____ Email: _____

LINE / WhatsApp / Skype / FB Messenger ID (Pls circle): _____

Year of birth: _____

Living situation:

Alone With friend With partner With parents/family Other _____

Sexual identity: Gay male Bisexual TG woman Other: _____

Clinical Info: CD4 count: ____ Date: _____ Viral load count: ____ Date: _____

Diagnosed AIDS-related conditions (if any):

--

Presenting symptoms of illness (if any):

--

Initial service received from place of intake:

HTC STI/ STI diagnosis and treatment CD4/ CD4 testing Viral load testing TB screening Other (specify): _____

Contextual factors

Signs of depression Using drugs Involved in sex work Unemployed
 Homeless Suicidal Other mental health problem Family problems Violence

The story of the client (*Summarize the story of the client as described in your first meeting*)

--

HIV RESILIENCE SCALE

Client UIC: _____ Step Completed: 1 | 4 (circle one) Date: ___/___/___

HOPELESSNESS							
		1 Definite No	2	3	4	5	6 Definite Yes
1	At the moment I take life one day at a time.						
2	Problems with HIV prevent me from planning ahead.						
3	I suffer a great deal of anxiety about HIV.						
4	I feel like giving up.						
5	I am not very hopeful about the future.						
6	I feel I better not make plans for the future						
7	I feel that life is hopeless.						
8	I feel I can't do anything to cheer myself up.						
9	I find it difficult to carry on my life as I have always done.						
FIGHT SPIRIT/SELF-EFFICACY							
		1 Definite No	2	3	4	5	6 Definite Yes
10	I have been doing things that I believe will change my health. E.g. diet, quit smoking.						
11	I firmly believe I will eventually be OK.						
12	I have been doing things that I believe will improve my health. E.g. exercise, yoga.						
13	I believe that my positive attitude will help me.						
14	I try to fight the illness.						
15	I feel that there are things I can do to help myself.						

PERSONAL CONTROL

		1	2	3	4	5	6
		Definite No					Definite Yes
16	I try to find out more about HIV.						
17	I want to make contact with others with HIV.						
18	I am trying to get as much information as I can about healthy lifestyles.						
19	I feel empowered to take charge of my health, and do not leave it all to my doctors.						

MINIMIZATION

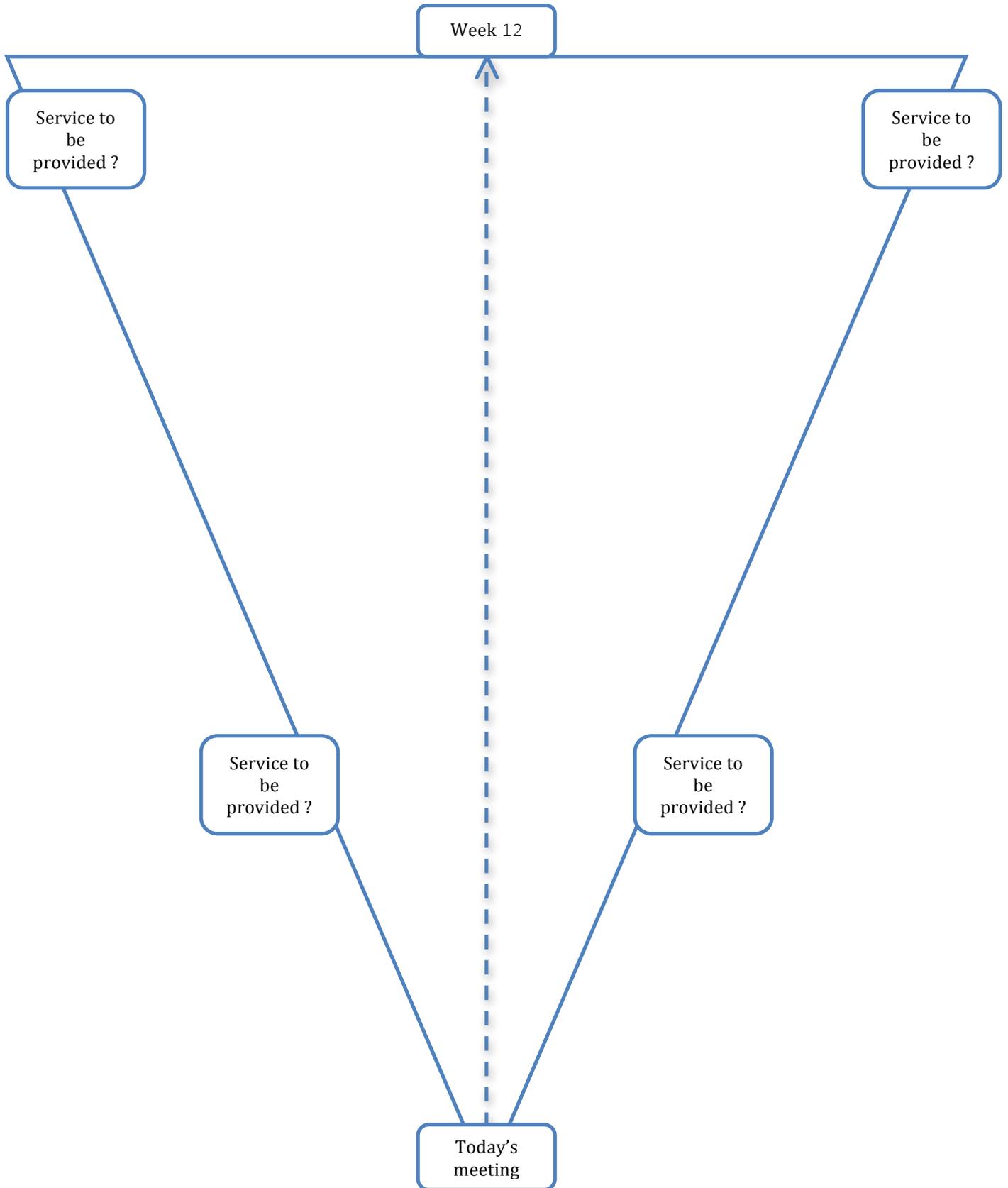
		1	2	3	4	5	6
20	I've put myself in the hands of God.						
21	I count my blessings.						
22	I keep busy so I don't have time to think about HIV.						

