LOS ANGELES COUNTY
COMMISSION ON HIV

NON-MEDICAL CASE MANAGEMENT STANDARDS OF CARE

DRAFT FOR PUBLIC COMMENT

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LOS ANGELES COUNTY
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Standards of Care Review
Guiding Questions

Utilize the questions below to guide your review and feedback to the Commission on HIV.

Service-Specific Questions

1. Are the standards up-to-date and consistent with national standards of high quality HIV care?

2. Are the standards reasonable and achievable for providers?

3. Will the services engage and meet consumer needs? Are the proposed standards client-centered?

4. Is there anything missing with regard to accessing non-medical case management services?

For more information on Ryan White Standards of Care visit https://targethiv.org/library/service-standards-guidance-ryan-white-hivaids-program-granteesplanning-bodies

LOS ANGELES COUNTY COMMISSION ON HIV

NON-MEDICAL CASE MANAGEMENT STANDARDS OF CARE

INTRODUCTION

Standards of Care for the Ryan White HIV/AIDS Part A Program outline the elements and expectations a service provider should follow when implementing a specific service category. The Standards set the minimum level of care Ryan White funded agencies should offer to clients. The Standards are intended for service providers, and help guide providers on what may be offered when developing their Ryan White Part A programs. Providers are encouraged to exceed these standards.

The Los Angeles County Commission on HIV developed the Non-Medical Case Management Standards of Care to establish the minimum standards of care necessary to achieve optimal health among people living with HIV (PLWH), regardless of where services are received in the County. The development of the Standards includes guidance from service providers, consumers, and members of the Los Angeles County Commission on HIV, Standards and Best Practices Committee.

NON-MEDICAL CASE MANAGEMENT OVERVIEW

Case management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet clients' health and human services needs. It is characterized by advocacy, communication, and resource amendment and promotes quality and cost-effective interventions and outcomes.[1] The Health Resources and Services Administration (HRSA) defines Non-Medical Case Management Services (NMCM) as 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 may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible. The objective of NMCM is to improve client access to services.

Non-Medical Case Management Services (NMCM) includes all types of case management models such as intensive case management, strengths based case management, and referral case management (Appendix A). An agency may offer a specific type of case management model depending on its capacity and/or the contract from the DHSP. Depending on the type of case management offered, NMCM may also involve assessing the client's support network, key family members, and other individuals that play a direct role in the client's health and well-being.

Service components include:

- Initial assessment of service needs
- Development of a comprehensive, Individual Service Plan
- Timely and coordinated access to needed health and support services and continuity of care
- Client specific advocacy and review of utilization of services

[1] Introduction to the Case Management Body of Knowledge. Commission for Case Manager Certification (CCMC). https://www.cmbodyofknowledge.com/content/introduction-case-management-body-knowledge

- Continuous client monitoring to assess Individual Service Plan progress
- Revisiting the Individual Service Plan and adjusting as necessary
- Ongoing assessment of client needs and, if appropriate based on the case management model offered, other key individuals in the client's support network

All contractors must meet the Universal Standards of Care in addition to the following Non-Medical Case Management Standards of Care.[2] In the past, the Los Angeles County Department of Public Health, Department of HIV & STD Programs (DHSP) has contracted Linkage Case Management and Transitional Case Management for Youth and Post-Incarcerated Populations under NMCM Services.

KEY COMPONENTS

Non-Medical Case Management coordinates services for people living with HIV to improve health outcomes and facilitate client self-sufficiency. Case managers at provider agencies are responsible for educating clients on available HIV non-medical support services as well as serving as liaisons in improving access to services. Case managers are responsible for understanding HIV care systems and wrap around services, advocating for clients, and assessing and monitoring client progress on an ongoing basis. Case managers identify client service needs in all non-medical areas and facilitate client access to appropriate resources such as health care, financial assistance, HIV education, mental health and other supportive services. Non-Medical Case Management services should be client-focused, increase client empowerment, self-advocacy and medical self-management, as well as enhance their overall health status.

