Metropolitan Washington Regional RYAN WHITE PLANNING COUNCIL

SERVICE STANDARDS
FOR
NON-MEDICAL CASE MANAGEMENT SERVICES (NMCMS)

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HRSA Ryan White & Global HIV/AIDS Programs

The Ryan White HIV/AIDS Program (RWHAP) is funded by the Ryan White HIV/AIDS Treatment Extension Act of 2009 and is administered by the U.S. Department of Health and Human Services (HHS) in the Health Resources and Services Administration (HRSA) within the HIV/AIDS Bureau (HAB).

I. PURPOSE OF SERVICE STANDARDS

The purpose of these service standards is to outline the elements and expectations all Ryan White service providers are to follow when implementing a specific service category. Service Standards define the minimal acceptable levels of quality in service delivery and to ensure that a uniformity of service exists in the Washington, DC EMA such that clients of this service category receive the same quality of service regardless of where or by whom the service is provided. Service Standards are essential in defining and ensuring that consistent quality care is offered to all clients and will be used as contract requirements, in program monitoring, and in quality management.

II. GOAL

The goal of Non-Medical Case Management Services (NMCMS) is to increase access to support services in order to promote and support self-reliance and improve individual navigation of health and human service systems.

III. SERVICE DESCRIPTION

Non-Medical Case Management Services (NMCMS) provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Under this service category, you can provide NMCM services, Benefits and Entitlement Counseling, and/or Re-entry Planning.

Benefits and Entitlement Counseling: Non-Medical Case Management Services may also include benefits counseling that assists eligible clients in obtaining 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, and health insurance plans through health insurance Marketplaces/Exchanges. This service category includes several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by the recipient. Key activities include:

- **A.** Initial assessment of emergent service needs, and appropriate referrals
- **B.** Development of a comprehensive, individualized care plan
- **C.** Continuous client monitoring to assess the efficacy of the care plan
- **D.** Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- **E.** Ongoing assessment of the client's needs and personal support systems

Re-entry Planning: Non-Medical Case Management Services can also provide transitional case management for incarcerated persons as they prepare to exit the correctional system.

Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services whereas Medical Case Management services have as their objective improving health care outcomes. This service category does not include the provision of Treatment Adherence Services.

IV. HRSA NATIONAL MONITORING STANDARDS AND PERFORMANCE MEASURE/METHOD

The National Monitoring Standards are designed to ensure that Ryan White service providers meet federal requirements for program and fiscal management, monitoring, and reporting to improve program efficiency and responsiveness. Ryan White service providers will work with the recipient/administrative agent in their respective jurisdiction to further discuss the implementation of the National Monitoring Standards and the required performance measures. For this service category, the following performance measures are required:

Documentation that:

- Scope of activity includes advice and assistance to clients in obtaining medical, social, community, legal, financial, and other needed services
- Where benefits/ entitlement counseling and referral services are provided, they assist clients in obtaining access to both public and private programs, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services
- Services cover all types of encounters and communications (e.g., face- to-face, telephone contact, other) as approved by the recipient.

Where re-entry planning (transitional case management) for incarcerated persons is provided, assurance that such services are provided either as part of discharge planning or for individuals who are in the correctional system for a brief period.

V. PROVIDER AGENCY POLICIES & PROCEDURES

A. Agency must be licensed and/or accredited by the appropriate city/county/state/federal agency, **if required.**
B. Staff must meet minimum qualifications detailed in the job description and service standards.
C. Services will be provided through the facility or through a written affiliation agreement.
D. **Records Retention** – Policies must exist for the production, maintenance and retention of client clinical records. The agency will keep inactive client records in a confidential locked location. Client records will be kept for seven (7) years.
E. **Confidentiality Policy -** All providers must assure the client that information provided by the client or information obtained on behalf of the client is confidential. All written and verbal communications regarding the client will be maintained with strict confidentiality according to the policy of the agency and in accordance to HIPAA (Health Insurance Portability and Accountability Act) requirements.
F. There will be a private confidential office space for seeing clients.
G. **Cultural and Linguistic Appropriateness** – The agency will adhere to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. Further information on the National CLAS Standards are located at www.thinkculturalhealth.hhs.gov . Agencies are to ensure that culturally sensitive and linguistically appropriate services are available in the client's preferred language or arrange for a certified interpreter. When providing medical services, the agency will arrange for a certified medical interpreter.
H. **Americans with Disabilities Act Compliance** – The agency must demonstrate that the needs of disabled clients are met.
I. **Client Consent** – Signed consent must be obtained from client prior to initiating services.
J. **Release of Information** - Written consent must be obtained to release/exchange client information. The consent must be specific as to type of information, agency to which the information will be shared, and length of time during which the consent is valid.
K. **Grievance Policy**- All providers must review the policy with the client and provide a copy in a language and format the client can understand.
L. The Agency must have a written **Emergency Continuity of Operation Plan (COOP)** that includes procedures for service provision during a wide range of emergencies, including localized acts of nature, fire, bomb threat, evacuation, accidents, technological or attack-related emergencies and natural disasters.

