DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)

Non-Medical Case Management

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 Eligible Metropolitan Area (EMA) such that customers 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 customers and will be used as contract requirements, in program monitoring, and in quality management.

I. SERVICE CATEGORY DEFINITION

Non-Medical Case Management Services 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).

Key activities include:

- 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 :

SERVICES DESCRIPTION: 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

Non-Medical Case Management Services (NMCM) 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 customers 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 customer 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 customer'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.
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II. INTAKE, ELIGIBILITY & ANNUAL RECERTIFICATION REQUIREMENTS

The Ryan White HIV/AIDS Program has the following eligibility criteria: residency, financial, and medical. HRSA requires Ryan White customers to maintain proof of eligibility annually. Supporting documentation is required to demonstrate customer eligibility for Ryan White Services.

A. INITIAL ELIGIBILITY DETERMINATION

1. **HIV-positive status:** written documentation from a medical provider or laboratory reports denoting viral load.

2. **Residency:** The following are acceptable methods of meeting the burden for residency:

- Current lease or mortgage statement
- Deed settlement agreement
- Current driver's license
- 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 the name and address of the customer (past 30 days)
- Letter from another government agency addressed to customer
- Active (unexpired) homeowner's or renter's insurance policy
- DC Healthcare Alliance Proof of DC Residency form
- If homeless, a written statement from case manager, facility or letter from landlord that customer is resident

1. **Income:** Customer income may not exceed 500% of the Federal Poverty Level (FPL). Income sources should be reported by the customer and any household members for whom customers have legal responsibility. For each income source, the customer must indicate the gross amount, how often the income is received, and whether it is your income or a household member's from each source.

The following are acceptable forms of proof of income:

- Pay stubs for the past 30 days. The pay stub must show the year to date earnings, hours worked, all deductions, and the dates covered by the paystub
- A letter from the employer showing gross pay for the past 30 days, along with a copy of the most recent income tax return

- Business records for 3 months prior to application, indicating type of business, gross income, net income, and most recent year's individual income tax return. A statement from the customer projecting current annual income must be included
- Copy of the tenant's lease showing customer as the landlord and a copy of their most recent income tax return
- SSD/SSI award letters, unemployment checks, social security checks, pension checks, etc. from the past 30 days
- Zero income attestation form and/or a letter from a supporting friend or family member stating how they support the customer

B. INTAKE

To establish a care relationship, the customer intake must include the collection of the following demographic information:

1. Date of intake
2. Name and signature of person completing intake
3. Customer name, address and phone number
4. Referral source, if appropriate
5. Language(s) spoken and/or preferred language of communication
6. Literacy level (customer 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. MAINTENACE OF ELIGIBILITY

To maintain eligibility for Ryan White services, providers must conduct annual eligibility confirmations to assess if the customer's income and/or residency status has changed. RWHAP providers are permitted to accept a customer's self-attestation of 'no change' when confirming eligibility, however, self-attestation could be used every other annual confirmation and not be used in two consecutive years.

III. KEY SERVICE COMPONENTS & ACTIVITIES

INITIAL ASSESSMENT OF SERVICE NEEDS	
Standard	**Measure**
NEEDS ASSESSMENT To identify customer issues and care needs. Each customer 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 customer 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	Documentation of assessment in customer's record signed and dated by health educator
DEVELOP INDIVIDUALIZED SERVICE PLAN	

