

Standards of Care

MARCH 2011



Non-Medical Case Management

STANDARDS OF CARE

The purpose of the Ryan White Part A Standards of Care and performance measures is to ensure that a uniformity of service exists in the Las Vegas Transitional Grant Area (TGA) as such that the consumers of services receive the same quality of service regardless of where the service is rendered. These standards align with current Public Health Services (PHS) Guidelines and the Health Resources and Services Administration's standards and performance measures for service delivery to ensure the highest quality of service.

APPLICATION OF STANDARDS

These standards apply to any agency receiving Part A funds to provide services as contracted for that time period. If any agency is unable to meet a particular standard, the agency must document why the standard was unable to be met and explain the steps underway to meet the standards. All standards and measures will be reviewed by Part A Grantee staff annually as designated.

I. Definition of Service

Health Resources and Services Administration (HRSA)

Case management services (non-medical) include advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments.

II. Purpose of Service

Non-Medical Case Management should be responsive to the immediate needs of a person living with HIV/AIDS. It is suitable for persons with discrete needs that can be addressed in the short term or for clients who have transitioned from Medical Case Management but still require a maintenance level of periodic support from a case manager. Follow-up to ensure that arranged services have been received and to determine whether more services are needed is central to Non-Medical Case Management. It also serves as a vital point of assessment to determine if the client is in need of a more intensive level of case management services for assistance with medical care and follow-up.

III. Goals of Service

To facilitate access to community services as a process of enabling linkage to medical care and other needed support services in addition to reducing barriers to care.

IV. Measures

Indicators are used to measure and determine, over time, performance of a particular element of care. Outcomes are benefits or other results (positive or negative) for clients that may occur during or after their participation in a program. The Las Vegas TGA has developed three categories of measures to accurately track compliance vs. client progress vs. overall program performance. All measures will be tracked on an annual basis by grant year in their respective categories, which are; Agency Compliance Indicators, Client

Level Outcome Measures, and Overall Program Performance Measures. The intent is that agency compliance with standards of care will improve the overall health and well-being of the clients and improve access to care. The primary method of data collection is CAREWare, in addition to an annual chart review at each agency receiving Part A funding and client satisfaction surveys.

1. Agency Compliance Measures

Agency Compliance Measures for non-Medical Case Management services and their percentage goals are listed next to their respective standards in the Service Standards section. All agencies are expected to uphold the outlined standards to a minimum of the designated percentage goal and annually their compliance will be assessed. Additional standards and guidelines pertinent to each agency regardless of the service categories they provide are outlined in the Universal Monitoring Standards document which will also be assessed annually.

2. Client Level Outcome Measures

The Client Level Outcome Measures are a reflection of our client's progress as they access Non-Medical Case Management Services. The following Client Level Outcome Measure and percentage goal will be assessed annually according to the client's level of case management:

In Medical Care

- 75% of clients that are in medical care (at least one medical visit per measurement period).

Maintained Adherence to Medical Care

- 75% of clients that maintain adherence to Medical Care visits within the measurement year (at least two medical visits with a provider with prescribing privileges at least three months apart in the measurement year).

Stabilized CD4

- 75% of clients will have stabilized (≥ 200) or increased their CD4 T-cell count from initial labs during the measurement period to final labs during the measurement period.

Most Recent CD4 Stable

- 75% of clients with at least one CD4 T-cell count within the measurement year and those that are considered medically stable ($CD4 \geq 200$).

Undetectable Viral Load

75% of clients will have a viral load that remained undetectable or decreased to ≤ 50 from initial labs during the measurement period to final labs during the measurement period.

Most Recent Viral Load Undetectable

- 75% of clients with at least one viral load within the measurement year will be considered undetectable (< 50).

Decreased Client Acuity

- 90% of clients will have a decreased client acuity score from initial score on intake to final score at discharge or final score within the measurement period.