M. Service providers must receive training/education annually in relationship to HIV, substance abuse, mental health, co-occurring disorders, health and related subjects such as "Prevention with Positives".
N. A **Quality Management Plan** shall be developed for HIV-specific patient care. This plan must be updated annually.
O. Agencies must maintain linkages via detailed Memoranda of Understanding/Agreement (MOUs/MOAs) among other agencies to enhance the coordination of service provision.
P. The agency must demonstrate input from clients via a client satisfaction survey or similar method at least annually.
Q. **Continuity of Care -** Agencies must ensure that service provision occurs regardless of staffing changes, shortages and closures. Clients must also be made fully aware of business operating hours and any changes, as needed.

VI. ACCESSIBILITY IN SERVICE DELIVERY

A. There will be no barriers due to client disability. The Agency must comply with ADA requirements for the provision of reasonable accommodations to address clients with special needs.
B. The agency must demonstrate a commitment to provide services that are culturally sensitive and linguistically appropriate in accordance to the National Standards for Culturally and Linguistically Appropriate Services (CLAS).
C. There will be no barriers due to language differences between the provider and clients. Agencies must have the ability to provide native language speakers for services when twenty percent (20%) or more of their clients prefer another language or arrange for a certified interpreter. When providing medical services, the agency will arrange for a certified medical interpreter.
D. Eighty percent (80%) of all persons initially seeking services will be established into the care system of the provider within five (5) working days of initial contact. If this is not possible, the reason must be documented in the client's file.

VII. RIGHTS AND RESPONSIBILITIES

AGENCY/PROVIDER

A. Agencies funded for Ryan White services shall have the ability to provide service in non-English languages when twenty percent (20%) or more of the clients speak a specifically identified language and must provide information for clients in that language or arrange for a certified interpreter.
B. All written materials must be printed in a language that is understandable to the client and must be written at no higher than a 5th grade reading level.
C. The agency will have a Clients Rights Statement posted and available to the client upon request.
D. The agency will have a Consent for Services Form, which is dated and signed by the client or person legally able to give consent. This form will be signed by the client upon initial intake, and at least annually thereafter.
E. The agency will have a Release of Information Form that is specific to the type of information released/exchanged, the agency to which the information will be shared, and the length of time during which the consent is valid. This form is used as needed and is signed by the client or person legally able to give consent.
F. The agency will have a written policy related to Client Grievance Procedures which is reviewed with the client in a language and format the client can understand as stated in A.
G. The agency will have a written Client Confidentiality Policy in conformance with State and Federal Laws.
H. Agencies must provide clients with complete and accurate information about services provided.

CLIENT

I. Clients have the right to be treated with dignity and respect. Clients have the responsibility to treat other clients and agency staff/volunteers with dignity and respect.
J. Clients have the right to refuse services and receive a full explanation of the consequences of refusing services.
K. Clients must be an active participant in the development, implementation, coordination and monitoring of their individual service plans. Clients must be provided with complete and accurate information about services received.
L. Clients are responsible for providing complete and accurate insurance, medical, financial and other eligibility information.
M. Clients are responsible for respecting the confidentiality of other clients receiving services.

N. Clients have the right to file a grievance if they feel their rights are being violated. Clients are responsible for following the proper procedures as outlined for grievances against any services, organization, or employee of organization.
O. Clients have the responsibility to keep illegal drugs, alcohol and weapons off agency property.

SERVICES MAY BE DISCONTINUED OR DENIED WHEN:

P. The client refuses to sign a Consent for Services and Release of Information Form.
Q. The client violates the rights of other clients or staff/volunteers
R. The client is involved in illegal activities on agency property
S. The client does not provide accurate insurance, medical, financial or benefits information
T. The client is receiving duplicate services from multiple providers.
U. The client is no longer eligible for Ryan White Services.

