Non-Medical Case Management

Service Definition

Non-Medical Case Management (NMCM), also referred to as Community Case Management, includes a range of client-centered activities focused on improving access to and retention in physical and mental health care in support of people living with HIV (PLWH). These client-centered activities include services and referrals for all areas of client's psychosocial needs which are provided in a way that is primarily community facing. NMCM includes all types of non-medical case management encounters (for example, face-to-face, phone contact, and any other forms of communication).

Key service components and activities for NMCM include:

- Initial assessment of needs.
- Development of a comprehensive, individualized service plan.
- Timely and coordinated access to appropriate levels of health and support services.
- Continuous client monitoring to assess the efficacy of the service plan.
- Re-evaluation of any service plan made in accordance with acuity score.
- Ongoing assessment of the client's and other key family members' needs and personal support systems.
- Improving access to and retention in physical and mental health care.
- Assisting clients in accessing livelihood needs.
- Client-specific advocacy and/or review of utilization of services.

NMCM may also include benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (for example, Medicaid, Medicare Part D, ADAP, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance marketplaces or exchanges).

Subrecipients providing NMCM services are expected to comply with the Universal Standards of Care, as well as these additional standards:

Standard 1: Providers of NMCM services must ensure services are delivered in accordance with the Wisconsin Ryan White Part B Eligibility and Recertification Policy and Procedures.

Providers are responsible for determining eligibility at enrollment and confirming eligibility annually.

Documentation

Client records must document that the client is living with HIV, resides in Wisconsin, and has household income under 500% FPL at initial enrollment in accordance with the Wisconsin Ryan White Part B Eligibility Policy, linked above.

Standard 2: During initial contact, key information about the client may be collected or verified in the Electronic Medical Record (EMR) if possible.

Providers must attempt to collect or confirm the following client information:

- Contact and identifying information
- Emergency contact, if available
- Insurance status
- Documentation of income and status of residing in Wisconsin
- Demographic information
- Contact information for other service providers and corresponding Release of Information (ROI) forms
- Proof of HIV diagnosis

Documentation

Documentation of all elements outlined above must be completed within 30 days of first NMCM visit, initial referral, or contact. Documentation must show any corresponding ROIs, as needed and applicable.

Standard 3: Immediate referrals must be made for clients with most needs.

Immediate referrals, internal and external, to the appropriate services are required for clients who:

- Are not engaged in medical care.
- Are taking medication but will run out prior to first medical appointment.
- Are a danger to themselves or others.
- Are under the age of 18.
- Are pregnant.

Documentation

Documentation of immediate referrals made and outcomes must be included in the client record.

Standard 4: Intakes may be performed by providers, non-service provider staff, or interns.

Intake may be performed by subrecipient staff or interns who are not NMCMs, provided they meet all the following criteria:

- Are an employee or intern of the subrecipients.
- Received proper onsite training and signed the agency confidentiality agreement.
- Completed the HIV Basics Online Course offered through the University of Wisconsin-Madison, HIV Training System.

Documentation

The client record must indicate who performed the intake.

If the client record shows that intake is performed by someone who is not a NMCM, the required criteria must be documented in their personnel file or somewhere easily accessible for chart audits.

Standard 5: The Wisconsin Acuity Index Tool (WAI) must be used to assess client's readiness to begin or reestablish HIV medical care and appropriateness of NMCM for client's needs.

The WAI must be completed within 30 days of intake and evaluates client's level of needs.

If a client has other Ryan White Part B case management services (for example, Medical Case Management or Linkage to Care), it must be decided which provider will complete the WAI. A client should not have to complete one for each service provider.

If it is determined the NMCM will complete the WAI, the NMCM must attempt to meet face-to-face, whenever possible, with the client at least once during the completion. Face-to-face can be in-person or virtual.

Documentation

Completed WAI form or WAI built into an electronic medical record is available for review.

The client record must document that the initial WAI was completed within 30 days of intake.

Standard 6: Based on the WAI, the provider determines if the client should continue in NMCM or be referred to another type of service.

A client is referred to Brief Services if their WAI score is 0. If a client's WAI score is 0 but requests to continue NMCM, the client's score must be manually adjusted to 1 with a narrative stating the move was due to client request.

When appropriate and available, the client is referred to Linkage to Care if their WAI score is 3.

Documentation

Documentation of WAI score and actions taken are consistent with the WAI score and are present in the client record. Any referrals based on the WAI must be documented in the client record.

If a client's WAI score is 0 but requests to continue NMCM services, documentation must show the score was adjusted manually from 0 to 1 with a narrative stating the move was due to client request. Documentation must show client enrollment in NMCM.

Standard 8: Within 30 days of the WAI completion, clients with an acuity score above 0 must receive an initial comprehensive assessment.

A comprehensive assessment describes the client's medical and psychosocial needs in detail. It identifies service needs being addressed and by whom; services that have not been provided; barriers to service access; and services not being appropriately coordinated. This assessment also evaluates the client's resources and strengths, including family and other supports, which may be utilized during service planning.

The assessment may include gathering information from existing client record(s), as well as meeting with the

client face-to-face. The assessment should include all the client information gathered at intake, and address client need(s) in the following areas:

- Education
- Financial information
- Medical care team
- Adherence to HIV medications
- Substance use
- Housing
- Social support and relationships
- Overall health
- Employment
- Health insurance
- Retention in HIV medical care
- Mental health
- Harm reduction methods
- Transportation
- Oral health
- Nutrition
- Vision care
- Activities of daily living
- Domestic violence screening
- Dependents
- Alternative therapies and/or medicines

Documentation

The client record must document that all required information in each area was, at minimum, attempted to be collected through the comprehensive assessment.

