PATERSON-PASSAIC COUNTY-BERGEN COUNTY
HIV HEALTH SERVICES PLANNING COUNCIL

NON-MEDICAL CASE MANAGEMENT SERVICES
SERVICE STANDARD

SERVICE CATEGORY DEFINITION

Non-Medical Case Management (NMCM) Services:

Non-Medical Case Management services provide guidance and assistance in accessing medical, social, community, legal, financial, and 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, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by the RWHAP Part recipient.

Key activities include:

- Initial assessment of service needs
- Health Literacy assessment using the TGA's Health Literacy screening tool
- Development of an individualized care plan
- 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
- Determine client eligibility for various RW-funded services (including MCM and the AIDS Drug Assistance Program [ADAP], Affordable Care Act [ACA] and other community resources;
- Obtain proper HIV status documentation and residency information;
- Conduct client intake interviews and complete intake application and all required forms;
- Schedule/coordinate MCM Assessment appointment;
- Provide client orientation for new clients;
- Perform the six-month eligibility review and obtain necessary documents as identified in the standards;
- Maintain documentation and program notes in the client records per program requirements and standards;
- Complete required data entry into eCOMPAS;

- Coordinate with Outreach, Peer Navigation, and Care Coordination staff to facilitate access to care or referral for out-of-care clients;
- Coordinate eligibility and intake services with community agencies, hospitals, and physician practices to assist clients to access services;
- Maintain current information on all frequently used community resources, as needed;
- Providing information and assistance with linkage to Medical Case Management and psycho-social services as needed;
- Providing benefits and entitlement counseling, including assisting eligible clients in obtaining access to public and private programs that they may be eligible for. This includes Medicaid, Medicare Part D, ADAP, Case Management Program, Pharmaceutical Manufacturer's Patient Assistance Programs, and other State and local health care and supportive services;
- Advocating on behalf of clients to decrease service gaps and remove barriers to services;
- Helping and empowering clients to develop and utilize independent living skills and strategies;
- Helping clients with applications for all other resources available for their service needs.\

Non-Medical Case Management Services have as their objective to provide guidance and assistance in <u>improving access</u> to needed services whereas Medical Case Management services have as their objective <u>improving health care outcomes</u>. Is a collaborative process that assesses, educates, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs. Case Management is seen as an encounter that involves assessment and basic care needs planning with the goal of independence for the client.

Due to the episodic nature of HIV, it is expected that clients will have varying levels of need throughout their enrollment in services. Some clients may demonstrate a low level of need and would therefore benefit from Non-Medical Case Management. Distinct case management categories are described in detail under separate sections (See description for Medical Case Management Services).

Enrollment in either Medical Case Management services or Non-Medical Case Management is not permanent; a client may move from one type of case management to the other depending on current circumstances. On-going and frequent assessment by a Non-Medical Case Manager and periodic review by Case Management Supervisor should occur to ensure that clients receive the level of care that is appropriate. Routine screening tools and acuity scales should be used consistently by all Case Management providers.

CLIENT INTAKE AND ELIGIBILITY

All Subrecipient's are required to have a client intake and eligibility policy on file that adheres to the TGA eligibility policy. It is the responsibility of the Subrecipient to determine and document client eligibility status, as outlined in the Ryan White Part A Eligibility Policy in accordance with HRSA/HAB regulations. Eligibility must be completed at least once every six months.

Eligible clients must:

- Live in the City of Paterson, Passaic County, and/or Bergen County, New Jersey;
- Have a documented diagnosis of HIV/AIDS;
- Have a household income that is at or below 500% of the federal poverty level;
- Be uninsured or underinsured.

Services will be provided to all Ryan White Part A qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

PERSONNEL QUALIFICATIONS

NMCM services must be provided by trained professionals, including both medically credentialed and other health care staff who provide a range of client-centered services that result in a coordinated individual care plan, which links clients to medical care and other clinical care, psychosocial, and other support services. The non-medical case manager will meet the qualifications for the position as outlined in the sub-recipient's job description as well as meet the following requirements:

1. A minimum of an Associate Degree from an accredited college or university; **and**
2. A minimum of one-year paid work experience with persons living with HIV/AIDS or other catastrophic illness **preferred**; **and/or**
3. State, National, or Local certification from a recognized state/national/local certification organization and/or licensing organization **preferred** (i.e. CSW, LCSW, LPC, LCADC, etc.,); or