VIII. SERVICE DELIVERY COMPONENTS AND ACTIVITIES

A. INITIAL ELIGIBILITY DETERMINATION & ANNUAL RECERTIFICATION REQUIREMENTS

1. Proof of HIV diagnosis (Confirmatory HIV test [multi-spot, P4antigen, western blot], Viral load within 6 months, or written statement from treating physician).
2. Proof of residence (Current lease mortgage statement or deed settlement agreement, current driver's license/government identification, current voter registration card, current notice of Decision from Medicaid, Fuel/utility bill (past 90 days), property tax bill or statement (past 60 days), rent receipt (past 90 days), pay stubs or bank statement with your name and address (past 30 days), letter from another government agency with your name and address, active (unexpired) homeowners or renters insurance policy, DC Healthcare Alliance Proof of DC Residency Form, if homeless; letter from service provider on agency letterhead or homeless verification form.
3. Verification of income/gross annual income (must be less than or equal to 500% of the Federal Poverty Level [FPL]) as required by the Recipient.
4. Insurance verification as proof of un-insured or under-insured status.
5. Determination of eligibility and enrollment in other third party insurance programs including Medicaid and Medicare. Providers are expected to vigorously pursue enrollment into health care coverage for which their clients may be eligible (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or private health insurance) to extend finite RWHAP grant resources to new clients and/or needed services.
6. For under-insured, proof this service is not covered by other third party insurance programs including Medicaid and Medicare.
7. Proof of compliance with eligibility determination as defined by the jurisdiction.
8. Living arrangements/Household size
9. Ensure military veterans with Department of Veterans Affairs (VA) benefits are deemed eligible for Ryan White services

B. INTAKE

To collect demographic information and establish a care relationship. Intake may be done by an Intake specialist or non-medical case manager. The client intake must include the following:

1. Date of intake
2. Name and signature of person completing intake
3. Client name, address and phone number
4. Referral source, if appropriate
5. Language(s) spoken and/or preferred language of communication
6. Literacy level (client self-report)
7. Emergency contact information
8. Communication method to be used for follow-up
9. Demographics (sex at birth/current gender/date of birth/race/ethnic origin)
10. Veteran status
11. Any other data required for the CareWare system
12. Any other service-specific data
13. Documented explanation about the services available within the provider agency and within the Ryan White Program.

C. NEEDS ASSESSMENT

To identify client issues and care needs. Each client will participate in at least one face-to-face interview with their assigned non-medical case manager within ten (10) business days of determining Ryan White eligibility to complete the Needs Assessment. The following information must be recorded and is required if a client does not already have a current assessment on file.

The Needs Assessment must include an assessment of need in the following areas:

1. Finances/benefits
2. Housing
3. Transportation
4. Substance Use
5. Mental Health
6. Domestic violence
7. Basic needs, such as nutrition, food, and clothing
8. Support system
9. Current medical providers and medical case management providers
10. Identification of Legal Issues, if they exist
11. Any additional information required by the CareWare system not obtained at the intake

D. INDIVIDUALIZED SERVICE PLAN

The Service Plan must document long and short-term goals and objectives to improve access to medical care and social services. It must be reviewed within 90 days and modified if necessary. Within ten (10) business days of determining Ryan White eligibility, the NMCM will develop an individualize service plan with input from the client. The Service Plan must contain:

1. Client signature and date, signifying participation with development and agreement with Plan
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. Solutions to address barriers which are client-specific.
6. Referrals for support services.
7. Documentation of the client's participation in primary medical care.

E. COORDINATION & MONITORING OF INDIVIDUALIZED SERVICE PLAN

There must be documented contact with active clients every 90 days or as dictated by client need. The non-medical case manager must monitor the Service Plan and document the client's progress on their goals. The goals are expected to be reached within 90 days. If goals are not met within 90 days Reassessment must occur. The client record must include:

1. Progress notes detailing each contact with or on behalf of the client to implement the service plan.
2. Progress of Service Plan
3. Any communication with any provider agency; such as documents, progress notes, etc.
4. Documentation of follow-up for referred services and missed appointments.
5. Documentation of Adjustment to Service Plan if necessary
6. Documentation of case conferencing when necessary
7. Documentation of emergency situations as they arise, such as crisis intervention.

F. REFERRALS & LINKAGES

The non-medical case manager will assist the client in accessing medical, dental, social, financial, housing and/or other needed services as specified in the client's individualized Service Plan. The NMCM will facilitate coordinated linkages to the services to promote successful referrals outcomes.

G. RE-ASSESSMENT OF NEEDS

A formal re-examination of the client's condition, needs and resources to identify changes which occurred since the initial assessment or most recent assessment. The Reassessment must include:

1. Service Plan re-assessment and revision, if necessary, must be on-going for continuing clients

and within 90 days of initial assessment for new clients.

2. A re-examination of plan must be on the recommendation of the client's health care provider or client's change of status
3. Summary of progress in goal achievement of goals must be in client's file.
4. Review of client's clinical, financial and support needs to identify changes and/or additional services needs
5. Multidisciplinary team Case Conference with other providers, when appropriate.
6. Re-screening for all areas in the original needs assessment must be completed annually.

