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Introduction

In an effort to promote its vision for an effective, compassionate, and comprehensive system of HIV/AIDS health care services for the diverse community of the Santa Clara County, the County of Santa Clara HIV Commission (Planning Body) in partnership with the Administrative Agent, the STD/HIV Prevention and Control Program, has initiated the development of Universal Standards of Care. Each of the requirements and standards highlighted in this document must be followed by any provider receiving Ryan White (RW) funding. These standards must be met or exceeded for all HIV service providers of Santa Clara County. It is responsibility of the service providers to be familiar with the USOC. The Recipient is responsible for applying these standards through their service contracting process on an ongoing basis at the individual service provider level throughout the funding cycle.

This document describes the Case Management – Non-Medical (NMCM) category funded through the Ryan White HIV/AIDS Program (RWHAP). It serves as a supplement to the Universal Standards of Care document (USOC) also released by the County of Santa Clara HIV Commission and Public Health Department (Planning Body). This document highlights the standards that apply to NMCM and must be followed by any provider receiving Ryan White funds.

Definition: 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, and other needed services. NMCM services may also include assisting eligible clients access public and private programs for which they may be eligible, such as Medi-Cal, Medicare Part D, AIDS Drug Assistance Program (ADAP), Health Insurance Premium Payment (OA-HIPP), Disability Insurance, Housing Opportunities for Persons with AIDS (HOPWA), Social Security, Pharmaceutical Manufacturer's patient assistance programs, Covered California, and other state or local health care and supportive services. This service category will be delivered through several methods of communication including face-to-face contact, phone contact, and other forms of communication deemed appropriate.

Purpose: NMCM is a multi-step process to provide 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 NMCM have as their objective improving health care outcomes.

Goals: The goal of NMCM is to promote and support independence and self-sufficiency. As such, the NMCM process will be based on a strength based, client-centered approach that requires the consent and active participation of the client in decision-making, and supports a client's right to privacy, confidentiality, self-determination, dignity and respect, nondiscrimination, compassionate non-judgmental care, a culturally competent provider, and quality case management services.

The intended outcomes of HIV/AIDS Case Management for persons living with HIV/AIDS include:

- Early access to and maintenance of comprehensive health care and social services.
- Improved integration of services provided across a variety of settings.
- Enhanced continuity of care.
- Prevention of disease transmission and delay of HIV progression.
- Increased knowledge of HIV disease.
- Greater participation in and optimal use of the health and social service system.
- Personal empowerment.
- An improved quality of life

Key Activities

Key activities for NMCM include:

- **Initial Appointment:** Provide first appointment within 5 days of referral to screen for eligibility (if needed). Initial assessment of the client's service needs must be completed within 30 days of the first visit.
- **Individualized Care Plan:** Develop a comprehensive, individualized care plan (ICP) during the initial assessment visit including client-centered goals and milestones.
- **Coordinating of Services:** Ensure timely and coordinated access to medically appropriate levels of healthcare and support services.
- **Client monitoring:** Provide a continuous client monitoring to assess the care plan.
- **Individualized Care Plan Re-evaluation**: Evaluate the care plan with the client at least every 6 months with revisions and adjustments as necessary.
- **Advocacy and Review:** Enable the client to access all necessary services and review their service utilization as appropriate.
- **Ongoing Assessment:** Ensure ongoing assessment at least every six months of the client's and other key family members' needs and personal support systems.
- **Client Transfer:** Ensure that clients who wish to (or need to) transition into NMCM services offered by another agency, have an appropriate linkage to care must occur.
- **Benefits Counseling**: Ensure staff assist eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Med-Cal, Medicare Part D, AIDS Drug Assistance Program (ADAP), Health Insurance Premium Payment (HIPP), Disability Insurance, Social Security, pharmaceutical manufacturers' patient assistance programs, Covered California, housing Opportunities for Person with AIDS (HOPWA), Housing Plus Program (HPP), and /or other state or local health care and supportive services).

Requirements

1.0 ARIES

Standards identified in Universal Standards of Care (USOC 1)

2.0 Intake

Standards identified in Universal Standards of Care (USOC 1)

3.0 Recertification

Standards identified in Universal Standards of Care (USOC 3)

4.0 Care and Treatment

4.1 Initial Assessment

An Intake is the formal process of collecting information to determine the client's eligibility for services and/or immediate service needs to encourage client's engagement and retention in services. The information collected during the Intake Assessment will determine the patient's individualized care plan (ICP) and will promptly addressed immediate needs.