3. Overall Program Performance Measures

Overall Program Performance Measures illustrate how accessible Non-Medical Case Management services are in our TGA in addition to how they are perceived by the client for not only the HIV/AIDS population but the minority population as well. These measures and respective goals are as follows:

MAI Measure-Service Utilization among Minority Populations

- 65% of minority clients (excluding only non-Hispanic White clients age 25+) will access non-Medical Case Management services at least once during the measurement period. (Minority AIDS Initiative Measure)

Increase Non-Medical Case Management Service Utilization

- 65% of clients in the Part A system of care will have at least one Non-Medical Case Management service visit within the measurement period.

Client Satisfaction

- 75% of clients will report being very satisfied or satisfied with the services they received from community case managers and social workers for their HIV/AIDS status over the last 12 months.

Understanding their Clients Needs

- 65% of clients will report feeling that their case manager understands their needs.

Received the Care and Services Needed

- 65% of clients will report that their case manager helped them get the services they need.

Received Needed Referrals

- 65% of clients will report getting the referrals they were in need of.

Understanding Case Management Care Plan

- 65% of clients will report that their case manager helped them understand their case management care plan.

Improved Psychosocial Status

- 65% of clients will report that their case manager helped them improve the problems, feelings, or situations they discussed.

V. Service Standards

A. PERSONNEL REQUIREMENTS

Employees providing Non-Medical Case Management services must meet the qualifications for the position as outlined in the agency’s job description in addition to holding a bachelor’s degree in the social or behavioral sciences or a minimum of 2 years experience working with PLWH/A.

B. STAFFING REQUIREMENTS

1. Caseloads

Staff shall have caseloads set at levels that allow them to conduct their activities adequately and competently. Case loads should be established based upon intensity of needs of clients and program managers should conduct periodic assessments to see if caseload assignments allow for quality services and completion of job duties.

The following is provided as a guideline for appropriate case levels:

Non-Medical Case Management Standards	Non-Medical Case Management Agency Compliance Indicators
✓ Case Load 81-100 <ul style="list-style-type: none"> • Low-15 points or less Scoring in level 0-1 	Assigned Case Manager <ul style="list-style-type: none"> ○ 100% of clients will be assigned to a Case Manager upon intake.

2. Case Manager Transition

Changes in client case manager assignment should be minimized to maintain continuity of care. Clients should be able to see the same case manager over time as this arrangement develops trust. However, the program should also be willing to change client-Case Manager assignments if a client expresses his/her wishes to do so based on negative experience or lack of trust.

C. NON-MEDICAL CASE MANAGEMENT SERVICE ACTIVITIES

1. Client Intake and Initial Assessment

Intake is a time to gather registration information, assess the clients overall health status and unmet needs, provide necessary referrals for care, and provide basic information about case management and other HIV services. It is also a pivotal moment for establishment of trust and confidence in the care system. Each client will receive an initial comprehensive assessment utilizing the standardized Ryan White Part A assessment forms.

The following must be completed during the initial assessment or as indicated:

Non-Medical Case Management Standards	Non-Medical Case Management Agency Compliance Indicators
<ul style="list-style-type: none"> ✓ Ryan White Part A Client Registration Form ✓ Client Acuity ✓ Individual Service Plan (ISP) Development 	<p>Complete Ryan White Part A Client Registration Form</p> <ul style="list-style-type: none"> ○ 100% of newly enrolled clients during the measurement period will have a Ryan White Part A Client Registration Form documented in the client chart on intake. <p>Complete Client Acuity Form</p> <ul style="list-style-type: none"> ○ 100% of newly enrolled clients during the measurement period will have an Acuity Form documented in the client chart on intake. <p>Client Care Plan or Individual Service Plan</p> <ul style="list-style-type: none"> ○ 100% of newly enrolled clients during the measurement period will have a Client Care Plan or Individual Service Plan documented in the client chart on intake.

Additionally, all clients will be provided, and sign if necessary, the following:

- ✓ A Statement of Consumer Rights
- ✓ Sanction policy and/or Zero Tolerance Information
- ✓ Explanation of the grievance policy
- ✓ Booklet of information regarding community resources (compiled by the Part A Grantee or another reputable source)

2. Case Management Reassessment

Case management is to be an ongoing management process, not simply an initial or occasional assessment and referral. The purpose of the reassessment process is to ensure continued progress in meeting consumer needs while identifying any new emerging needs or problems.