H. RE-CERTIFICATION (six months) REQUIREMENTS

To maintain eligibility for Ryan White services, the client (while active), must complete the sixth-month recertification process to verify the following information:

- Proof of residence
- Low income documentation
- Un-insured or under-insured status (Insurance verification as proof)
- Determination of eligibility and enrollment in other third party insurance programs including Medicaid and Medicare

Note: *At six month recertification one of the following is acceptable: full application and documentation, self-attestation of no change or self- attestation of change with documentation.*

I. PROCEDURE FOR MISSED APPOINTMENTS

- The client must be contacted within 2 days of missed appointment to determine if there was a reason why the appointment was not kept.
- The provider must attempt to reach the client no less than 2 times during a one-week period using the client-identified preferred contact method.
- Documentation of attempts to contact client must be noted in case file.

J. TRANSITION & DISCHARGE/CASE CLOSURE

Case Closure/Discharge

1. Reasonable efforts must be made to retain the client in services by phone, letter and/or any communication method agreed upon by the client. These efforts must be documented in the client's record.
2. The provider will make appropriate referrals and provide contacts for follow-up.
3. The provider must document date and reasons for closure of case including but not limited to: service provided as planned, no contact, client request, client moves out of service area, client died, client ineligible for services, etc.
4. A summary of the services received by the client must be prepared for the client's record.

Case Transfer

1. If the client is being transitioned, the provider must facilitate the transfer of client records/information, when necessary.
2. The client must sign a consent to release of information form to transfer records which is specific and dated.

K. DOCUMENTATION

Documentation must be kept for each client, which includes:

1. Client's name and demographic information
2. Name and contact info of client's Medical Case Manager and Primary Care Provider, if they have one
3. Proof of HIV+ status.
4. Initial intake and needs assessment forms.
5. Signed, initial and updated individualized service plan.
6. Consent for services.
7. Progress notes detailing each contact with or on behalf of the client. These notes must include date of contact and names of person providing the service.
8. Documentation that the client received rights and responsibilities information.
9. Signed "Consent to release information" form. This form must be specific and time limited.
10. Discharge and/or case closure information including person completing discharge and/or case closure,

date and reason for discharge and/or case closure.

IX. PERSONNEL QUALIFICATIONS

Each agency is responsible for establishing comprehensive job descriptions that outline the duties and responsibilities for each of the positions proposed in their program. All staff must be given and will sign a written job description with specific minimum requirements for their position. Agencies are responsible for providing staff with supervision and training to develop capacities needed for effective job performance.

A. NON-MEDICAL CASE MANAGER

1. Associate's/Bachelor's degree in health or human services related field preferred. High School diploma or GED required.
2. A minimum of 2 years of past experience working with persons living with HIV or at high risk of HIV acquisition preferred.
3. Ongoing education/training in HIV related subjects.
4. Agency will provide new hires with training regarding confidentiality, client rights and the agency's grievance procedure.

B. CASE MANAGEMENT ASSISTANT/ COMMUNITY HEALTH WORKER

1. Para-professional with a High School diploma or GED preferred and two years of experience working with persons living with HIV and/or health care training, such as certified medical assistants and medical clerks.
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 when appropriate.
6. Ongoing education/training in HIV related subjects.

C. ELIGIBILITY/INTAKE SPECIALIST

1. Para-professional with a High School diploma or GED preferred and two years of experience working with persons living with HIV and/or health care training, such as certified medical assistants and medical clerks.
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 when appropriate.
6. Ongoing education/training in HIV related subjects.

- All Non-Medical Case Managers, Case Manager Assistants, Community Health Workers and /Eligibility/Intake Specialists must complete a minimum training regimen within one year of hire date that includes:
    1. ADAP requirements and application
    2. Overview of Medicaid, Medicare, SSI, SSDI
    3. Non-Medical Case Management Service Standards
    4. National Standards for Culturally and Linguistically Appropriate Services (CLAS)
    5. Ryan White eligibility criteria.

- If newly-hired Non-Medical Case Manager/Eligibility/Intake Specialists have previously obtained all of the required training, they do not need to repeat it. Documentation of completion of required trainings must be kept in the Non-Medical Case Manager/Eligibility/Intake Specialist's personnel file.

- Sixteen hours of training/education in HIV/AIDS is required annually. Ongoing training on changes to benefit program and their eligibility, such as Medicare, Medicaid, SSI, SSDI, Ryan White etc. is also required annually. Documentation of completion of required trainings must be kept in the Non-Medical Case Manager/Eligibility/Intake Specialist's personnel file.