NMCM must be offered in a way that addresses barriers to accessing medical care and uses resources to support positive health outcomes for clients.

#	Standard Providers must comply with USOC 2.0	Measure
4.1.1	**First Intake Appointment:** It shall take place as soon as possible, at a maximum **within five (5) business days** from referral or initial client contact. An Intake must be completed for new or re-enrolling case management clients. • Immediate needs must be addressed promptly.	Documentation of intake and immediate needs See USOC 2
4.1.2	**Initial Assessment:** Provide first appointment **within 5 days** of referral to screen for eligibility (if needed) and assignment a case manager (non- medical). Initial assessment of the client's service needs must be completed **within 30 days of the first visit.**	Performance of a timely initial assessment, along with complete documentation of assessment findings and applicable referrals/linkage, will be monitored via site visit chart review.
4.1.3	**Determine Level of Acuity**: The scale is a tool for the case managers to use in conjunction with the initial Intake Assessment to develop an ICP. See Appendix A and B for more information. Provider can add items to this template but can't remove items.	Level of acuity will be monitored via chart review during site visit.
4.1.4	**Orientation**: New clients enrolled in NMCM must receive an orientation to the Ryan White services. Orientation needs to take place as part of the first intake appointment.	Document the orientation in the client file.
4.1.5	**Appointments:** Must be made as soon as possible to avoid potential drop out. As clients may miss appointments, agencies must have a process in place to ensure timely follow up, preferably **within 24 hours**.	Timeframe for intake appointments will be monitored through chart review. Documentation of rescheduling attempts will be

	Agencies will be asked to submit written policies and procures for client's missed appointments.	monitored via chart review during site visits.
4.1.6	**Referral/Linkage:** Client ineligible for NMCM services must be referred or linked to another agency or linked to another safety net provider as appropriate utilizing a warm hand off when possible.	Documentation of referral to other services will be monitored via chart review during site visit
4.1.7	**Primary Case Manager:** Each client must have a primary case manager who helps coordinate services with other members of the treatment and services team. This primary case manager will serve as the main point person for the client to streamline communication and maximize care coordination. The case manager must be assigned during the initial assessment period.	Review of primary case manager assignment will be conducted during chart review.
4.1.8	**Sharing Information:** Information **can be shared after client consent**, with other providers to coordinate services and avoid duplication of efforts. Documentation include Authorization for the Release of HIV Confidential Information and other releases for information as required by applicable law.	Authorization documents will be monitor via site visit chart review.
4.1.9	**Partner Services:** Providers must have a process for Partner Services Counseling and referral for clients. Partner Services information must be offered, and referrals made for clients according to establish policies and procedures.	Providers must submit written policies and procedures related to this topic. Implementation of the police will be monitored via site visit chart review.

4.2 Initial Assessment

The initial assessment will describe the client's status and identify their strengths, weaknesses, resources, and/or stressors in order to develop an ICP which allows the patient to function and manage their condition as independently as possible. It describes in detail the client's medical, physical, and psychosocial condition and needs. It identifies service needs being addressed and by whom; services that have not been provided; barriers to service access; and services not adequately coordinated. **This assessment must be thoroughly documented and will be client-centered** (the client may defer or choose not to discuss any specific issues during the assessment). Topics for discussion during the assessment include:

• Primary care connection • Connection with other care providers (e.g., dentist, specialist, key social services). • Current health status/medical history, including last and next medical appointment, most recent CD4 and VL, and any reasons for terminating care (if applicable)	• Self-management skills and history • History of incarceration • Family composition • Living situation and housing needs • History and risk of abuse, neglect, and exploitation • Social community supports. • Food/clothing needs • Transportation needs • Legal needs

• Demographic and contact information. • Confidential concerns • Insurance status • Proof of HIV status • Current healthcare and social service providers (including Case Management offered elsewhere) • Level of engagement in health care services • Current medications and adherence • Immediate health concerns • Substance use history and needs. • Language spoken	• Financial / program entitlement • Emergency financial assistance needs and history. • Partner service's needs; and • Summary of unmet needs. • Domestic violence • Support system • Level of HIV health literacy • Awareness of safer sex practices • Sexual orientation and gender identity • Sexual history • Mental health / psychiatric history and needs.

Monitoring

Initial Assessment - Performance of a timely initial assessment, along with complete documentation of assessment findings and applicable referrals/linkages, will be monitored via site visit chart review.

