NON-MEDICAL CASE MANAGEMENT

(Approved by Planning Council 7/27/15)

I. DEFINITION/ OVERVIEW

Non-Medical Case Management provides advice and assistance to empower clients to access a variety of necessary services (including medical, social, community, legal and financial) to support medically related outcome measurements.

Clients will have varying levels of need throughout their enrollment in services. Clients who demonstrate a low level of need may benefit from *Non-medical Case Management*. Distinct case management categories are described under separate sections (See description for Medical Case Management).

Enrollment in either medical case management (active) or non-medical case management (direct services only) is not permanent; a client may move from one type of case management to the other depending on current circumstances. Ongoing and frequent assessment by a non-medical case manager and a medical case management supervisor should occur to ensure clients receive the appropriate level of care. Routine assessment tools and acuity scales must be used consistently by all Medical Case Management providers, as mandated by the Office of Health Policy (OHP). [Copies of tools can be obtained from OHP.]

II. SERVICES

Key activities include: (1) completion of comprehensive assessment of service needs conducted by a non-medical case manager meeting the same qualifications as a medical case manager, (2) coordination of services required to support health outcomes, and (3) periodic reevaluation of client needs. Non-medical case managers will encounter clients in their environment, which may include a residence, a public facility, in the streets, or in the facilities of the Non-Medical Case Management service provider.

Clients with a lower level of need, requiring only the direct services offered or referred by the service provider would benefit from *Non-Medical Case Management*. Assignment to either Medical or Non-Medical Case Management is based on criteria as established by the Office of Health Policy.

III. ELIGIBILITY

Eligibility for non-medical case management services is explained under the Universal Standards for All Ryan White Part A Services Eligibility section.

IV. SECTIONS

Note: Universal Standards apply to all service categories. This additional service specific standard contains the following sections:

→ Personnel	→ Assessment/Reassessment	→ Discharge/Transition
→ Enrollment into Part A system	→ General Standards	→ Coordination and Referral

V. STANDARDS OF CARE AND MEASURES

#	Standard	Measure
1.0	**PERSONNEL**	
1.1	**Staff Qualifications**	
1.11	**Minimum qualifications**: All case managers will meet the qualifications for the position as outlined in the service provider's job description. The minimum requirements are: a. A bachelor's degree (preferred) in any field; OR b. Three (3) years of experience regarding HIV services AND a minimum of a high school diploma/GED (required).	Personnel files/resumes/applications for employment reflect requisite experience and education.
1.12	**Minimum supervisory qualifications**: A Non-Medical case management supervisor must meet the *minimum* qualifications for education and experience listed below: A. A currently licensed social worker (RSW, CSW, LMSW, LCSW) from a program accredited by the Council on Social Work Education and two years of paid post degree experience in providing case management services; OR B. A currently licensed nurse (RN or LPN) in Louisiana and two (2) years of paid post degree experience in providing case management services; OR C. A bachelor's (required) or master's degree (preferred) in a human service related field which includes: psychology, education, counseling, social services, sociology, family and consumer sciences, criminal justice, rehab services, child development, substance abuse, gerontology, and vocational rehabilitation and two (2) years of paid post degree experience in providing case management services; OR D. A bachelor's in liberal arts or general studies with concentration of at least 16 hours in one of the fields listed in item C of this part and two (2) years of paid post degree experience	Personnel files/resumes/applications for employment reflect requisite experience and education.

