HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

Subject: Non-Medical Case Management Service Standards for Persons Living with HIV/AIDS

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Policy: This document represents the service standards to be utilized when providing Non-medical Case Management services to Ryan White (RW) eligible clients in the Sacramento TGA. The Sacramento TGA utilizes non-medical Case Management services for the purposes of Benefits and Eligibility enrollment in various entitlement programs. This standard is to be used in conjunction with other service standards for medical, psychosocial and support services as developed and approved by the HIV Health Services Planning Council.

As directed by the HIV Health Services Planning Council priorities, when funded, the following service standards will apply to Ryan White contracted service providers.

1. Ryan White funding is to be used for HIV/AIDS medical services and for psychosocial and support services, which significantly improve access and adherence to such medical services. As such, any Non-medical Case Management services which are paid for through Ryan White (RW) funding shall be related to HIV healthcare or other social support service appointments related to maintaining healthcare (i.e. AIDS Drug Assistance Program [ADAP], Medi-Cal, etc.).

2. Ryan White funding is to be expended in a cost effective, equitable manner, which is based upon verified client need and encourages self-empowerment of clients. Non-medical Case Management services paid for with Ryan White funds shall be provided in accordance with the allocation priorities and directives adopted by the Sacramento TGA HIV Health Services

Planning Council ("HIV Planning Council"), or through an alternative assessment process administered by a RW Agency.

3. The purpose of Non-Medical Case Management services is to provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Non-Medical Case Management services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medi-Cal, Medicare Part D, AIDS Drug Assistance Program (ADAP), Health Insurance Premium Payment (OAHIPP),Disability Insurance, Housing Opportunities for Persons With AIDS (HOPWA), Social Security, Pharmaceutical Manufacturer's patient assistance programs, Covered California, or other state or local health care and supportive services. This service category can be delivered through several methods of communication including face-to-face contact, phone contact, and any other forms of communication deemed appropriate.

Key activities for Non-Medical Case Management include:

- First appointment within 10 days of referral to screen for eligibility (if needed) and assign a non-medical case manager;
- Initial assessment of the client's service needs within 30 days of the first visit;
- Development of a comprehensive, individualized care plan during the initial assessment visit including client-centered goals and milestones;
- Ongoing client monitoring to determine the efficacy of the care plan;
- Re-evaluation of the care plan with the client at least every 6 months with revisions and adjustments as necessary;
- Ongoing assessment of the client's and other key family members' needs and personal support systems.

Benefits and Eligibility Services include the following activities or services:

- Assessing clients' need for financial and health care benefits
- Informing clients of various public and private financial and healthcare benefits that he/she may be eligible for
- Determining client eligibility for benefits
- Working with clients in making informed choices which maximize their available benefit
- Assisting clients to understand the disability and/or benefits application process and/or appeal process
- Assisting clients in understanding, applying and completing appropriate forms/paperwork for public and private financial, disability, and health care benefits
- Assisting clients through the stages of applying for financial, health care and/or disability benefits
- Working with clients to obtain the proper eligibility documentation needed

to apply for benefits
- Provides education to the patient/client on responsibilities for co-pays, deductibles, share of cost, sliding fee scales, annual income caps and insurance coverage
- Works closely with case managers, case workers, physicians and outside agencies to ensure positive outcome for eligibility determination
- Providing client with accurate information on available resources in the community

Service Characteristics
Non-Medical Case Management must be offered in a way that addresses barriers to accessing medical care and uses resources to support positive health outcomes for clients. All Non-Medical Case Management services must include at a minimum the Key Activities included in the Service Definition section of this document. Other key characteristics include:

Eligibility Screening: If the Non-Medical Case Manager is the client's first contact with the Ryan White program, the client must be screened for eligibility as described in the Common Standards of Care.

Initial Non-Medical Case Management Appointments: Initial Non-Medical Case Management appointments should be made as soon as possible to avoid potential drop out. Appointments must occur no later than 10 calendar days after first client referral. As clients may miss appointments, agencies must have a process in place to ensure timely follow up, preferably within 24 hours. Missed appointments and case management attempts at rescheduling must be documented in the file.

Referral/Linkage: Clients ineligible for Non-Medical Case Management services through Ryan White must be referred to another community-based organization or linked to another safety net provider as appropriate utilizing a warm hand off when possible. Documentation of that referral must be in the client file and available upon request.

Primary Case Manager: Each client should always have a primary case manager who helps coordinate services with other members of the treatment and services team. This primary case manager (who may or may not be the Non-Medical Case Manager) will serve as the main point person for the client to streamline communication and maximize care coordination.

Partner Services: Providers funded for Non-Medical Case Management must have a process for Partner Services counseling and referral for clients. Partner Services information should be offered and referrals made for clients according to established processes.