If the comprehensive assessment is conducted at another subrecipient, clear documentation of the name and location of the provider must be in the client record. During scheduled site visits, the Wisconsin Communicable Disease Harm Reduction (CDHR) Section may confirm with the other provider that the comprehensive assessment was completed as noted.

NMCMs are encouraged to use the comprehensive assessment form developed by the Wisconsin CDHR Section to ensure they are gathering all the required information listed above.

Subrecipients may revise the Wisconsin CDHR Section form or develop their own assessment tool as long as all of the elements on the comprehensive assessment form are covered. Any assessment tools developed must be strengths-based and easily accessible.

Standard 9: The NMCM has primary responsibility for completion of the comprehensive assessment.

If a client has other Ryan White Part B case management services (for example, Medical Case Management or Linkage to Care) it must be decided which provider will complete the comprehensive assessment. A client should not have to complete one for each service provider.
If it is determined the NMCM will complete the comprehensive assessment, the NMCM must attempt to meet face-to-face, whenever possible, with the client at least once during the assessment process. Face-to-face can be in-person or virtual.

Documentation

The client record must document actions taken by NMCM that are consistent with this requirement.

Standard 10: Based on the findings of the initial comprehensive assessment, the provider and client collaboratively develop an initial service plan.

Development of a service plan is a central component of NMCM and provides the client and case management team with a proactive, concrete, step-by-step approach to addressing client needs. If the comprehensive assessment was completed at another subrecipient, the NMCM must work with that provider to gather information to create a service plan.

Client needs identified during the WAI and comprehensive assessment are prioritized and translated into a service plan, which defines specific goals, action steps needed to meet goals, and who will be the responsible party for each action step.

The NMCM has primary responsibility for the development of the service plan. Active client involvement, defined by client participation, input, and agreement in each aspect of the service plan development is required. Goals, objectives, and activities of the service plan are determined with the participation of the client and, if appropriate, family, close support persons, and other providers.

At minimum, the initial service plan includes:

- Goal(s).
- Action steps [to be taken towards goal(s)].
- Individual responsible for the action step.
- Anticipated timeframe for each action step.
- Client signature and date, or documentation of verbal approval.
- Supervisor's signature and date indicating review and approval, when applicable.

Documentation

A service plan, with all required elements, must be available for review by the Wisconsin CDHR Section upon request.

Standard 11: Action steps begin immediately after development of the service plan.

Specific activities performed during service plan use will vary based on the unique needs of each client. However, at least one goal must promote and support client engagement in HIV medical care and overall health.

Documentation

The client record must document specific activities and promotion and/or support of client engagement in HIV medical care and overall health.

Standard 12: Communication and coordination with the client's care team is essential for effective case management to occur.

Frequent care consultation must happen with other members of the client's care team. When a client is receiving additional services at the NMCM agency or a different social services agency, the NMCM must work with other service providers to ensure coordination of care and reduce barriers to care.

Documentation

The client record must contain evidence of regular and ongoing contact with key members of the client's care team.

Standard 13: The type and frequency of contact with the client must be based on client needs.

Expectations for type and frequency of client contact are based on WAI score and listed on the WAI form.

Documentation

The client record must document a frequency of contact consistent with the most recent WAI score.

Standard 14: Client acuity must be reassessed periodically, based on acuity level.

The frequency of reassessment is based on WAI score and listed on the WAI form.

Documentation

The client record must document that the client's acuity was reassessed at the appropriate frequency based on the most recent WAI score, and/or if significant changes in life circumstances occur.

Standard 15: The client must receive a comprehensive assessment periodically, based on the acuity level.

A comprehensive assessment must be re-administered annually at minimum for all NMCM clients. Expectations for re-administering a comprehensive assessment are listed on the WAI form.

A comprehensive assessment does not need to be re-administered for clients who have significant life changes. Instead, a new WAI is to be administered and the timing of other required documents will be determined by that score.

Documentation

The client record documents that the client received a new comprehensive assessment at the appropriate frequency based on the most recent WAI score.

The client record should also include documentation of any reason for missing information, documentation of referral(s) made, and outcomes of referral(s).

Standard 16: The client's service plan must be reviewed periodically, based on acuity level.

Service plan review includes updating the status of existing action steps and identifying new goals and action steps to work towards meeting goals.

The NMCM has primary responsibility for updating the service plan. Client input and approval of the plan is required each time when reviewing the plan. Expectations for frequency of service plan review are based on WAI score and listed on the WAI form. Supervisory review of the service plan occurs as outlined on the WAI form.

Documentation

The client record must document that the service plan was reviewed at the required frequency by the client, the NMCM, and the supervisor, when applicable.

Changes in the service plan must be documented in the client record. Supervisory review of the service plan occurs at intervals stated on WAI form.

Standard 17: Upon termination of active NMCM services, the client is discharged from this type of case management.

Criteria for client discharge are:

- Client completes service plan goals.
- Client acuity score reaches 0.
- Client is no longer eligible for services.
- Client is lost to follow-up or does not engage in service. *
- Client is referred to another HIV NMCM program.
- Client is incarcerated for more than six months.
- Client relocates outside of service area.
- Agency initiated termination due to behavioral violations. This should be a last resort.*
- Client chooses to terminate service.
- Client death.

*See Universal Standards for guidance.

Documentation

The client record must document which discharge criteria were met.

A brief discharge narrative must be included in the client record.