The following must be completed during each reassessment at a minimum of the indicated intervals:

Non-Medical Case Management	Non-Medical Case Management Agency Compliance Indicators
<p>Non- Medical Case Management clients should be reassessed at a minimum of every six months, however this may occur more often if necessary. These interactions should be face-to-face and coincide with the client’s redetermination of eligibility for Part A services. Each six month reassessment should, at a minimum, include the following:</p> <ul style="list-style-type: none"> ✓ Ryan White Part A Client Reassessment Form ✓ Client Acuity ✓ Update Individual Service Plan (ISP) 	<p>Client Reassessment</p> <ul style="list-style-type: none"> ○ 85% of clients will have a completed reassessment form documented twice each at least three months apart within the 12 month measurement period. <p>Updated Client Acuity</p> <ul style="list-style-type: none"> ○ 85% of clients will have an updated client acuity documented at least twice each at least three months apart within the 12 month measurement period. <p>Updated Individual Service Plan (ISP)</p> <ul style="list-style-type: none"> ○ 85% of clients will have an updated ISP documented at least twice each at least three months apart within the 12 month measurement period.

3. Follow-up and Monitoring

Follow-up and monitoring contacts may be done by telephone. However, the client must be seen face-to-face at a minimum of every six months for a full reassessment and a re-determination of eligibility. Each follow-up contact should include, at a minimum, discussion of the client’s progress on their ISP and goals outlined therein, current needs and necessary referrals, and the clients overall wellbeing.

The following must be completed during each follow-up at a minimum of the indicated intervals:

Non-Medical Case Management Standards	Non-Medical Case Management Agency Compliance Indicators
<p>Minimum contact frequency for clients receiving Non-Medical Case Management is every three months.</p> <ul style="list-style-type: none"> ✓ Non-Medical Case Management Encounter Form or other approved method of tracking follow-up contacts. 	<p>Client Follow-Up Every Three Months</p> <ul style="list-style-type: none"> ○ 85% of clients will have a follow-up documented by a Non-Medical Case Management client encounter form (or other approved method such as case notes) at least twice per year in between each period of reassessment.

4. Discharge Planning

Unplanned discharge from case management services may affect the client’s ability to maintain access to care. Therefore it is mandatory that at least three attempts be made over a three month period to contact the clients who appear to be lost to follow-up (those who haven’t had an appointment with the agency for a period of twelve months or more). Clients who cannot be located after three attempts shall receive a formal letter by mail explaining their reason for discharge. A client may be discharged from case management services for any of the following conditions:

- The client has died.

- The client has become ineligible for services (e.g., due to relocation outside the TGA or fails to meet other eligibility criteria).
- The client no longer demonstrates need for case management due to their own ability to effectively advocate for their needs.
- The client chooses to terminate services.
- The client’s needs would be better served by another agency.
- The client is being discharged from the correctional facility at which they are receiving jail case management services.
- The client demonstrates pervasive unacceptable behavior that violates client rights and responsibilities.
- The client cannot be located after documented three attempts for a period of no less than three months.
- The client is transitioning into another level of case management services within the Part A system. In this case to ensure a smooth transition, relevant intake documents maybe 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.

All clients exiting case management services must have the following documented in their chart:

Non-Medical Case Management Standards	Non-Medical Case Management Agency Compliance Indicators
<ul style="list-style-type: none"> ✓ Discharge summary in the clients chart/case notes explaining: <ul style="list-style-type: none"> ● Reason for discharge ● That at least three attempts were made over a period of three months to contact the client if they have been lost to follow-up 	<p>Discharge Summary</p> <ul style="list-style-type: none"> ○ 90% of clients discharged from case management will have a discharge summary documented in the client chart. <p>Final Acuity Score at Discharge</p> <ul style="list-style-type: none"> ○ 90% of clients will have an updated acuity score documented in their chart at the time of discharge.