4.3 Development of the Individualized Care Plan (ICP)

The Initial Assessment builds upon information from the intake and provides information to enable the development of an initial service plan. Patient needs identified through the intake assessment are prioritized and translated into an ICP. The plan defines specific goals, objectives, and activities to address patient needs. The ICP includes all types of case management intended to improve client access to health care including face-to-face, phone contact, and any other forms of communication with clients. The ICP must begin immediately to enable patients to secure services to meet initial presenting needs as well as be responsive and supportive of the prescribed medical treatment plan.

	Standard	Measure
4.3.1	**Requirements:** NMCM will develop an ICP that: • Is individualized and incorporates client input. • Prioritizes the needs identified in the Initial Assessment. • Identifies resources to meet the needs identified in the Initial Assessment and provides referrals to other relevant providers (e.g., substance abuse counselors, physicians, housing specialists). • Encourages a client's active participation and empowers the client to become self-sufficient. • Clients with significant unmet medical needs must be referred to Medical Case Management (MCM) for additional support in improving health outcomes.	Development of ICP that meet the requirements will be monitored via review of client charts and /or electronic health records during site visits. ICP must be uploaded to ARIES. Documentation of ICP development per ARIES will be reconciled with the existence of care plans in patients charts during site visits, as applicable.

4.3.2	**Frequency:** An ICP must be developed during the initial assessment and re-evaluated at least **every 6 months** with modifications as needed.	ICP reevaluation will be monitored during site visit chart review.
4.3.3	**Updates:** As the client's status changes, the client and case manager must work together to establish new goals, objectives, and timelines.	Documentation of ICP in client records
	Documentation: ICP will be documented in paper charts, or in ARIES under the "Care Plan" tab. Copies of completed individualized care plans must be uploaded to ARIES and/or retained in the client file, signed by both client and provider if paper based. Client, case manager, and supervisor's must also sign/date the ICP and updated plans.	Monitored via review of client charts and/or electronic health records during site visits.
4.3.4	**Advocacy:** Case managers must ensure the provision of a basic needs assessment and assistance (through appropriate referrals) in obtaining medical, social, community, legal financial, and other needed services.	Monitored during site visit chart review.
4.3.5	**Quality Assurance and Supervision:** All agencies providing NMCM must have a quality assurance plan in place describing a supervisory review to assess documentation of client's needs and if those needs were addressed. All clients who are discharged from NMCM must also have a supervisor review **within 3 months of discharge.** Supervisor review must be documented in the client's chart with signature, date of review, and findings.	Annually, a representative sample of at least **10 percent** of charts of active NMCM clients must have a supervisor review.
4.3.6	**Client Record:** All NMCM must be recorded in the client record as soon as possible and entered in ARIES within **seven business days**.	Documentation of activities must be legible, signed, and dated by the NMCM.
4.3.7	**Plan Implementation Activities:** • Contacting clients in person, by phone, or in writing based on client needs and or minimum requirements per SOC. • Assisting in arranging services, making appointment, confirming services delivery date • Encouraging to client/collaterals to carry out tasks they agreed to • Directing education to the client/collaterals as needed • Supporting to enable client/collaterals to overcome barriers and access services. • Assisting with other activities including linkage, referral, and follow-up	Monitoring Annually via site visit.

4.3.8	**Client's participation:** ICP must be developed during face-to-face meeting and negotiated between client and case manager in order to encourage client participation and empowerment. Measurable goals and activities must take into consideration the client's cognitive and physical abilities. Family members and collaterals may assist in ensuring a client receives needed service. They can be included in the ICP.	A copy of the ICP must be offered to the client. This reinforces client ownership and involvement in the case management process. ICP plan will be signed by the client.
4.3.9	**Policies and Procedures:** Provider must have written Policies and Procedures pertaining to ICP development and implementation. It must address acuity level, client contact, monitoring, and follow-up. It must also include responsible staff and supervisory oversight.	Monitoring Annually via site visit.
4.3.10	**Case load** • NMCM Managers are expected to maintain a case load of between 30-75 clients per 1.0 FTE at any given time **depending on client acuity.**	Monitoring Annually via site visit.

4.4 Crisis Intervention

Crisis intervention policy and staff training on crisis intervention help ensure quick resolution of emergencies to minimize any damaging consequences (i.e., acute medical, social, physical, or emotional distress).
A crisis plan is specific to an individual client's needs. Plans must be developed to ensure a client is able to navigate service during crisis and has specific instructions and provider contact information. Co-occurring disabilities or life circumstances affect the nature and extent of the plan, i.e., people with mental illness or at risk of domestic violence need to have their special needs addressed in advance to minimize the impact of emergencies.

