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SERVICE STANDARDS FOR Non-Medical Case Management Services

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In addition to the Universal Standards, you are also expected to follow the following guidelines.

I. GOAL

The goal of Non-Medical Case Management Services is to promote and support independence and self-sufficiency of the individual to the fullest degree possible.

II. DESCRIPTION [HIV/AIDS BUREAU POLICY 16-02 10/22/18]

Non-Medical Case Management Services (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM Services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication).

NMCM Services have as their objective providing coordination, guidance and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas Medical Case Management Services have as their objective improving health care outcomes.

III. KEY SERVICE COMPONENTS AND ACTIVITIES

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health, support services, and continuity of care.
- Client-specific advocacy and/or review of utilization of services
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Assistance with enrollment in entitlement programs
- Assistance in the acquisition of-support services

IV. SERVICE LIMITATIONS/ REQUIREMENTS

Parameters for service category spending are determined by the recipient's office and communicated directly to funded organizations by the recipient.

V. ASSESSMENT AND SERVICE PLAN

A. <u>Individual/Family Comprehensive Needs Assessment</u> – To identify the client's problems and care needs. The following information should be recorded and is required if a client does not have an active Medical Case Manager on file:

- Medical Care Provider
- Gender/ gender assigned at birth/race/ethnic origin
- Family History
- Exposure category
- Support systems
- Disclosure issues
- Nutritional screening
- Mental Health screening
- Substance Abuse screening
- Oral Health screening
- Educational/literacy assessment
- Living arrangements/Household size
- Identification of Legal Issues, if they exist
- Financial status to determine eligibility for entitlements
- Abuse, neglect and violence history
- Explanation of confidentiality and HIPAA requirements
- Explanation of the Grievance process
- Explanation of client's rights and responsibilities
- Explanation about the services available
- Signed consent for services
- Signed consent must have a date of activation and include a consent expiration date
- Current social needs
- Any additional information required by the CHAMP system not obtained at the intake

B. <u>Development and Implementation of Service Plan</u> – The Service Plan should document long and short-term goals and objectives. It should be reviewed within 90 days and modified if necessary. Plan should include:

- Documentation of client participation in service decisions
- Goals and measurable objectives responding to client needs
- Timeframes to achieve objectives
- Screening for eligibility for entitlements and assistance in completing applications
- Ways to address barriers which are client specific
- Referrals for support services and documentation that appointments were kept
- Documentation of the client's participation in primary medical care.
- Notation of ongoing HIV education/counseling.
- Client signature and date, signifying agreement with Plan

C. <u>Reassessment of Individualized Service Plan</u> - A formal re-examination of the patient's condition, needs and resources to identify changes which occurred since the initial assessment or most recent assessment.

- Service Plan re-assessment and revision, if necessary, should be on-going for continuing clients and within 90 days of initial assessment for new clients
- To maintain eligibility for Ryan White services, the client (while active), must be re-certified at least every six months to ensure that an individual's residency, income, household size, and insurance status continues to meet Recipient eligibility requirements and to verify that Ryan White is the payor of last resort.
- Summary of progress in goal achievement should be documented
- Review of client's clinical, financial and support needs to identify changes and/or additional service needs
- Case conference with other providers, when appropriate
- Bi-annual re-screening for Nutritional, mental health, oral health and substance use issues should be completed

D. DOCUMENTATION

Written documentation is kept for each client, which includes:

- Documentation of need (e.g. bill or letter of termination)
- Signed initial and updated individualized service plan
- Progress notes detailing each contact with or on behalf of the consumer. These notes should include date of contact and names of person providing the service
- Signed "Consent to release information" form. This form must be specific and time limited
- This shall comply with all required documentation from NEMA Universal Standards of Care

VI. ENGAGEMENT AND RETENTION OF CLIENTS

Refer to Universal Service Standard

VII. STAFF QUALIFICATIONS AND TRAINING

Each funded agency is responsible for establishing job descriptions and qualifications for each of the case management positions. It is suggested that a team approach better accomplishes the activities required for comprehensive Case Management.

CASE MANAGER

Qualifications/Training

1. Associate's/Bachelor's degree in health or human services related-field preferred
2. A minimum of 1-year past experience working with persons with or at high risk of HIV infection preferred
3. Ongoing education/training in related subjects including "prevention with positives"
4. Agency will provide new hires with training regarding confidentiality, Stigma, Health Education and Risk Reduction, Health Literacy, client rights and the agency's grievance procedure
5. Case Managers must participate in clinical quality improvement activities, Early Interventions and Retention Committee meetings (ERIC) and projects.
6. Knowledge of community resources
7. Annual staff evaluation/performance review

Duties/Responsibilities

- Responsible for providing non-medical case management for clients and their families/support system
- Advocates for clients to obtain the full range of needed services
- Ensures coordination of services and retention in care

- Promotes linkage development and monitors the effectiveness of these linkages
- Responsible for accurate and timely recording of client progress notes
- Ensures that data is entered in the CHAMP system within 5 days of service
- When necessary, escorts clients to ensure that appointments are kept
- Assists with scheduling of appointments
- Follow-up activities such as telephone calls, text, and/or emails to clients who have missed appointments
- Verification of client status