Intake
The Non-Medical Case Manager must ensure that the client intake has been performed at the start of service provision and perform an intake if one has not previously been completed. See the Common Standards of Care for detailed intake requirements.

Orientation
Each new client enrolled in Non-Medical Case Management must receive an orientation to the services; document this orientation in the client file.

Initial Assessment
The Non-Medical Case Manager must conduct a face-to-face psychosocial needs assessment within 30 days of the start of Non-Medical Case Management services. The needs assessment will describe the client's current status and identify their strengths and weaknesses, resources, and/or stressors in order to develop a care plan which allows the patient to function and manage their condition as independently as possible. This assessment must be thoroughly documented and should be client-centered (the client may defer or choose not to discuss any specific issues during the assessment). Topics for discussion during the assessment should include:

- Current healthcare and social service providers (including Case Management offered elsewhere);
- Level of engagement in health care services;
- Current medications and adherence;
- Immediate health concerns;
- Substance use history and needs;
- Mental health / psychiatric history and needs;
- Level of HIV health literacy;
- Awareness of safer sex practices;
- Sexual orientation and gender identity;
- Sexual history;
- Self-management skills and history;
- History of incarceration;
- Family composition;
- Living situation and housing needs;
- History and risk of abuse, neglect, and exploitation;
- Social community supports;
- Food/clothing needs;
- Transportation needs;
- Legal needs;
- Financial / program entitlement;
- Emergency financial assistance needs and history;
- Partner services needs; and
- Summary of unmet needs.

Development of Care Plan
Existing Care Plan: When an existing care plan is present (e.g., if the client has received other Ryan White services), that care plan should be reviewed

and utilized in the creation of the Non-Medical Case Management care plan. The Non-Medical Case Management care plan should be made available to other providers as needed for care coordination.

Frequency: An individualized care plan must be developed during the initial assessment and re-evaluated at least every 6 months with modifications as needed.

Requirements: Non-Medical Case Managers developing an individualized care plan should ensure that the plan, at a minimum:

- Is individualized and incorporates client input;
- Prioritizes the needs identified in the Initial Assessment;
- Identifies resources to meet the needs identified in the Initial Assessment and provides referrals to other relevant providers (e.g. substance abuse counselors, physicians, housing specialists);
- Includes specific measurable goals and objectives with activities and timeframes to meet each objective; and
- Encourages a client's active participation and empowers the client to become self-sufficient.

Clients with significant unmet medical needs should be referred to Medical Case Management for additional support in improving health outcomes.

Updates: As the client's status changes, the client and case manager must work together to establish new goals, objectives, and timelines.

Documentation: Care plans can be documented in paper charts or electronic health records. Copies of completed individualized care plans must be retained in the client file, signed by both client and provider if paper based. Client and provider must also sign any updated plans if paper based.

Quality Assurance and Supervision: All agencies providing Non-Medical Case Management must have a quality assurance plan in place describing a supervisory review to assess documentation of client's needs and if those needs were addressed. Annually, a representative sample of at least 10 percent of charts of active Non-Medical Case Management clients must have a supervisor review. All clients who are discharged from Non-Medical Case Management must also have a supervisor review within 3 months of discharge. Supervisors' reviews must be documented in the client chart with signature, date of review, and findings.

Client Record: All Non-Medical Case Management activities including but not limited to all contacts and attempted contacts with or on behalf of clients and coordination with referral agencies, must be recorded in the client record as

soon as possible Documentation of activities must be legible, signed, and dated by the Non-Medical Case Manager.

Client Monitoring

Follow-Up and Monitoring. Non-Medical Case Management is an ongoing process.

Follow-up and monitoring ensures that:

- The resources provided are sufficient to meet the client's needs
- The client is working toward their care plan objectives
- New or changing needs are addressed

During monitoring, the Non-Medical Case Manager should follow-up on referrals and linkage and assess whether the client has further needs. Frequency of follow-up is dependent on client needs and may be done in-person, or by phone; however, follow-up should occur at least every six months at the time of re-certification.

Lost to Follow-up. The client is lost to follow-up if the client cannot be located after at least three documented attempts per month over a period of three consecutive months. Attempts to contact the client must take place on different days and times of the day during this time period. Providers are strongly encouraged to refer clients who are lost to follow-up to the local public health department for further outreach and re-engagement in care activities. See the *Client Transfer and Case Closure* section of this document.

Reassessment/Revision of Care Plan

Non-Medical Case Managers should routinely review the successes and challenges clients are having in achieving outcomes as outlined in the care plan, measure progress in meeting goals and objectives, and revise the plan as necessary.

Revision of care plan: Client assessment and revision to the care plan as appropriate must be made at least every six months, or more frequently as client condition changes.

Documentation: Non-Medical Case Managers must routinely document the outcome of reassessments and service activities in the client record, client contact form, and outcome log (if applicable). Any changes to the care plan should be signed and dated by both the Non-Medical Case Manager and the client if paper based.

