



315 NORTH 6TH STREET, 2ND FLOOR; P.O. Box 7007

NEWARK, NJ 07107

PHONE: 973-485-5220

FAX: 973-485-5085

E-MAIL: [NEWARKEMA@NEWARKEMA.ORG](mailto:NEWARKEMA@NEWARKEMA.ORG)

VISIT US AT [WWW.NEWARKEMA.ORG](http://WWW.NEWARKEMA.ORG)

JOIN US ON FACEBOOK AT [WWW.FACEBOOK.COM/NEWARKEMA](http://WWW.FACEBOOK.COM/NEWARKEMA)

## CASE MANAGEMENT SERVICES (Non Medical) STANDARDS OF CARE

Origination date: March, 1997

Amended: August 17, 2005

Approved by Planning Council: September 17, 2005

Reviewed/Approved by the Continuum of Care Committee :November 10, 2011

Approved by the Planning Council: January 25, 2012

### **I. PURPOSE OF STANDARDS**

The purpose of these standards is to ensure that a uniformity of service exists in the Newark Eligible Metropolitan Area (NEMA) such that the consumers of service receive the same quality of service regardless of where the service is rendered.

### **II. GOAL**

The goal of case management is to promote and support independence and self-sufficiency of the individual to the fullest degree possible.

### **III. DEFINITION OF SERVICES**

Case management services 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. It also includes:

Benefits and Entitlement Counseling - Referring or assisting eligible clients to obtain access to other public and private programs for which they may be eligible, e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other State or local health care and supportive services.

#### Discharge Planning

- Transitional case management for incarcerated persons as they prepare to exit the correctional system.
- Non Medical transitional case management for persons being released from the hospital or other institutional facility.

### **IV. OUTCOMES**

- A. Early access to and maintenance of comprehensive health care and social services.
- B. Integration of services among providers
- C. Continuity of care
- D. Increased knowledge of HIV disease
- E. Reinforcement of positive health behaviors
- F. Personal empowerment
- G. An improved quality of life

### **IV. PROVIDER POLICIES AND PROCEDURES**

- A. Staff must meet minimum qualifications detailed in the job description and standards of care.
- B. Providers will ensure the development of an Infectious Disease Prevention & Control Program.

---

*"To plan for the development, implementation and continual improvement of the health care and treatment services for People Living With and Affected by HIV & AIDS who reside in the five New Jersey Counties of Essex, Morris, Sussex, Union and Warren."*

- C. Services will be provided through the facility or through a written affiliation agreement.
- D. **Record 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** – The agency will have a written Confidentiality Policy in conformance with State and Federal Laws. All written and verbal communications regarding clients must meet HIPAA requirements.
- F. There will be a private confidential office space for seeing clients
- G. **Cultural Competence** – The Agency will ensure that culturally and linguistically appropriate services are available and be able to provide services in the clients' preferred language or arrange for a competent translator. Funded agencies shall have the ability to provide service in the client's native language when twenty (20%) or more of their clients prefer another language.
- H. **Consumer Consent** –The agency will have a Consent for Services and Release of Records Form, which is dated and time limited, signed by the client or person legally able to give consent. This form will be signed by the client after reviewing the initial "Service Plan" and when the client is reassessed and/or when the plan is updated or changed.
- I. **Grievance Policy** – 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.
- J. The Agency must have a written **Emergency Plan** which includes procedures for fire, bomb threat, evacuation, accidents and natural disasters.
- K. Service providers should receive continuing education in relationship to HIV, substance abuse, mental health, co-occurring disorders, health and related subjects such as "Prevention for Positives".
- L. A Quality assurance Plan specific to case management should be in place. This plan should be reviewed annually to evaluate the effectiveness of case management interventions and identify barriers case managers face in meeting client goals. Procedures should be implemented to ensure that corrective actions take place in a timely manner.
- M. Agencies must maintain linkages among other agencies to better coordinate service provision.
- N. The agency must demonstrate input from clients via a client satisfaction survey or similar method.

## **V. ACCESSIBILITY/STANDARDS OF SERVICE**

- A. There will be no barriers due to client disability. The Agency must comply with **American Disabilities Act** requirements for the provision of reasonable accommodations to address clients with special needs.
- B. There will be no barriers due to hours of service. There will be twenty-four (24) hour accessibility for emergency medical services and crisis counseling where applicable.
- C. There will be no barriers due to lag time. Eighty per cent (80%) of all persons seeking services will be seen within five (5) working days of the initial contact. If this is not possible, the reason must be documented in the client's file.

