Nevada Office of HIV
Nevada Ryan White Part B Program
Non-Medical Case Management Service

I. HRSA Service Definition

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 client 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 Manufacture's Patient Assistance Programs, Department of Labor or Education-funded services, other 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.
- 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

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, whereas Medical Case Management Services have as their objective improving health case outcomes.

The State of Nevada recommends that all agencies utilize validated best practices for the execution of their service category. If an agency needs resources or recommendations to locate or implement best practice tools, please contact the Recipient Office and we will provide necessary guidance. It is an expectation that all agencies implement a program that can have measurable positive effects for clients.

II. Service Goals and Objectives

To provide coordinated HIV services that improves the quality of life for clients in Nevada.

A. Provide HIV/AIDS non-medical case management benefits counseling, eligibility and enrollment services, referrals and related activities, and intervention services by identifying and minimizing barriers to care access, developing personal care plans, setting goals and obtaining needed services.

B. One of the components of a non-medical case management program *can be* the provision of eligibility and enrollment services. The eligibility process gathers information necessary to determine a client's eligibility for Ryan White services and benefits and refers clients to further core and supportive services. The non-medical case manager is often the first contact for new clients and plays an important role in educating clients about the HIV Case Management or other benefit programs, as well as assists clients to successfully navigate HIV care services. For existing clients, the non-medical case manager conducts the six-month eligibility review process and documents outcomes.

III. Currently Funded Non-Medical Case Management Services

A.) Eligibility - Annual Review (NMCM)
B.) Eligibility - Recertification (NMCM)
C.) Eligibility - Other Contact (NMCM)
D.) Initial Assessment/Development (NMCM)
E.) Reassessment/Redevelopment (NMCM)
F.) Referral & Related Activities (NMCM)
G.) General Monitoring (NMCM)
H.) Discharge Summary from NMCM
I.) ADAP Coordination (NMCM)
J.) HIP CSAP Coordination (NMCM)
K.) Health & Wellness Engagement/Reengagement (RiC)

IV. Service Delivery

Eligibility Annual Review (Service A)

Each brand-new client must receive a comprehensive eligibility assessment to determine the ability of that client to access Ryan White Part B (RWPB) Services, based on specific eligibility criteria. Each client must then be reassessed annually, during the client's birth month. At a minimum the following documentation must be provided:

- Common Guidance Document (CGD) 18-04a Universal Eligibility Application- Brand New Client **or** CGD 18-05a Universal Eligibility Application- Annual Review Client
- Proof of HIV Diagnosis
- Proof of Nevada Residency
- Proof of Low-Income Status (income and household size to determine federal poverty level.

The CGD 18-04a Universal Eligibility Application - Brand New Clients should only be used upon a client's initial enrollment into Ryan White services. Annually, the client should be reassessed for

eligibility using the CGD 18-05a Universal Eligibility Application - Annual Review Client. If a client lapses in care for any period, the client should be reassessed for eligibility using the CGD 18-05a Universal Eligibility Application - Annual Review Client.

The Universal Eligibility Application can be used in lieu of a non-medical case management comprehensive assessment (i.e. care plan) of the individual needs, to determine the need for any medical, support, social, or other services. Eligibility Annual Review should be used when the non-medical case manager has received a *completed* eligibility application and supplement documentation.

Eligibility Recertification (Service B)

Every six months, during a client's half-birth month, a client must be reassessed for Ryan White eligibility. Non-medical case managers will update client eligibility fields in CAREWare and upload a recertification eligibility application and supporting documentation at that time. At a minimum the following documentation must be provided:

- 18-06a Universal - Six Month Self-Attestation Packet **or** CGD 18-05a Universal Eligibility Application- Annual Review Client
- Proof of Nevada Residency
- Proof of Low-Income Status (income and household size to determine federal poverty level.

The Universal Eligibility Application can be used in lieu of a non-medical case management comprehensive reassessment (i.e. care plan) of the individual needs, to determine the need for any medical, support, social, or other services. Eligibility Recertification should be used when the non-medical case manager has received a *completed* eligibility application and supplement documentation, if required.

Eligibility Other Contact (Service C)

The Eligibility Other Contact should be used for follow-up contacts/interactions with a client related to a client's eligibility application or related activity. Examples include: when a client drops off eligibility documents, when client is called to be reminded of an eligibility appointment, when a client is called to be told of eligibility end date, or when a client's record is reviewed even if no actual contact is made but the record is touched.

The Eligibility Other Contact is distinguished from the General Monitoring Contact in that Eligibility Other Contacts only apply to eligibility contacts and activities, whereas General Monitoring Contacts relate to all other non-medical case management follow-up contacts and client interactions.

Initial Assessment/Development (NMCM) (Service D)

An initial assessment must be developed when a non-medical case management agency does not perform eligibility activities, and therefore cannot use the Universal Eligibility Application in lieu of a comprehensive non-medical case management plan. Initial Assessment/Development should be used when the non-medical case manager and client have created an individualized non-medical case management care plan and it has been uploaded into CAREWare.

