



ADAHPT Case Management Model

This fact sheet is to assist services working with ADAHPT to understand case management and the ADAHPT model of Co-case Management.

Case Management: a definition

Case management assumes that clients with complex and multiple needs will require a range of services and that this be achieved as seamless service delivery. Case management is based in service provision arrangements that require different responses from within organisations and across organisational boundaries. The process is seen as a boundary spanning strategy to ensure that

service provision is client rather than organisationally driven (Case Management Society of Australia 2002).

Although there are numerous definitions, the common theme is seen as a process for ensuring that clients are provided with whatever service/s they require in a coordinated, effective and efficient manner.

Case Management: the objective

The main objective of case management is 'continuity of care'. This is seen to have two facets. One being that services are comprehensive and coordinated and the other is that these services can continue over time

as well as being provided as the client's needs change. This is particularly crucial when the client group is seen to have a significant and 'lifelong' disability.

What are the components of case management?

There are five (5) functions of case management that appear in almost every description regardless of it's context. These are:

- **assessment** which establishes what the individual's needs are; this can occur both by individual assessment or by a particular team or service. This should include both the case manager's and particularly the client's view of the problem/s
- **planning** to ensure service provision is coordinated and comprehensive
- **linking** with services to ensure needs are met;
- **monitoring** to become aware of any changes;
- **review** on a regular basis to ensure services remain responsive to changing needs.

ADAHPT can assist the case manager in carrying out these functions.

What is the Case Management Model supported by ADAHPT?

ADAHPT aims to assist the reorientation of services to better cater for people with complex needs associated with HIV related cognitive impairment and/or mental illness by promoting a case management model of service provision.

As previously mentioned, the most fundamental objective of case management is to enhance continuity of care to the client.

In practice, a number of models of case management have been developed usually differentiated by the degree of the case manager's clinical involvement with clients. These range from a brokerage model (bringing services in, including private agencies) to an

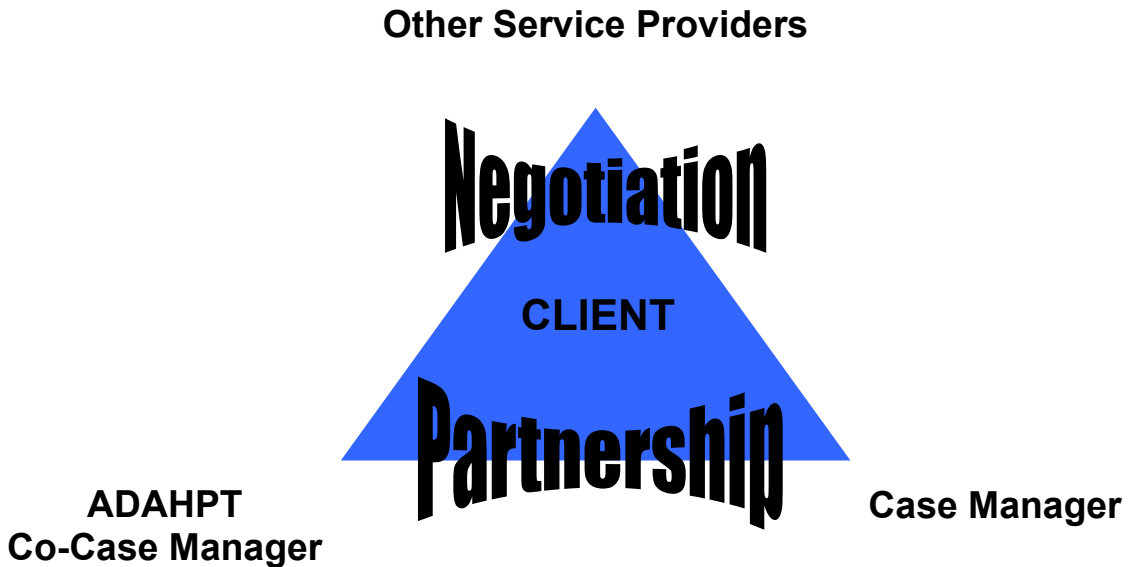
intensive case management model providing outreach, therapeutic and practical support. The model of case management advocated by ADAHPT encourages the active participation of the client, in conjunction with their carers, in identifying their needs and establishing their goals. Together with their service coordination function, the clinical role of the case manager in providing a range of direct services to clients, is recognised and supported. Ideally the case manager is able to offer outreach by visiting clients in their own homes. Allied with the support ADAHPT is able to offer, this model is intended to meet the continuum of care arrangements for people with complex needs.



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ADAHPS Model of Service Provision



Co-case management:

In the ADAHPT model of service provision, co-case management is where the designated ADAHPT worker assists the case manager in an ongoing capacity to intensely coordinate a client's care. ADAHPT workers do not take on the role of primary case manager. Where a client without an identified case manager is referred to the service, ADAHPT will work with the referral agency and client to locate an appropriate service provider who is able and willing to act as the person's case manager.

To avoid confusion and maintain a central point of reference, it is still preferable to distinguish between the case manager as the primary worker with a secondary, supportive role being undertaken by the co-case manager. Successful co-case management relies upon clear negotiation and understanding of each worker's respective roles and responsibilities, shared goals for client care and ongoing communication.



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Who can be a case manager?

The majority of case managers ADAHPT encounter are health care professionals with nursing, social work, psychology or welfare qualifications. These professionals usually work as part of multi-disciplinary teams located in community settings (eg. community health centres, non-government organisations, sexual health services etc), but may also be hospital based. Although there may be more

than one professional involved in any client's care, the case manager is identified as the primary and consistent worker. This person ensures that their client's involvement in decisions regarding their care arrangements is maximised and that all parties are in good communication and share common understandings.

What happens following referral to ADAHPT

- All referrals to ADAHPT are channelled through ADAHPT, the outreach component of the service. ADAHPT comprises a multidisciplinary team of workers combining HIV and mental health nursing, clinical psychology, welfare and social work knowledge and skills. Following referral to ADAHPT, an ADAHPT co-case manager or worker is allocated during the agency intake process when preliminary information about the client's circumstances is shared. This person will then contact the client's case manager and arrange a meeting to ascertain what support is being requested.
- During the initial assessment stage the ADAHPT worker obtains information from key health providers about results from medical assessments including (when available and if consented to by the client) a full medical and mental health history, relevant blood tests, neuroimaging (CT scan or MRI), neuropsychological assessment, and when possible a lumbar puncture to provide CSF analysis. These assessments are designed to provide an accurate diagnosis, whilst at the same time excluding other neurological complications associated with HIV infection.
- At this stage the ADAHPT worker, case manager and the client meet so the worker can gain an understanding from the client about their circumstances in terms of their psychosocial needs including accommodation, emotional/psychological issues, support, financial and legal situation, and to determine what services are involved. From this process the client's perceptions, needs and goals can start to be ascertained. The level of rapport reached during this phase should not be underestimated.
- Following the initial assessment and information gathering, the ADAHPT worker will encourage the case manager to convene a case conference with the client, their significant other(s) (i.e., partner, carer, family or friend) and key service providers to devise a management plan based on the assessment. The plan identifies what the client's needs are, what strategies and services are required to meet them, who is responsible for implementation and a way of measuring how they are met. At this point the role of the ADAHPT worker in the ongoing support of the client, their carers and the other workers involved can be negotiated and established. (See attached example).
- e. Ongoing methods of regular communication between all parties as well as the next case management plan review date are then set.



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ADAHPT - HIV & COMPLEX CONDITIONS CASE MANAGEMENT PATHWAY