#	Standard	Measure
4.4.1	**Policies:** Providers must have a policy for client crisis intervention services that ensures all onsite emergencies are addressed immediately and effectively. • Staff must be trained on agency crisis policy and how to respond to crisis situations. • Polices must addresses crisis intervention protocol for incidents that occur on site	Monitoring Annually via site visit.
4.4.2	**Crisis Plan:** Must include at minimum information on service providers who are accessible 24 hours a day and able to handle emergency situations.	Monitoring Annually via site visit.

4.5 Client Monitoring

NMCM client monitoring is an ongoing process that determines the efficacy of the ICP. Its implementation involves carrying out of tasks listed in the ICP, including referrals and linkage, and an assessment of whether the client has further needs.
Client's monitoring is expected to be **frequent and proactive** in order to anticipate problems, stabilize the client's status, prevent crises, and support the client in achieving service goals.

#	Standard	Measure
4.5.1	**Frequency:** the frequency of the client's monitoring is dependent on client needs and may be done in-person, or by phone; however, follow-up must occur at least every **six months** at the time of re-certification.	Monitored through review of services in ARIES
4.5.2	**Follow-Up and Monitoring:** NMCM is an ongoing process. Follow-up and monitoring ensure that: • The resources provided are sufficient to meet the client's needs. • The client is working toward their care plan objectives. • New or changing needs are addressed. • If the contact information is invalid, providers may contact the Public Health Department to attain information for further outreach and re-engagement in care activities.	
4.5.2	**Lost to Follow-up**: The client is lost to follow-up if the client cannot be located after **at least three documented attempts per month over a period of three consecutive months.** Attempts to contact the client must take place on different days and times of the day during this time period. See USOC 5.3.1 and 5.3.3	Annual monitoring

4.5 Coordination of Services

Coordination of services ensures that the client's ICP includes the input of all service providers. It also ensures prompt referrals to other needed services. Coordination includes communication, information sharing, and collaboration, and occurs regularly with case management and other staff serving the client within and between agencies in the community. Coordination activities may include directly arranging access; reducing barriers to obtaining services; establishing linkages; and other activities recorded in progress notes.

#	Standard	Measure
4.5.1	**Coordination Recording:** All NMCM activities including but not limited to all contacts and attempted contacts with or on behalf of clients and coordination with referral agencies, must be recorded in the client within **seven business days.**	Documentation must be entered in ARIES in the **next seven** business days.

	Documentation of activities must be legible, signed, and dated by the Non-Medical Case Manager.	
4.5.2	**Referrals:** the NM-CM Manager must follow-up on referrals and linkage and assess whether the client has further needs.	Agencies must keep track of the referrals.

4.6 Case Conferencing/Case multidisciplinary feedback

Case Conferencing/Case multidisciplinary feedback: It is a formal, planned, and structured event separate from regular contacts. The goal of case conferencing is to provide holistic, coordinated, and integrated services across providers, and to reduce duplication. Case conferences are usually interdisciplinary and include one or multiple internal and external providers and, if possible and appropriate, the client and family members/close supports.
Case conferences can be used to identify or clarify issues regarding a client or collateral's status, needs, and goals; to review activities including progress and barriers towards goals; to map roles and responsibilities; to resolve conflicts or strategize solutions; and to adjust current service plans.

#	Standard	Measure
4.6.1	• **Mode of Communication:** Case conferences may be face-to-face or by phone/videoconference, held at routine intervals or during significant change. Case conferences are documented in real time in the client's record. • Names and titles of those attending the case conference and key information discussed must be recorded	• Annual chart review during site visit.
4.6.2	• **Memoranda of Understanding (MOUs)** or other standardized agreements may be necessary to ensure participation by the multidisciplinary team.	• Annual chart review during site visit.
4.6.3	• **Client input:** The client and /or his/her caregiver or legal representative may provide input to the case manager during case conference and telephone contacts. • **Confidentiality:** the client's right to privacy and confidentiality in contact with other providers must be maintained. ○ The client's consent to consult with other service provider must be obtained.	• Annual chart review during site visit.
4.6.4	• **Policies and Procedures**: Provider must have written Policies and Procedures of case conferencing including staff responsible for performing it, and supervisory oversight.	• Annual chart review during site visit.
4.6.5	**Frequency:** • Case conferences are based on the client needs.	Annual chart review during site visit.