## **VI. CLIENTS RIGHTS AND RESPONSIBILITIES**

- A. All written materials should be presented in a language that is understandable to the consumer and should be written at no higher than a 5<sup>th</sup> grade reading level.
- B. The agency will have a Clients Rights Statement posted and available to the client upon request. This will be in the client's language or explained to the client in the client's preferred language.
- C. A Signed written consent must be obtained to release/exchange client information. The consent must be specific as to type of information, purpose for release of information, agency to which the information will be shared, and length of time during which the consent is valid... The consumer must be notified of the release of information.
- D. The agency must explain the grievance policy to the client in a language and format that the client can understand and provide a copy to the client.
- E. All new clients will receive HIV/AIDS orientation and be provided with educational materials in their native language, when possible, and in a culturally appropriate manner.
- F. Clients have the right to refuse services.

## **VII. PROCESS**

- A. Intake**
  - B. Individual/Family Comprehensive Needs Assessment**
  - C. Development and Implementation of a Service Plan**
  - D. Coordination and monitoring of Individual/Family Service Plan**
  - E. Re-Assessment of Service Plan**
  - F. Case Transfer/Closure/Discharge**
- A. Intake** - To determine eligibility and collect demographic information as a basis for initiating a comprehensive needs assessment. The consumer intake must be completed during a face-to-face visit and should include the following:
1. Date of intake
  2. Name of person completing intake
  3. Client name, address, phone number and unique identifier
  4. Referral source if appropriate
  5. Proof of HIV + status to determine eligibility for Ryan White Part A funding.
  6. Summary of medical benefits/insurance
  7. Verification of Insurance status
  8. Preferred language of communication
  9. Emergency contact
  10. Communication method to be used for follow-up
  11. Employment status
  12. Verification of income /Gross annual income
  13. Living arrangements
  14. Gender/date of birth/race/ethnic origin
  15. County of residence
  16. Any other data required for the CHAMP system
- B. Individual/Family Comprehensive Needs Assessment** – To identify the client's problems and care needs.  
The following information should be recorded:
1. Family History
  2. Exposure category
  3. Support systems
  4. Disclosure issues
  2. Nutritional screening
  3. Mental Health screening
  4. Substance Abuse screening
  - 5 Oral Health screening
  5. Educational/literacy assessment
  6. Identification of Legal Issues, if they exist
  7. Financial status to determine eligibility for entitlements
  8. Medical History including medications
  9. Abuse, neglect and violence history
  10. Explanation of confidentiality and HIPAA requirements
  11. Explanation of the Grievance process
  12. Explanation of client's rights and responsibilities
  13. Explanation about the services available
  14. Signed consent for services
  15. Signed, dated and limited release
  16. Current social needs
  17. Any additional information required by the CHAMP system not obtained at the intake.

### **C. Development and Implementation of Service Plan**

The Service Plan should document long and short term goals and objectives. It should be reviewed within 90 days and modified if necessary. Plan should include:

1. Documentation of consumer participation in service decisions.
2. Goals and measurable objectives responding to consumer needs.
3. Timeframes to achieve objectives
4. Screening for eligibility for entitlements and assistance in completing applications
4. Ways to address barriers which are client-specific.
5. Referrals for support services.
6. Documentation of the client's participation in primary medical care.
7. Notation of ongoing HIV education/counseling
8. Client signature and date, signifying agreement with Plan

D. Coordination and monitoring of Individual/Family Service Plan – There should be at least one documented contact with the client every 90 days or as dictated by client need. The client record should include:

1. Progress notes for each contact
2. Progress notes recording activities on behalf of the client to implement the service plan
3. Progress of Service Plan
4. Communication with referring agency i.e., if appointments were kept and medications prescribed.
5. Maintain contact with client by phone or at face-to-face meetings. Depending on client need; this contact should be a minimum of every six (6) months.
6. Documentation of follow-up for referred services
7. Documentation of follow-up to missed appointments
8. Address emergency situations as they arise.
9. Adjustment to Care Plan if necessary
10. Case conferencing
11. Crisis intervention

E. Re-Assessment of Service Plan - A formal re-examination of the patient's condition, needs and resources to identify changes which occurred since the initial assessment or most recent assessment.