CLIENT ASSESSMENT & REASSESSMENT

All Non-Medical Case Management providers must complete an initial assessment, within 30 days of intake, through a collaborative, interactive, face-to-face process between the Case Manager and client with the client as the primary source of information. With client consent, assessments may also include additional information from other sources such as service providers, caregivers, and family members to support client well-being and progress. Staff members must comply with established agency confidentiality policies (Refer to Universal Standards, Section 1) when soliciting information from external sources. The initial assessment may be scalable based on client need and the type of case management offered by the agency. Accommodations may be made for clients who are unable to attend an appointment within the 30-day timeframe due to health reasons.

It is the responsibility of staff at the provider agency to conduct reassessments with the client as needed and based on contract guidelines from the Department of HIV & STD Programs (DHSP). If a client's income, housing status, or insurance status has changed since assessment or the most recent reassessment, agencies must ensure that the data on the Client Information Form is updated accordingly.

The client assessment identifies and evaluates the medical, non-medical, physical, environmental, and financial strengths, needs and resources. It is conducted to determine:

- Client needs for treatment and support services
- Client capacity to meet those needs
- Ability of the client social support network to help meet client need
- Extent to which other agencies are involved in client care

[2] Universal Standards of Care can be accessed at http://hiv.lacounty.gov/Projects

- Areas in which the client requires assistance in securing services

Assessment and reassessment topics may include, but are not limited to:

- Client strengths and resources
- Medical care
- Nutrition/food
- Housing or housing related expenses
- Family and dependent care
- Transportation
- Linguistic services
- Social support system
- Community or Family violence
- Financial resources
- Employment and education
- Legal needs
- Knowledge and beliefs about HIV
- Agencies that serve client and household

Case managers will identify medical and non-medical service providers and make appointments as early as possible during the initial intake process for clients that are not connected to primary medical care. Services provided to the client and actions taken on behalf of the client must be documented in progress notes and in the Individual Service Plan, which is developed based on the information gathered in the assessment and reassessments.

INDIVIDUAL SERVICE PLAN

The purpose of the Individual Service Plan is for the client and case manager to collaboratively develop an action plan that includes short-term and long-term client goals based on needs identified in the assessment. The Individual Service Plan should include specific service needs, referrals to be made, clear timeframes and a plan for follow up.

Individual Service Plans will be completed for each client within two weeks after the comprehensive assessment or reassessment. Similar to the assessment process, the service plan is an ongoing process and working document. It is the responsibility of case managers to review and revise Individual Service Plans as needed, based on client need.

As part of the Individual Service Plan, case managers must ensure the coordination of the various services the client is receiving. Coordination of services requires identifying other staff or service providers with whom the client may be working. As appropriate and with client consent, program staff acts as a liaison among clients, caregivers, and other service providers to obtain and share information that supports optimal care and service provision. If a program is unable to provide a specific service, it must be able to make immediate and effective referrals. Staff is responsible for facilitating the scheduling of appointments, transportation, and the transfer of related information.

Individual Service Plans (ISP) will, at minimum, include the following:

- Client and case manager names
- Client and case manager signatures and date on the initial ISP and on subsequent, revised ISPs

- Description of client goals and desired outcomes
- Timeline for when goals are expected to be met
- Action steps to be taken by client and/or case manager to accomplish goals
- Status of each goal as client progresses

CLIENT MONITORING

Implementation, monitoring and follow-up involve ongoing contact and interventions with, or on behalf of, the client to achieve the goals on the Individual Service Plan (ISP). Staff is responsible for evaluating whether services provided to the client are consistent with the ISP, and whether there any changes in the client's status that require a reassessment or updating the ISP. Client monitoring ensures that referrals are completed and needed services are obtained in a timely, coordinated fashion.

Programs shall strive to retain clients in Non-Medical Case Management services to ensure continuity of medical and support services care. Follow-up strives to maintain a client and family participation in care and can include telephone calls, written correspondence and/or direct contact. Such efforts shall be documented in the progress notes within the client/family record.

In addition, programs will develop and implement a contact policy and procedure to ensure that clients/families that are homeless or report no contact information are not lost to follow-up.

STAFFING REQUIREMENTS AND QUALIFICATIONS

Staff will have the knowledge, skills, and ability to fulfill their role including striving to maintain and improve professional knowledge related to their responsibilities, basing all services on assessment, evaluation, or diagnosis of clients, and providing clients with a clear description of services, timelines and possible outcomes at the initiation of services.