Monitoring

Case Conference- MOUs will be monitoring annually. Appropriate documentation must be kept in the client chart.

4.7 Reassessment/Revision of ICP

Reassessment provides an opportunity to review a client's progress, consider successes and barriers, and evaluate previous period of case management activities and the client's level of acuity. It re-evaluates client functioning, health and psychosocial status, identifies changes, and determines new or ongoing needs.

NMCM Managers will routinely review the successes and challenges clients are having in achieving outcomes as outlined in the ICP, measure progress in meeting goals and objectives, and revise ICP as necessary. See below the key activities of reassessment:

#	Standard	Measure
4.7.1	**Policies and Procedures:** Provider must have written Policies and Procedures of reassessment including frequency, documentation, staff responsible for conduction the reassessment, the staff responsible for performing it, and supervisory oversight of the reassessment process.	Policies and Procedures will be review during site visit.
	Staff Responsible: case manager has primary responsibility for the Reassessment.	
4.7.2	**Revision of ICP:** Client assessment and revision to the ICP must be made **at least every six months**, or more frequently as client condition changes. The assessment will routinely review the success in achieving service outcomes as outlined in the ICP, measure progress in meeting goals and objectives, and revise the plan, as necessary. • Case managers meet face-to-face during the reassessment is encouraged, otherwise, will be implemented via phone call or video calling.	Documentation of ICP reassessment and revision will be monitored via review of client charts and/or electronic health records during in-person site visits
4.7.3	**Documentation:** Non-Medical Case Managers must routinely document the outcome of reassessments and service activities in the client record, ARIES, client contact form, and outcome log. Any changes to the ICP will be signed and dated by both the NMCM and the client if paper based.	Documentation must be available in the client's chart **in real time** and/ or ARIES within **seven business days.** Documentation will be reviewed during in-person site visit.
4.7.4	**Feedback:** Non-Medical Case Managers must provide constructive feedback to clients when reviewing the ICP and progress made toward goals	Documentation must be accessible in client's chart and/ or electronic health records during in-person site visit;

	and objectives. Constructive feedback is based on concrete observations and is focused on providing information to the client in a non-judgmental way. Feedback will be strength-based whenever possible.	timing and quality of feedback will be monitored via client chart review during site visit.
4.7.5	**Changes on the Levels of Care:** Agencies will have written protocol to transfer clients into a less-intensive level of care as they become more independent and self-sufficient and their need for case management is reduced or transfer clients into a higher level of care as they become more dependent and their need for case management increase.	Documentation must be accessible in ARIES and client's chart.

5.0 Service Access, Management, and Closure

Standards identified in Universal Standards of Care (USOC 5)

4.8 Client Transfer and Case Closure

Agencies will close a client's file according to written procedures.		
#	**Standard** Agencies must comply with USOC 5.3	**Measure**
4.8.1	**Transfer of Clients:** In the event that a client wishes to (or needs to) transition into NMCM services offered by another agency, relevant intake documents will be forwarded to the new service provider. Case managers from both agencies will work together to provide a smooth transition for the client and ensure that all critical services are maintained. Transfer of clients between agencies or case managers is initiated when: • The client notifies the case manager that they have moved to a different service area, • The client notifies the case manager of their intent to transfer services, • The Forced Disenrollment Grievance Procedure has been followed as defined in the USOC 6. • The agency no longer receives funding.	Agencies must keep track of the clients who transitioned to another area. Records must be available for auditing purposes
4.8.2	**Case Closure**: Agencies will close a client's file according to the written procedures established by the agency, as well as those outlined in the USOC 5.3. • A client file may be closed under any of the conditions listed in the USOC 5.3.1.	Agencies must keep track of the Case closure. Records must be available for auditing purposes

6.0 Grievances

Standards identified in Universal Standards of Care (USOC 6)

7.0 Client Rights, Responsibilities, & Confidentiality

Standards identified in Universal Standards of Care (USOC 7)

8.0 Staff Requirements and Qualifications

8.1 Staff Requirements & Qualifications

The educational requirements for NMCM include any health or human services bachelor's degree from an accredited college or university. NMCM who do not meet this minimum educational level may substitute related direct consumer service experience under the supervision of a health and human services professional for a period of two years of full-time work, regardless of academic preparation. **Examples of health or human services fields** include, but are not limited to social work, counseling, and psychology.