Feedback: Non-Medical Case Managers must provide constructive feedback to clients when reviewing the care plan and progress made toward goals and

objectives. Constructive feedback is based on concrete observations, and is focused on providing information to the client in a non-judgmental way. Feedback should be strengths-based whenever possible.

Client Transfer and Case Closure

Transfer of Clients: In the event that a client wishes to (or needs to) transition into Non-Medical Case Management services offered by another agency, relevant intake documents should be forwarded to the new service provider and case managers from both agencies should work together to provide a smooth transition for the client and ensure that all critical services are maintained. Transfer of clients between agencies or case managers is initiated when:

- The client notifies the case manager that they have moved to a different service area,
- The client notifies the case manager of their intent to transfer services,
- The Forced Disenrollment Grievance Procedure has been followed as defined in the Common Standards of Care, or
- The agency no longer receives funding.

Case Closure: Agencies should close a client's file according to the written procedures established by the agency, as well as those outlined in the Common Standards of Care.

A client file may be closed under any of the conditions listed in the Common Standards of Care. Additional circumstances for closing a Non-Medical Case Management case include:

- The client no longer demonstrates need for Non-Medical Case Management due to their own ability to effectively advocate for their needs.
    - Agencies must have written Protocol to "graduate" clients out of Non-Medical Case Management including specific criteria for determining that the client is ready to graduate.
- A client is being incarcerated for more than 6 months.
    - If a client's incarceration is for a period of 6 months or less, the Non-Medical Case Manager should coordinate services with correctional medical staff in order to ensure continuity of case management upon release.
- The client is transitioning into Non-Medical Case Management services offered by another agency, as described above.

Education / Experience / Supervision

The experience standards are to ensure all staff providing benefits and eligibility services are properly trained and have an understanding of the scope of their job

responsibilities.

The educational requirements for a Non-Medical Case Manager include any health or human services bachelor's degree from an accredited college or university. Licensure is not required. Examples of health or human services fields include, but are not limited to:

- Nursing
- Social Work
- Counseling
- Psychology
- Gerontology
- Clinical Pharmacy

Non-Medical Case Managers who do not meet this minimum educational level may substitute related direct consumer service experience under the supervision of a health and human services professional for a period of two years of full-time work, regardless of academic preparation.

Additional Skills:

- Ability to learn complex information on specialized benefits such as Social Security, Consolidated Omnibus Budget Reconciliation Act (COBRA), Medi-Cal, ADAP and welfare, as well as, state and federal laws regarding disability benefits
- Experience working and/or volunteering in direct client services within a social service setting
- Ability to provide one-on-one counseling and advocacy
- Skill and ability in working with a diverse clientele including but not limited to heterosexual, homosexual, bisexual, transgender, people of color, substance users, homeless, immigrants, veterans, previously incarcerated, and/or individuals with mental health issues
- Ability to enter accurate information into various databases

All Non-Medical Case Managers must be trained and knowledgeable about HIV and familiar with available HIV resources in the area.

Staff Orientation and Training

Initial: All staff providing Non-Medical Case Management must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire; topics must include:

- General HIV knowledge, such as HIV transmission, care and prevention
- Privacy requirements and Health Insurance Portability and Accountability Act (HIPAA) regulations
- Navigation of the local system of HIV care
- Basic case management skills

Ongoing: Staff must also receive ongoing annual HIV training as appropriate for their position. Training may be any combination of (1) in-person, (2) articles, (3) home studies, or (4) webinars, and must be clearly documented and tracked for monitoring purposes.

Caseload: Non-Medical Case Managers are expected to maintain a caseload of between 30 and 75 clients at any given time depending on client acuity. (State Office of AIDS has a monitoring component for this.)

4. All services shall be provided in culturally and linguistically competent manner which is respectful to the client's cultural health beliefs, practices and preferred language.

5. If available funding levels are anticipated to be less than the total need, agencies shall ensure that funds are distributed among the maximum possible number of clients living with HIV/AIDS who rely on RW funded services. Agencies shall assure that no client receives any RW funded services unless such client is found to be eligible for services under such Eligibility Standards as may be adopted by the Planning Council.

6. Ryan White Agencies may, at any time, submit to the RW Fiscal Agent requests for interpretation of these or any other Services Standards adopted by the HIV Health Services Planning Council, based on the unique medical needs of a client or on unique barriers to accessing medical care which may be experienced by a client.

7. RW Agencies shall provide a means by which their staff can obtain in-servicing and on-call advice related to interpreting client medical needs.

8. Clients shall have the right to request a review of any service denials from the agency that denied the service. The most recent review/grievance policies and procedures for the RW Agency shall be made available to each client upon intake. A copy of the grievance policy, signed by the client, shall be maintained in the client's file.

Signed:  Date: 02/26/20

Kristina Kendricks-Clark, Chair