Case Managers and Case Manager Supervisors should have experience in or participate in trainings on:

- HIV/AIDS and related issues
- Effective interviewing and assessment skills
- Appropriately interacting and collaborating with others
- Effective written and verbal communication skills
- Working independently
- Effective problem-solving skills
- Responding appropriately in crisis situations

Table 1. NON-MEDICAL CASE MANAGEMENT SERVICES STANDARDS OF CARE

SERVICE COMPONENT	STANDARD	DOCUMENTATION
Staff Requirement and Qualifications	Case Managers with experience in clinical and/or case management in an area of social services. Bachelor's degree in a related field preferred.	Staff resumes on file
	Case Management Supervisors with experience in clinical and/or case management in an area of mental health, social work, counseling, nursing with specialized mental health training, psychology. Master's degree in a related field preferred.	Staff resumes on file

Client Assessment and Reassessment	Assessments will be completed within 30 days of the initiation of services and at minimum should assess whether the client is in care. Accommodations may be made for clients who are unable to attend an appointment within the 30-day timeframe due to health reasons.	Completed assessment in client chart signed and dated by Case Manager
	Staff will conduct reassessments with the client as needed and in accordance with DHSP contract guidelines.	Completed reassessment in client chart signed and dated by Case Manager.
Individual Service Plan (ISP)	ISPs will be developed collaboratively between the client and Case Manager within two weeks of completing the assessment or reassessment and, at minimum, should include: • Description of client goals and desired outcomes • Action steps to be taken and individuals responsible for the activity • Anticipated time for each action step and goal • Status of each goal as it is met, changed or determined to be unattainable ISPs should be completed as soon as possible given case management services should be based on the ISP.	Completed ISP in client chart, dated and signed by client and Case Manager
	Staff will update the ISP every six months, or as needed based on client progress or DHSP contract requirements, with client outcomes or ISP revisions based on changes in access to care and services.	Updated ISP in client chart, dated and signed by client and Case Manager
Client Monitoring	Case Managers will ensure clients are accessing needed services and will identify and resolve any barriers clients may have in following through with their ISP. Responsibilities include, at minimum: • Monitor changes in the client's condition • Update/revise the ISP based on progress • Provide interventions and follow-up to confirm completion of referrals • Ensure coordination of care among client, caregiver(s), and service providers	Signed, dated progress notes on file that include, at minimum: • Description of client contacts and actions taken • Date and type of contact • Description of what occurred • Changes in the client's condition or circumstances • Progress made toward ISP goals • Barriers to ISPs and actions taken to resolve them • Linked referrals and interventions and current status/results of same

	• Advocate on behalf of clients with other service providers • Empower clients to use independent living strategies • Help clients resolve barriers to completing referrals, accessing or adhering to services • Follow up on ISP goals • Maintain client contact at minimum one time per year, as needed, or based on DHSP contract requirements. • Follow up missed appointments by the end of the next business day	• Barriers to referrals and interventions/actions taken • Time spent • Case manager's signature and title

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APPENDIX A

Case Management Models

Referral (Brokerage) Case Management
This is the first formally articulated approach to case management. Focuses on assessing needs, referring to services, and coordinating and monitoring on-going treatment. The case manager coordinates services provided by a variety of agencies and professionals. Similar to Linkage Case Management, a previously funded contract by DHSP, where the case management is short-term and primarily focused on linking clients to primary HIV medical care.

Strengths-based Case Management
Developed in response to concerns that services and systems focus mainly on limitations and impairments vs. strengths and capabilities, this model focuses on individual strengths, the helping relationship as essential, contact in the community, and a focus on growth, change and consumer choice. Case managers provide direct services.

Intensive Case Management
Developed to meet the needs of high service users, focuses on low staff to client ratios, outreach, services brought to the client, and practical assistance in a variety of areas. May include outreach and counseling services, including skill-building, family consultations and crisis intervention. Caseloads are not normally shared.

Retrieved from https://www.homelesshub.ca/resource/step-step-comprehensive-approach-case-management