Standard	Measure
INDIVIDUALIZED SERVICE PLAN Provider must develop individualized service plan, must document long and short-term goals and objectives to improve access to medical care and social services. Within ten (10) business days of determining Ryan White eligibility, the NMCM must develop an individualized service plan with input from the customer. The Service Plan must contain: 1. Goals and measurable objectives responding to customer needs. 2. Timeframes to achieve objectives 3. Screening for eligibility for entitlements and assistance in completing applications 4. Solutions to address barriers which are customer-specific. 5. Referrals for support services. 6. Documentation of the customer's participation in primary medical care. 7. Customer signature and date, signifying participation with development and agreement with Plan Provider must review the service plan within 90 days and modified accordingly.	Individualized service plan documented in customer record, signed and dated by the customer and non medical case manager
COORDINATION & MONITORING OF INDIVIDUALIZED SERVICE PLAN/REASSESSMENT	
Standard	**Measure**
COORDINATION & MONITORING OF INDIVIDUALIZED SERVICE PLAN	Documentation of review and update of HE/RR plan as appropriate signed and dated by customer and health educator

Provider must document contact with active customers every 90 days or as dictated by customer's needs. The nonmedical case manager must monitor the Service Plan and document the customer'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 customer record must include: 1. Progress notes detailing each contact with or on behalf of the customer 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.
Provider must ensure that at least eighty percent (80%) of all persons initially seeking services will be established into the care system within five (5) working days of initial contact. If this is not possible, the reason must be documented in the customer's file.	Documentation of referrals in customer's record
ONGOING ASSESSMENTS FOR SUPPORT	
Standard	**Measure**
Provider must provide education on HIV transmission and how to reduce the risk of infection to others	Documentation that customers were educated about HIV transmission and how to reduce the risk of HIV transmission to others. Documentation must Include description of the types of information, education, and counseling provided to customers
Provider must provide information on available psychosocial support services to customers	Documentation that customers received information about available medical and psychosocial support services. Includes description of the types of information, education, and counseling provided to customers
RE-ENTRY PLANNING	

Standard	Measure
Providers must provide transitional case management for incarcerated persons as they prepare to exit the correctional system. The PLWH is expected to be eligible for Ryan White services upon their release.	Documentation on customer's record of plan for engagement in services after release
Providers must review ● Discharge planning, ● Continuity of treatment and ● Provide community linkages	Documentation on customer's record
TRANSITION & DISCHARGE/CASE CLOSURE	
Standard	**Measure**
TRANSITION & DISCHARGE/CASE CLOSURE Case Closure/Discharge 1. Reasonable efforts must be made to retain the customer in services by phone, letter and/or any communication method agreed upon by the customer. 2. The provider will make appropriate referrals and provide contacts for follow-up. 3. The provider must document the date and reasons for closure of the case including but not limited to: service provided as planned, no contact, customer request, customer moves out of service area, customer died, customer ineligible for services, etc. 4. A summary of the services received by the customer must be prepared for the customer's record. Case Transfer: 1. If the customer is being transitioned, the provider must facilitate the transfer of customer records/information, when necessary. 2. The customer must sign a consent to release of information form to transfer records which are specific and dated.	Documentation of discharge plan and summary in customer's record with clear rationale for discharge within 30 days of discharge, including certified letter, if applicable. Documentation must be kept for each customer, which includes: 1. Customer's name and demographic information 2. Name and contact info of customer'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 customer. These notes must include the date of contact and names of the person providing the service. 8. Documentation that the customer 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.

IV. PERSONNEL QUALIFICATIONS

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, customer rights and the agency's grievance procedure.

B. Non Medical Case Management Supervisor: Licensure as a Physician, Registered Nurse (RN), Nurse Practitioner , or as an advanced level graduate /Clinical Social Worker in the Jurisdiction(s) in which services are rendered.

C. 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.

D. 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 NonMedical 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.

V. CLINICAL QUALITY MANAGEMENT

Include at least one performance measure in the clinical quality management program for the service. Please refer to Policy Clarification Notice (PCN) #15-02 (updated 09/01/2020).

VI. APPROVAL & SIGNATURES

This service standard has been reviewed and approved on January 2, 2024. The next annual review is July 31, 2025.

Avemaria Smith
Interim Division Chief
Care and Treatment Division
DC Health/HAHSTA

Jane Wallis
Community Co-Chair
Washington DC Regional Planning
Commission on Health and HIV (COHAH)