4. Extensive knowledge of community resources and services;

5. Personnel who do not meet the qualifications listed above will need to have annually, sixteen (16) hours of training on target populations and the HIV service delivery system in the service area including but not limited to:
   a. The full complement of HIV/AIDS services available in the TGA service area, and how to access such services [including how to ensure that particular sub-populations are able to access services (e.g., undocumented individuals)];
   b. Procedure manual;
   c. Education on applications for eligibility under entitlement and benefit programs other than Ryan White services

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall goal of non-medical case management is to provide coordination of services for eligibility in RW core and support services, medical case management and benefits coordination.

Clinical Quality Improvement outcome goals for non-medical case management are:

- 100% of all client files include documentation of a completed initial eligibility intake.
- 90% of clients receiving non-medical case management services are actively engaged in medical care as documented by a medical visit in each six (6) month period in a two-year measure and in the second half of a single year measure.
- 90% of clients receiving non-medical case management services are prescribed Antiretroviral Therapy (ART) in the measurement year.
- 90% of clients receiving medical case management services are virally suppressed as documented by a viral load of less than 200 copies/mL at last test.

SERVICE STANDARDS, MEASURES, AND GOALS

	Standard	Measure	Goal
1.	Services are provided by trained/licensed professionals.	Documentation of current licensure and credentials.	100%
2.	New non-medical case management clients receive an initial assessment of service needs within five (5) business days of enrollment/intake.	Documentation of initial assessment of service needs (biopsychosocial assessment) is included in the file of all clients entering service in the measurement year.	100%
3.	Clients will have an acuity scale completed and documented, reflecting their current acuity level.	Documentation of acuity scale is included in the file of all clients in the measurement year.	100%
4.	Clients receive coordinated referrals and information for services required to implement the care plan.	Documentation of referrals and service coordination are noted in the file for clients receiving services in the measurement year.	100%
5.	Clients are linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the measurement year as documented by the medical case manager.	100%
6.	Clients are retained in medical care	Documentation that the client had at least one medical visit in each six-month period of a 24-month measurement period with a minimum of 60 days between visits as documented by the medical case manager.	90%

	Standard	Measure	Goal
7.	Clients have no gaps in medical care.	Documentation that the client had a medical visit in the first and second halves of a 12-month measurement period as documented by the medical case manager.	90%
8.	Clients are assessed and enrolled in the Affordable Care Act (ACA) when eligible.	Documentation of assessment and enrollment when applicable.	90%
9.	Clients are on Antiretroviral Therapy (ART).	Documentation that client was prescribed ART in the 12-month measurement year as documented by the medical case manager.	90%
10.	A discharge summary (for all reasons) must be placed in each client's file within 30 days of discharge date.	Discharge Summary in client file within 30 days of discharge date.	90%
11.	Clients lost to care have documented attempts of contact prior to discharge. ***Note: EIS applies to all clients newly diagnosed and re-engaged.***	If client is “lost-to-care” (cannot be located), the subrecipient will: a. make and document a minimum of 3 follow-up attempts over a 3-month period after first attempt. b. A certified letter must be mailed to the client’s last known mailing address within five business days after the last phone attempt notifying the client of pending inactivation within 30 days from the date on the letter if the client does not make an appointment to re-screen. c. Subrecipient refers client to EIS services.	90%

	Standard	Measure	Goal
10.	Clients are virally suppressed.	Documentation that the client has a viral load <200 copies/mL at last test as documented by the medical case manager.	90%

CLIENTS RIGHTS AND RESPONSIBILITIES

Subrecipient's providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each Subrecipient will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Subrecipient's providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Subrecipient's must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the client's record. Information on all clients receiving Ryan White Part A funded services must be entered in the HRSA sponsored, Bergen-Passaic TGA managed, eCOMPAS Database.

CULTURAL AND LINGUISTIC COMPETENCY

Subrecipient's providing services must adhere to the National Standards on Culturally and Linguistically Appropriate Services.

CLIENT GRIEVANCE PROCESS

Each Subrecipient must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the client's record.

CASE CLOSURE PROTOCOL

Each Subrecipient providing services should have a case closure protocol on file. The reason for case closure must be properly documented in each client's file. If a client chooses to receive services from another provider the Subrecipient must honor the request from the client.