#	Standard	Measure
8.1.1	**Non-Medical Case Manager Supervision Activities:** It include staff responsible for supervision, type and frequency of supervisory activities (including evaluation of staff job performance) and required documentation. **Non-Medical Case Management Supervisor Qualifications** • Preferred qualifications for a Non-Medical Case Management Supervisor include a Master's or higher degree in Health or Human Services, one year of supervisory experience, and one year of case management experience with people living with HIV (PLWH), and/or mental illness, homelessness, or chemical dependence. Management Supervisor, experience with families is preferred. • Alternately, a Non-Medical Case Management Supervisor will hold a Bachelor's degree in Health or Human Services, and have two years of supervisory experience and two years of Case Management experience with HIV+ persons, and/or persons with a history of mental illness, homelessness, or chemical dependence. Management Supervisor, experience with families is preferred. • Alternately, a Non-Medical Case Management Supervisor will possess an Master's or higher degree in health or human services, licensure as an RN or LVN, and two years of Case Management experience with HIV+ persons, and/or persons with a history of mental illness, homelessness, or chemical dependence. For a Case Manager in a Comprehensive pathway, and for certain Supportive Case Management initiatives,	Monitored during site visit.

	experience with families is preferred.	
8.1.2	**Waiver for Meeting Case Management Supervisor Qualifications** • The qualification requirements listed above for Non-Medical Case Management Supervisor may be waived on a case-by-case basis with approval of the RW Recipient. • Non- Medical Case Management experience must encompass the functions of intake, assessment, reassessment, service planning, case coordination, case conferencing, and service plan implementation, crisis intervention, monitoring and follow-up of services provided, and case closure.	Monitored during site visit.
8.1.3	**Non- Medical Case Manager Qualifications**: Preferred qualifications for a case manager include a Bachelor's or Master's degree in health, human or education services and one year of case management experience with PLWH, and/or mental illness, homelessness, or chemical dependence.	Monitored during site visit.
8.1.4	**Waiver for Meeting Non- Medical Case Manager Qualifications:** The qualification requirements listed above may be waived on a case-by-case basis with approval of RW Recipient. Experience or education which would be considered for waiving case manager qualifications include: • Two years' experience providing Case Management services or HIV related services, or • One year of Case Management experience and an associate's degree in health or human services, or • One year Case Management experience and an additional year of experience in other activities with PLWH, or • A bachelor's or master's degree in health or human services	Monitored during site visit.

Monitoring

Staff Qualifications- Agencies must maintain personnel files with hire date, educational qualifications or experience, these records must be available for review during site visits

8.2 Trainings

All Non-Medical Case Managers must be trained and knowledgeable about HIV and familiar with available HIV resources in the area.

#	Standards Agencies must comply with USOC 8.0	Measure
8.2.1	**Initial Staff Orientation and Training:** All staff providing NMCM must complete an initial training session related	All trainings provided, and dates of trainings must be available for

	to their job description and serving those with HIV. Training must be completed **within 15 days of hire**; topics must include: General HIV knowledge, such as HIV transmission, care and prevention, Privacy requirements and HIPAA regulations, navigation of the local system of HIV care, basic case management skills, and partner services	review during site visit or upon request
8.2.2	**Ongoing Staff training:** Staff must also receive ongoing annual HIV training as appropriate for their position. Training may be any combination of (1) in-person, (2) articles, (3) home studies, or (4) webinars, and must be clearly documented and tracked for monitoring purposes.	All trainings provided, and dates of trainings must be available for review during site visit or upon request
8.2.3	**Prefer provider training:** Providers must complete initial and ongoing training in Partner Services, de-escalation and conflict resolution, have upper-level training in HIV medical care and medical/support resources for PLWH/A in San Jose TGA, have multiple language capabilities, be familiar with the Affordable Care Act and Covered California.	Provider training list must be available for review during site visit or upon request
8.2.4	**Annual Confidentiality Training:** staff providing NMCM must include annual confidentiality training with an attestation signed by each staff person agreeing to abide by confidentiality requirements	Provider confidentiality training must be available for review during site visit

9.0 Cultural and Linguistic Competency

Standards identified in Universal Standards of Care (USOC 9)

10.0 Fiscal Responsibility

Standards identified in Universal Standards of Care (USOC 10)

11.0 Licensure and Quality Assurance

Standards identified in Universal Standards of Care (USOC 11)

11.1 Quality Assurance

Standards identified in Universal Standards of Care (USOC 11)	
• All agencies providing MCM must have a supervisory review process to assess documentation and resolution of client needs. • All clients who are discharged from MCM must have a supervisor review within 3 months of discharge. • Supervisor review must be documented in the client's chart with signature, date of review, and findings.	• Annually via chart review of a representative sample of at least 10 percent of charts of active MCM clients.

