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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

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).

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 and 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

INDICATORS/PERFORMANCE MEASURES

- A. Early access to and maintenance of comprehensive health care and social services.
- B. Coordination of services among providers

“To plan for the development, implementation and continual improvement of the health care and treatment services for People Living With and Affected by HIV & AIDS who reside in the five New Jersey Counties of Essex, Morris, Sussex, Union and Warren.”

- C. Retention in care
- D. Increased knowledge of HIV disease
- E. Viral suppression
- F. Reinforcement of positive health behaviors
- G. Personal empowerment
- H. An improved quality of life

IV. SERVICE LIMITATIONS/REQUIREMENTS

None

V. ASSESSMENT AND SERVICE PLAN

Individual/Family Comprehensive Needs Assessment – 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.

1. Medical Care Provider
2. Gender/ gender assigned at birth/race/ethnic origin
3. Family History
4. Exposure category
5. Support systems
6. Disclosure issues
7. Nutritional screening
8. Mental Health screening
9. Substance Abuse screening
10. Oral Health screening
11. Educational/literacy assessment
12. Living arrangements/Household size (-added NS)
13. Identification of Legal Issues, if they exist
14. Financial status to determine eligibility for entitlements
15. Abuse, neglect and violence history
16. Explanation of confidentiality and HIPAA requirements
17. Explanation of the Grievance process
18. Explanation of client's rights and responsibilities
19. Explanation about the services available
20. Signed consent for services
21. Signed consent must have a date of activation and include a consent expiration date
22. Current social needs
23. Any additional information required by the CHAMP system not obtained at the intake

Development and Implementation of Service Plan – 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:

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

Reassessment of Service Plan - 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.

1. 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
2. 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 statuses continue to meet Grantee eligibility requirements and to verify that Ryan White is the payor of last resort.
3. Summary of progress in goal achievement
4. Review of client's clinical, financial and support needs to identify changes and/or additional services needs
5. Case conference with other providers, when appropriate
6. Re-screening for Nutritional, mental health, oral health and substance abuse issues should be completed annually

DOCUMENTATION

Written documentation is kept for each client, which includes:

1. Consumer's name and unique identifier number
2. Proof of HIV+ status
3. Initial Intake
4. Documentation of need (e.g. bill or letter of termination)
5. Documentation of Certification and Recertification
6. Documentation of assessment/reassessment
7. Signed initial and updated individualized service plan
8. Evidence of consent for services
9. 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
10. Evidence of the client's understanding of his/her rights and responsibilities
11. Signed "Consent to release information" form. This form must be specific and time limited
12. 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. 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

CASE MANAGER ASSISTANT/ COMMUNITY FOLLOW-UP WORKER

Qualifications/Training

1. Para-professional with a High School diploma or GED preferred
2. Ability to read, write, understand and carry out instructions
3. Knowledge of community resources
4. Sensitivity towards persons living with HIV/AIDS
5. Bi-lingual preferred
6. 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
7. Ongoing education/training in related subjects including "prevention with positives"
8. Annual staff evaluation/performance review

Duties/Responsibilities

- Performs duties under the direction of the Case Manager
- When necessary, escorts clients to ensure that appointments are kept
- Assists with scheduling of appointments
- Follow-up activities such as telephone calls to clients who have missed appointments
- Verification of client status
- Assist in data entry

VIII. ADDITIONAL PROGRAM GUIDANCE: [HIV/AIDS BUREAU POLICY 16-02]

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.