1. Service Plan re- assessment and revision, if necessary, should be on-going for continuing clients and within 90 days of initial assessment for new clients.
2. A re-examination of plan should be conducted every 6 months or on the recommendation of the client's health care provider or client's change of status
3. Summary of progress in goal achievement
4. Review of client's clinical, financial and support needs to identify changes and/or additional services needs
5. Case conference with other providers
6. Re-screening for Nutritional, mental health, oral health and substance abuse issues should be completed annually.

F. Case Transfer/Closure - Reasonable efforts must be made to retain the client in care by phone and letter and in coordination with the Medical Case Manager and other service providers.

Case Closure

1. The Case Manager must document date and reasons for closure of case including but not limited to; no contact, client request, client moves out of service area, client died, client ineligible for services, discharged-stable, etc.
2. The case manager will make appropriate referrals and provide contacts for follow-up
3. A summary of the services received by the client must be prepared for the client's record.

Case Transfer

1. The case manager should facilitate the transfer of client records/information and prepare a summary of the client's file for the new case manager.
2. The client must sign a consent form to transfer records which is specific and dated

## **VIII. DOCUMENTATION**

Written documentation is kept for each consumer which includes:

1. Consumer's name and unique identifier number
2. Name of primary case manager
3. Proof of HIV+ status
4. Initial needs assessment
5. Signed initialed and updated individualized care plan
6. Evidence of consent for services
7. Progress notes detailing each contact with or on behalf of the consumer. These notes should include date of contact and names of person providing the service
8. Evidence of the client's understanding of his/her rights and responsibilities
9. Signed "Consent to release information" form. This form must be specific and time limited
10. Status of client if they are no longer receiving services.

## **IX. ENGAGEMENT AND RETENTION OF CONSUMERS**

The best way to retain clients in care and be aware of barriers that are preventing a client accessing care is to maintain an ongoing relationship.

### **Procedure to be followed for missed appointments:**

1. The consumer should be contacted within 2 days of missed appointment to determine if there was a reason why the appointment was not kept.
2. The case manager will attempt to reach the consumer no less than 2 times during a one-week period.
3. If the consumer can not be reached by phone, a letter (certified) will be sent to the consumer stating that an appointment has been missed and requesting that the consumer contact the agency to set up another appointment.
4. The case manager should check with other agencies which are providing services to the client.
5. If appropriate and with prior approval of the client, contact the emergency contact

## **X. STAFF QUALIFICATIONS/TRAINING**

Each funded agency is responsible for establishing job descriptions and qualifications for each of the case management positions. It is suggested that a team approach better accomplishes the activities required for comprehensive Case Management.

### **CASE MANAGER**

#### **Qualifications/Training**

1. Bachelor's or Master's degree in health or human services preferred.
2. A minimum of 1 year past experience working with persons with or at high risk of HIV infection preferred.
3. Ongoing education/training in related subjects including "prevention with positives."
4. Agency will provide new hires with training regarding confidentiality, client rights and the agency's grievance procedure.
5. Annual staff evaluation/performance review.

#### **Duties/Responsibilities**

- Responsible for providing intensive case management for clients and their families/support system
- Advocates for clients to obtain the full range of needed services
- Ensures coordination of services.
- Promotes linkage development and monitors the effectiveness of these linkages.
- Ensures follow-up to engage and retain clients in care
- Promotes and monitors compliance with medical appointments
- Responsible for accurate and timely recording of client progress notes
- Ensures that data is entered in the CHAMP system within 5 days of service.

## CASE MANAGER ASSISTANT/ COMMUNITY FOLLOW-UP WORKER

### Qualifications/Training

1. Para-professional with a High School diploma or GED preferred
2. Ability to read, write, understand and carry out instructions
3. Knowledge of community resources
4. Sensitivity towards persons with HIV
5. Bi-lingual preferred
6. Ongoing education/training in related subjects including “prevention with positives”
7. Annual staff evaluation/performance review

### Duties/Responsibilities

- Performs duties under the direction of the Case Manager
- When necessary, escorts clients to ensure that appointments are kept
- Assists with scheduling of appointments
- Follow-up activities such as telephone calls to clients who have missed appointments
- Assists in activities aimed at retaining clients in care such as contacting clients that have not been seen for 9 months or more.
- Verification of client status
- Assist in data entry