12.0 Continuous Quality Improvement

Standards identified in Universal Standards of Care (USOC 12)

References and Published Guidelines:

1. Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds. Policy Clarification Notice (PCN) #16-02
2. California State Office of AIDS (OA) a division within California Department of Public Health, Center for Infectious Diseases, last modified August 29, 2012
3. Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds. Policy Clarification Notice (PCN) #16-02
4. Ryan White Part B HIV/AIDS Medical and Non-Medical Care Management Standards. Georgia Department of Public Health. April 1, 2018 – March 31, 2019. Pages 11-16 and 20-21 and 36 and 49.
5. Ryan White HIV/AIDS Program Case Management Standards of Care for New York. Retrieve April 27, 2020. https://www.health.ny.gov/diseases/aids/providers/standards/casemanagement/case_coordination_conferencing.htm
6. Ryan White HIV/AIDS Program Standards of Care for the Oakland Transitional Grant Area, June 2016. Pages 11-17.
7. Boston Public Health Commission, Ryan White Services Division. FY 2019 Standards of Care Boston EMA. Revised March 2019.

APPENDIX A

A-Determine the Level of Acuity

CMNM services will be provided based on the client's level of acuity. The intent of the level of acuity is to provide a framework for documenting important assessment elements and standardizing the key questions that will be asked as part of an assessment. This scale also translates the assessment into a level of programmatic support designed to provide the client assistance appropriate to their assessed need and function.
Selection of the appropriate level is critical for providing the most effective and appropriate services to the clients. The most effective case management providers are culturally competent and employ staff who culturally and linguistically represent the community served.
All new and re-enrolling clients must have an Acuity Scale completed.

A.1	**Determine the level of acuity:** Acuity level shall be categorized according to the acuity scale used by the agency providing service. They will be categorized in level 1-4 according to client need for NMCM and may be based on progression of HIV disease or other issues impacting their HIV care or risk for further HIV transmission. • Level 1 and 2 clients are lower levels of acuity, which require less intensive case management services. Level 3 clients are at a higher acuity level which require more case management services. Level 4 clients are at the highest acuity level which require intensive case management services.
A.2	**Level 1 Self-management:** Self-management is appropriate for clients who adhere to medical care and treatment, are independent, and are able to advocate for themselves. Clients may need occasional assistance from the case manager to update eligibility forms. These clients have demonstrated the capability of managing themselves, are independent, medically stable, virally suppressed and have no problem accessing HIV care. • Additionally, their housing and income source will be stable. If clients have a mental health diagnosis, they will be in the care of a mental health provider and compliant with their treatment plan. If clients have a history of substance abuse, they will have more than 12 months of sobriety and will preferably be accessing continued support services to maintain their sobriety. • The majority of case management services provided will be non-medical. The objective is to provide guidance and assistance in improving access to needed services. Revision of the acuity scale must occur at least every 6 months with adaptations as necessary.
A.3	**Level 2 Supportive:** Supportive case management is appropriate for clients with needs that can be addressed in the short term. Clients will be compliant with their medical care and treatment, independent, and able to advocate for themselves. • Additionally, these clients require minimal assistance, and their housing and income source(s) will be stable. Clients may require service provision assistance no more that 2-3 times a year. If the clients have a mental health diagnosis, they will be in the care of a