Reassessment/Redevelopment (NMCM) (Service E)

A comprehensive reassessment of the individual's needs must be developed when a non-medical case management agency does not perform eligibility activities, and therefore cannot use the Universal Eligibility Application in lieu of a comprehensive non-medical case management plan. A reassessment should be done every six months after the previous assessment. Reassessment/Redevelopment should be used when the non-medical case manager and client have created a reassessment of the individualized non-medical case management care plan and it has been uploaded into CAREWare.

Referral and Related Activities (Service F)

Referral and Related Activities should be used to help the eligible individual obtain needed services through referrals internal and external to CAREWare, including activities that help link the individual with medical, social, and support providers or other programs and services that are capable of providing needed services to address identified needs. Referral and related activities should also be used when non-medical case managers follow-up on a referral made to another provider to ensure completion or rejection of a referral, or when following-up with a client to ensure the client's needs have been met.

General Monitoring (Service G)

General Monitoring should be used when a non-medical case manager engages in interactions with a client to assess the client's service needs and satisfaction; this can be done through telephone, face-to-face contacts, emails, etc. This can be collaboration with the client, family or caregiver, or providers of services. The case manager should be in contact regularly with the client to be aware of any changes in the client's service needs or life events. General Monitoring should be non-eligibility based interactions and contacts.

Discharge Summary from NMCM (Service H)

A non-medical case management agency that utilizes *individualized care plans* may use Discharge Summary for a variety of options, such as: to indicate the client has satisfactorily met the goals of their care plan, the client has moved out of jurisdiction, the client is no longer in need of non-medical case management, the client is lost to care or can no longer be located, the client's needs are more appropriately addressed in another program such as medical case management, the client exhibits a pattern of abuse as defied by agency's policy, or the client has deceased. To determine if client is lost to care or cannot be located, the subrecipient will

attempt and document 3 follow-up contacts over a period of time, i.e., contacts are not to be conducted on the same day. Examples of a client being lost to care or cannot be located include: the client is non-responsive to agency contacts regarding referral follow-up, or the client is non-responsive to agency attempts at complete a 60-day general monitoring check-in. The reason for a discharge summary must be notated in CAREWare within the service notes.

A non-medical case management agency that performs *eligibility based services* and does not utilize individualized care plans may use Discharge Summary for a variety of options, such as: the client is lost to care or can no longer be located, the client moved out of jurisdiction, the client has deceased, the client is no longer in need of Ryan White services, or the client chooses to receive eligibility based services at another non-medical case management agency. To determine if client is lost to care or cannot be located, the subrecipient will attempt and document 3 follow-up contacts over a period of time, i.e., contacts are not to be conducted on the same day. Examples of a client being lost to care or cannot be located include: the client is non-responsive to agency contacts regarding referral follow-up, the client is non-responsive to agency attempts at complete a 60-day general monitoring check-in, the client has lapsed in eligibility and is non-responsive to agency contacts to redetermine eligibility. The reason for a discharge summary must be notated in CAREWare within the service notes.

ADAP Coordination (NMCM) (Service I)

ADAP Coordination should be used when working with clients related to ADAP services. Examples include: obtaining ADAP-related documents from clients or employers, entering client data into the Ramsell Pharmacy Benefit Management system, making health insurance premium payments on behalf of a client, coordinating with pharmacies on behalf of a client, etc.

HIP CSAP Coordination (NMCM) (Service J)

HIP CSAP Coordination should be used when working with clients related to Health Insurance Premium and Cost Share services. Examples include: coordinating with clients or medical providers related to a client's medical/ vision/ dental cost share or copayments, making dental insurance premium payments on behalf of a client, obtaining Health Insurance Premium and Cost Share back-up documentation from clients, etc.

Health & Wellness Engagement/Reengagement (RiC) (Service K)

Health & Wellness Engagement/Reengagement (RiC) should be used when making contacts with clients who may be able to lapse in care, have been lost to care, or who have not picked-up a medication through the ADAP program in over 45 days. Contacts may be made via telephone, face-to-face contacts, or email. Non-medical case managers funded to perform Retention-in-Care activities, should work with the client to develop an individualized care plan with the client to assist the client transitioning back into care.

V. Process

The Service Standards provide a step-by-step process for conducting non-medical case management activities. The process steps below provide additional information in implementing these roles.

Non-Medical Case Management Eligibility Agencies

A. Timelines: All completed and signed eligibility applications and follow-up documents must be scanned into CAREWare same-day or within 24 hours.

B. Complete and Accurate Eligibility Applications: The eligibility agency is responsible for maintaining complete, accurate and up-to-date client-level information in CAREWare. The eligibility agencies are required to verify, scan, and upload into CAREWare supporting documentation demonstrating the client's eligibility as well as other necessary documents and forms.