5. Documentation Tools and Minimum Requirements

RYAN WHITE PART A CLIENT REGISTRATION FORM

The Ryan White Part A Client Registration Form must be filled out on intake for all clients, whether they are new to the system of care or re-entering (haven’t had an appointment for a period of 12 months or more). Information collected on this form will provide a portion of the eligibility requirements in addition to all data required in CAREWare.

Completed information on this must include, at a minimum, the following:

- Demographics
- HIV/AIDS Status and Medical Information
- Emergency Contact Information
- Living Status and Relationship Information
- Employment and Income Information
- Current Service Needs
- Case Managers and Client Signature
- Case Notes

CLIENT ACUITY

The client acuity scale is a tool that is used to measure the intensity and severity of a client's condition. This can be useful in guiding the Case Manager's assessment, client progress, and can help identify serious problems that need attention. Points range from 1 (non-critical) to 4 (very critical). All clients should receive a client acuity assessment on intake and at a minimum of every six months at the client's reassessment. Referrals for appropriate levels of case management should be made accordingly.

Client acuity level guidelines provide a basic framework for the level of case management needed, they are as follows:

Level of Case Management	General Case Load	Client Acuity Level	Minimum Reassessment Frequency	Minimum Contact Frequency
Basic(Medical/non-Medical)	81-100	Low 15 points or less Scoring level 0-1 Only	6 months	3 months
Intensive (Social)	30-60	Moderate 15-39 points Scoring level 1 & 2	6 months	2 months
Intensive (Medical)	20-30	High 31 points or higher Scoring level 2 & 3	2 months	1 month

Acuity assessments must be filled out completed for each life area and an overall score documented on the acuity assessment in order for it to be considered complete.

INDIVIDUAL SERVICE PLAN (ISP)

The Case Manager shall develop an Individual Service Plan (ISP) for each client. Care planning begins at admission to case management services and is based upon initial or reassessment. Once the client's needs have been assessed, Case Managers, with assistance from the client, shall prioritize care, support needs, and identify activities to address them.

This individualized plan provides a guide for both the client and the Case Manger on how to address the client's needs in a manner that promotes self-sufficiency of the client. Discernment is required on the part of the Case Mangers to provide enough support to assist clients in meeting their needs, while fostering the clients' ability and responsibility for self-care. This requires an approach that is heavier in initial support, which includes a transition over time to increased client responsibility. Good communication regarding roles and expectations is essential from the beginning of the client-Case Manager relationship. While the ISP must be developed in collaboration with the client, other members of the support team (i.e. family, medical providers) if appropriate may participate if they are able to take into account his/her priorities and perception of needs.

The ISP must be completed at time of appointment to ensure it is discussed with the client in addition to the client receiving a copy. Additionally, a copy must be retained in the client's file. A Ryan White Part A Individual Service Plan form must be used and shall contain, at a minimum, the following:

- ✓ The needs and goals for the client (this may include referrals to other organizations/programs/services)
- ✓ Concrete actions that need to be taken to address them
- ✓ The timeframes for each action
- ✓ The responsibility parties for each activity
- ✓ Contact information for the Case Manager
- ✓ Signature of both parties (Case Manager and client)
 - By the client signing the ISP they are indicating that they agree to the terms and that they received a copy of their ISP

Case Managers shall have a mechanism in place for checking on ISP progress that coincides with timing of activities on

the plan. For example, if the ISP indicates that the client will apply for the ADAP program by May 1st, then the Case Manager shall have a mechanism for follow-up on that activity with the client. The ISP should also be considered a dynamic tool. It should be updated as needs are addressed or identified. At a minimum, the ISP needs to be updated once every six months for Non-Medical Case Management clients.

CASE MANAGEMENT CLIENT ENCOUNTER FORM

The date, method of contact and notes related to the conversation must be documented in the clients chart utilizing the Client Encounter form. If notes from each encounter are primarily entered into CAREWare or another system a copy must be provided in the client chart and labeled Client Encounter if this method is to replace the Ryan White Part A Client Encounter form. This must be completed at a minimum of every three months in-between each reassessment for all Non-Medical Case Management clients.