#	Standard	Measure
	in providing case management services.	
1.2	**Supervision**	
1.21	**Minimum components of case management supervision**. A. Each case management service provider must have and implement a written plan for supervision of all case management staff. B. Supervisors must review a 10 percent sample of each case manager's case records each quarter for completeness, compliance with these standards, and quality and timeliness of service delivery. C. Case managers must be evaluated at least annually by their supervisor according to written service provider policy on performance appraisals.	• Service provider has written plan for supervision of all case management staff. • Service provider will keep on file supervision logs demonstrating the review of random client files citing the date and outcome of chart reviews • Personnel files contain annual performance evaluations.
1.22	Each supervisor must maintain a file on each case manager supervised and hold supervisory sessions on at least a weekly basis. The file on the case manager must include, at a minimum: • Date, time, and content of the supervisory sessions • Results of the supervisory case review addressing, at a minimum of completeness and accuracy of records, compliance with standards and effectiveness of service.	• Documentation of supervision provided • Supervisors' files on each case manager reflect ongoing supervision, supervisory sessions and case review as described above.
1.3	**Orientation – See Universal Standards for Tier X Staff**	
1.4	**Training – See Universal Standards for Tier X Staff**	
2.0	**ENROLLMENT INTO PART A SERVICES**	
2.1	**The objectives of the enrollment process are to:** ➢ Inform the client of: • all Ryan White Part A funded services available AND • all Ryan White Part A funded case management agencies in NO EMA AND • what client can expect if s/he enrolls in case management services; ➢ Establish and/or verify client eligibility for services; ➢ Collect required state/federal client data for reporting purposes; and ➢ Completion of a full Client Eligibility Review and Verification Form (CERV).	N/A

#	Standard	Measure
2.2	Funded Non-Medical Case Management service providers must be able to: ➢ Provide enrollment on a walk-in basis; ➢ Schedule an appointment at the client's convenience; ➢ Refer client to another service provider in the event of a waiting list or any capacity constraints prohibiting a provider from serving a client immediately.	Service provider policy and procedures reflect the availability of walk-in services. Documented referral kept on file at the agency.
2.3	The presentation to the client of information regarding the Ryan White Part A service delivery system will include: • Confidentiality and release of information, and HIPAA privacy notification as appropriate • Statement of Consumer Rights and Responsibilities • Service provider grievance/complaint procedures	Documented in client's file.
2.4	Financial resources and insurance status for all clients shall be documented and payment shall be sought from any and all third party payers before using Ryan White Part A funds. Documentation of a discussion with each client regarding various options for payment shall be noted in client charts.	• Documented CERV on file with client signature verifying discussion regarding application for Medicaid/SSI or other benefits resources and will document the dates of these activities. • A supervisory review will assure that case managers are discussing options for alternative payment with each client on a quarterly basis.
3.0	**ASSESSMENT/REASSESSMENT**	
3.1	**The objectives of the assessment/reassessment process are to:** ➢ Establish whether client demonstrates a need or continued need to enroll in non-medical case management services offered by the service provider; ➢ Gather on an on-going basis appropriate client information in order to determine client needs; ➢ Reassess at least every six months or as required to respond to a change in client status, utilizing assessment tools as mandated by OHP.	N/A
	Initial Assessment	

#	Standard	Measure
3.2	Within three (3) working days of enrollment, a comprehensive needs assessment shall be completed to evaluate the client's needs, including, but not limited to the following: • Medical history and current health/primary care status • Available financial resources (including insurance status) with emphasis on securing 3rd-party insurance coverage, public benefits, and other resources. • Availability of food, shelter, and transportation • Available support system • Need for legal assistance • Substance abuse history and status • Emotional/mental health history and status	Client chart contains documentation of each client's need for (or problems with) food, substance abuse treatment, childcare, transportation, obtaining and storing medications, etc. Such information should be general and all-inclusive.
3.3	After completion of initial comprehensive needs assessment, results shall be reviewed and analyzed by a supervisor and/or multi-disciplinary team to determine appropriate level of case management services. Clients who are newly diagnosed or new to HIV care should be assigned to medical case management, unless justifiable documented circumstances dictate otherwise.	Client chart contains documentation of review and case assignment by supervisor or multi-disciplinary team.
3.4	Complete comprehensive reassessment should occur annually.	Client chart contains documentation.
3.5	In order to maintain appropriate provision of services to clients, providers are expected to ensure the availability of both Medical and Non-Medical Case Management. OHP will monitor to verify clients are assigned based on the documented client need as related to established criteria.	Client file appropriately scored per acuity scales with cases assigned to categories based on need levels as documented.
3.6	Upon reassessment and review of client record by supervisor or multi-disciplinary team, a client may be assigned to medical case management.	Documentation in client file.
3.7	Providers must demonstrate adequate linkages with Ryan White and non-Ryan White agencies to ensure timely coordination and referral to services to meet the client's needs.	Documented by memorandum of understanding and provider policies
4.0	**GENERAL STANDARDS**	
4.1	Each service provider providing case management services shall have an outreach program and/or working linkages in place designed to reach the population eligible for services and to target individuals with HIV/AIDS requiring multiple interventions, such as disproportionately affected and emerging populations.	• Written outreach plan and publicity/educational materials with evidence/record of distribution in targeted areas; or • Linkage agreements and documented