HOPEFULNESS

		1	2	3	4	5	6
23	I try to keep a sense of humor about my situation.						
24	Other people worry about my health situation more than I do.						

CLIENT PLAN OF ACTION FORM

Map of Clients Life Pathway



Plan of activity for and with the client

No.	Activity	Deadline	Who?	Remarks
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

MEETING NOTES - TO BE ADDED TO CLIENT FILE

CM name: _____ Place of intake: _____ Date: _____

Client Name: _____ UIC Code: _____

Notes

Meeting 1 *(Keep notes on what happened during the session)* DATE: _____

Meeting 2 *(Keep notes on what happened during the session)* DATE: _____

Meeting 3 *(Keep notes on what happened during the session)* DATE: _____

Meeting 4 (*Keep notes on what happened during the session*) **DATE:** _____

<hr/>

Meeting 5 (*Keep notes on what happened during the session*) **DATE:** _____

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Meeting 6 (*Keep notes on what happened during the session*) **DATE:** _____

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CHECKLIST UPON EXITING THE CASE MANAGEMENT SERVICE

If, after reviewing progress with the client during Step 4, it is decided that the client has reached their objectives in the Plan of Action and feels confident and ready to continue their treatment by themselves, the following checklist should be ticked and signed by client and case manager, and added to the Client File.

- ___ Client is adherent to treatment, is not facing side effects or complications related to treatment, and/or his CD4 is stable or rising;

- ___ All issues, tasks and objectives stipulated in the case management Plan of Action agreed with the client during the Intake (Step 2) have been achieved;

- ___ The Resilience Scale has been filled out for the second time (after Step 2) and is stable and/or shows signs of improvement;

- ___ The client consents to leaving the Case Management service for now, but can still contact the Case Manager and knows they can come back for additional service and support in the future, if needed.

Signed at _____ on the date of _____:

Case Manager

Client

CLIENT SATISFACTION SURVEY

Thank you for participating in the Client Satisfaction Survey. Your feedback is important. It will help us learn more about what is good and what we can improve about our services. Please complete and then enclose it in the envelope provided.

ABOUT YOU

a. Where do you live? _____ UIC code: _____

(CITY/ZIP CODE ONLY PLEASE)

b. What is your gender? Male Female Transgender

c. What is your sexual orientation? Homosexual Bisexual Hetero Other: _____

d. At which clinic did you meet your case manager? _____

e. When did you start case management services? _____

FIRST CONTACT WITH THE PROGRAM

During your first or second contact with a case manager did they inform you of:

f. Your rights and responsibilities as a client? Yes No

g. How to make a complaint? Yes No

h. How information about you would be stored? Yes No

i. Your rights to privacy? Yes No

Is there anything else you'd like to add about your first contact with us?

CONTACT WITH OUR OFFICE & OTHER STAFF

a. Was the case manager always polite/friendly? Yes Mostly No

b. Did the case manager always contact back quickly?

Yes Most of the time Sometimes No

c. Did they do what they said they would do?

Yes Most of the time Sometimes No

d. Did they review/evaluate your case with you?

Yes Most of the time Sometimes No

e. Did your case manager attend meetings with you as agreed?

Yes Most of the time Sometimes No

Is there anything else you'd like to add about contact with staff?

RESULTS FROM OUR SERVICE TO YOU

f. Were you satisfied with the results of our case management service to you?

Very satisfied Satisfied Neutral Unsatisfied Very unsatisfied

g. Do you feel better able to manage now than before our service to you?

No Somewhat Yes

h. Do you feel better able to achieve your hopes for the future now than before our service to you?

Yes Somewhat No

i. Do you have more contact with other PLHIV now?

No Somewhat No

j. Do you have easier access to local services now?

Yes Sometimes No

k. Are you more confident about your future?

No Somewhat No

Is there anything else you'd like to add about the results of our service to you?

Thank you again for taking the time to complete and return this survey.