The client is responsible to report any change in their information regardless of the timing during their recertification cycle; the change must be documented immediately within the client's CAREWare file. If a client is deemed ineligible based on Universal Eligibility Application guidance, such as income level, the client should be advised to contact their non-medical case manager for a re-determination if circumstances change. A client may be deemed ineligible at any point during the eligibility process for falsification of information.

C. Case-by-Case Eligibility Determinations: If a client has a unique circumstance or if eligibility is not conclusive based on the information submitted by the client, the non-medical case manager should reach out to the Ryan White Recipient offices for clarification of client eligibility.

D. Referrals: After each initiated referral, non-medical case managers must conduct a 30-day follow-up on a referral made to another provider to ensure completion or rejection of a referral, or when following-up with a client to ensure the client's needs have been met. *Internal Referrals* should be closed out in CAREWare by the receiving agency, *External Referrals* should be closed out by the initiating agency.

E. General Monitoring: Non-medical case managers must contact the client within 60-days after completing each Universal Eligibility Application; Brand New, Annual, and Six-Month Self-Attestation. The general monitoring contact should assess the client's service needs and satisfaction; this can be done through telephone, face-to-face contacts, emails, etc.

F. Eligibility Reminder Calls: Non-medical case managers will notify clients at least 1 month in advance of eligibility re-determination to help remind clients of the need to maintain eligibility. This is an opportunity to remind client of which eligibility documents are needed for their eligibility application. To ensure clients are not contacted by multiple agencies, non-medical

case managers should contact clients where they are listed as the *Most Recent Eligibility Agency* in CAREWare.

G. Confidentiality: Clients must be informed of their right to confidentiality. It is important not to assume that anyone - even a client's partner/spouse or other family member – knows that the client is HIV-positive. The Non-Medical Case Manager should discuss with the client how he or she prefers to be contacted.

- When trying to contact the client Case Management staff should identify themselves only by name and never give an organizational affiliation that would imply that the client has a particular health status or receives Ryan White or other services.
- When Case Manager is being contacted, they must determine the identification of the caller and what, if any, information may be disclosed.
- Confidential information is discussed by phone only in areas where the conversation cannot be overhead.

Non-Medical Case Management Non-Eligibility Agencies

A. Individualized Care Plans: An Individualized care plan provides the basis from which the non-medical case manager and client work together through an interactive process, where problems are identified, prioritized, and are addressed through a planning process the includes the development of goals, assigned activities, and reporting of outcomes.

- The individualized care plan should be updated every six-months to evaluate the effectiveness and relevance of the plan, measuring the clients progress toward meeting stated goals and activities, and to revise the plan as needed.
- Follow-up and monitoring activities can occur through direct contact (i.e., face-to-face meeting, telephone communication, texting, email, instance messing) with the client.

B. General Monitoring: Non-medical case managers must contact the client within 60-days after completing an initial or reassessment individualized care plan. The general monitoring contact should assess the client's service needs and satisfaction; this can be done through telephone, face-to-face contacts, emails, etc.

C. Confidentiality: Clients must be informed of their right to confidentiality. It is important not to assume that anyone - even a client's partner/spouse or other family member – knows that the client is HIV-positive. The Non-Medical Case Manager should discuss with the client how he or she prefers to be contacted.

- When trying to contact the client Case Management staff should identify themselves only by name and never give an organizational affiliation that would imply that the client has a particular health status or receives Ryan White or other services.
- When Case Manager is being contacted, they must determine the identification of the caller and what, if any, information may be disclosed.

- Confidential information is discussed by phone only in areas where the conversation cannot be overhead.

VII. Licensing, Knowledge, Skills, and Experience

Non-medical case management is provided by non-medical personnel but shall have had at least six (6) months of relevant experience in the areas of outreach work, community services, supportive work with families and individuals, aging, supportive work with youth, corrections, or public relations. The suggested minimum educational experience shall be a B.A. or B.S. degree in any of the following disciplines: psychology, social work, counseling, sociology, community health, and public health or an associate degree with three years in a related field. If qualified individuals do not have relevant and current experience related to working with individuals living with HIV, they must receive HIV specific training within six months of hire.

VIII. Summary

These service specific standards shall be followed by all funded providers that provide Part B funded Non-Medical Case Management. It is expected that all providers follow these standards as well as the universal programmatic and administrative National Monitoring Standards. Provider organizations and staff may exceed any of these standards as part of the program delivery.

IX. Recommendations

All Part B funded providers are to adhere to these service category specific standards, program standards, the national monitoring standards, and ensure that they are familiar with their individual Part B subgrant to meet the expectations of their deliverables.

Revision Schedule

Published	February 9, 2017	Located at dpbh.nv.gov
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Contact

For further information or clarification please contact the Nevada Office of HIV Prevention and Care: NVPrev@health.nv.gov