#	Standard	Measure
		referrals from linked service providers.
4.2	Does not require service plan	Documentation of reason client is under non-medical case management (acuity scale score)
4.3	At minimum, a semi-annual face-to-face contact will occur with each client and will include an assessment/reassessment of eligibility.	All contacts and attempted contacts must be documented
4.4	If client presents with increased need, a reassessment should occur and client should be referred into Medical Case Management.	Documented in the program's policy.
4.5	In the event a funded service provider is unable to adequately communicate in the client's preferred language, it is then the service provider's responsibility to refer the client to service provider with the appropriate language capacity. If no such service provider exists, interpreter services will be provided at no cost to the client.	Service provider maintains updated documentation of staff's language capabilities, including the names and job titles of specific staff. A list will be provided to OHP and updated as needed.
4.6	Non-Medical Case Manager will review documentation of monitoring client's current immunological parameters (for example, CD4 count, and HIV viral load) and appointment adherence at least semi-annually.	Documentation of review of current immunological data in client's file
4.7	A **full-time Non-Medical Case Manager** may manage a maximum active caseload of 100 clients.	Job descriptions reflect maximum caseloads as described above.
4.8	A **Case Management Supervisor** may supervise eight (8) full-time case managers or a combination of full-time case managers and other professional-level human services staff.	Caseloads are monitored to ensure the maximum allowable standard is not exceeded.
5.0	**DISCHARGE/TRANSITION**	
5.1	**The objective of discharge/transition planning are to:**	

#	Standard	Measure
	➢ Ensure a smooth transition for a client no longer needing services at the service provider or moving to medical case management; ➢ Accurately track and document clients receiving non-medical case management services; and assist service providers to more easily monitor caseload.	
5.2	A client may be discharged from case management services through a systematic process that includes a discharge or case closure summary in the client's record. The discharge/case closure summary will include a reason for the discharge/closure and a transition plan to other services or other provider agencies, if applicable. If client does not agree with the reason for discharge, s/he should be informed again of the service provider's grievance procedure. A client may be discharged from HIV case management services for the following reasons: • if client no longer meets Ryan White eligibility standards; • at the request of the client (client no longer needs or desires services); • if a client's actions put the service provider personnel or other clients at risk; • if client moves out of the service area; if possible an attempt should be made to connect client to services in the new service area; • if after repeated and documented attempts, a case manager is unable to reach a client for a period of twelve (12) months. Ideally case managers should check in with their clients as determined by client need, but at a minimum of every six (6) months. If after twelve (12) months, the case manager has made repeated attempts to reach a client and is unsuccessful, the client should be discharged from case management services at the service provider; • death.	Documentation of case closure in client's record. Documentation of reason for discharge/case closure (e.g., case closure summary)
5.3	In all cases, case managers shall ensure that, to the greatest extent possible, clients who leave Non-medical Case Management are linked with appropriate services to meet their needs and are prepared for the transition. For example, if a client were moving to another area, the case manager would ideally refer the client to an appropriate provider in that area; or if the client has to be discharged from services, the case manager may, as is appropriate to the circumstance, provide the client with a list of alternative resources.	Documentation in client's record indicating referrals or transition plan to Medical Case Management or other provider(s).