	mental health provider and adherent to their treatment plan. If clients have a history of substance abuse, they will have no less than 6 months of sobriety and will preferably be accessing continued support services to maintain their sobriety. This includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. • The majority of case management services provided will be non-medical. The objective is to provide guidance and assistance in improving access to needed services. Revision of the acuity scale must occur at least every 6 months with adaptations as necessary.
A.4	**Level 3 Intermediate (alternating between severe episodes and periods of functioning well):** Intermediate case management is appropriate for clients who are considered medically case managed. Coordination and follow-up of medical treatment is a component of medical case management. These clients require assistance to access and/or remain in care and are at risk of medication and appointment non-compliance. They may have opportunistic infections and other co-morbidities that are not being treated or addressed and have no support system in place to address related issues. • The case manager will ensure timely and coordinated access to medically appropriate levels of health and support services, and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. • The majority of case management services provided will be medical and the objective is to improve health care outcomes. The re-evaluation of the acuity scale and Individualized Care Plan (ICP) must occur at least **every 6 months** • Documentation will be reflective of goals, activities and outcomes in the case notes. Consultation with a multi-disciplinary team, case management supervisor and/or others as needed will be documented.
A.5	**Level 4 Intensive (Severely Impacted):** Intensive case management is appropriate for clients who are considered medically case managed. These clients require assistance to access and/or remain in care. The clients are at risk of becoming lost to care and are considered medically unstable without Treatment assistance to ensure access and participation in the continuum of care. • The case manager will ensure timely and coordinated access to medically appropriate levels of health and support services, and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. • The Initial Assessment must be completed **within 15 days**, development of an ICP **within 30 days** of beginning Intake, and re-evaluation of the acuity scale and ICP must be performed at **least every 3 months**. • The majority of case management services provided will be medical and the objective is to improve health care outcomes. • Documentation will be reflective of goals, activities, and outcomes in the case notes. Consultation with a multi-disciplinary team, case management supervisor and others as needed will be documented. • Clients have considerable health care needs because of the existence of any mental health issues or the progression of their HIV illness.

	• If the client requires referrals for hospice care and/or end-stage disease planning. The case management team will provide the psychosocial resources necessary for level 4 clients not receiving hospice services.
A.6	**Assign appropriate Primary Case Manager:** Each client will always have a primary case manager who helps coordinate services with other members of the treatment and services team. This primary case manager will serve as the main point person for the client to streamline communication and maximize care coordination. • If the level of acuity of a client was 1 or 2, the client will be assigned to NM-CM. If the level of acuity of a client is 3 or 4, the client will be assigned to a Medical Case Management (MCM).

Appendix B

Santa Clara County HIV Commission

Santa Clara County PUBLIC HEALTH

Acuity Scale Assessmemt

County of Santa Clara Public Department Collaborating with HIV Planning Committee

Client Name: _____

Date: _____

Housing							
Level 1		**Level 2**		**Level 3**		**Level 4**	
☐	Living in housing of choice: clean, habitable apartment or housing.	☐	Living in stable subsidized housing.	☐	Formerly independent person temporarily residing with family or friends.	☐	Need assisted living facility; unable to live independently
☐	Living situation stable; not jeopardy.	☐	Safe & secure non-subsidized housing.	☐	Living in temporary transitional shelter	☐	Home uninhabitable due to health and /or safety hazards.
☐		☐	Housing is in jeopardy due to projected financial strain; needs assistance with rent/utilities to maintain housing.	☐	Pregnancy or minors under 18 years old	☐	Recently evicted from rental or residential program.
☐		☐	Living in long-term transitional rental housing.	☐		☐	Homeless, (living in emergency shelter, car, or street/camping, etc.).
						☐	Arrangements to stay with friends have fallen through.
							Points: _____ **Level:** _____

Income

Level 1		Level 2		Level 3		Level 4	
☐	Steady source of income which is not in jeopardy	☐	Has steady source or income which is in jeopardy	☐	No income.	☐	Immediate need for emergency financial assistance
☐	Has savings and /or resources.	☐	Occasional need of financial assistance or awaiting outcome of benefits applications.	☐	Benefits denied.	☐	Needs referral to representative payee.
☐	Able to meet monthly obligations.	☐	Needs information about benefits, financial matters.	☐	Unable to apply without assistance	☐	
☐	No financial planning or counseling required.	☐	Has short-term benefits.	☐	Need financial planning and counseling.	☐	

Points: _____ Level: _____

Nutrition/Food

Level 1		Level 2		Level 3		Level 4	
☐	Client is eating at least two meals daily	☐	Unplanned weight loss in the past 6 months.	☐	Visual assessment shows initial signs of wasting syndrome or other obvious physical maladies.	☐	Persistent nausea, vomiting and or diarrhea.
☐	No significant weight problems	☐	Request assistance in improving nutrition.	☐	Abdominal problems reported	☐	Severe problems eating (e.g. difficulty swallowing or chewing).
☐	No problems with eating	☐	Obesity	☐	Eligible for food bank and or food voucher	☐	Significant weight loss in past 3 months.
☐	Does not need to request assistance in obtaining food	☐	Eligible for food bank and or food voucher	☐	Obesity or Pregnancy	☐	Obesity impairing activities
☐	No other chronic medical condition (e.g., diabetes, hypertension, hyperlipidemia) requiring changes in diet.	☐	No other chronic medical condition (e.g., diabetes, hypertension, hyperlipidemia) requiring changes in diet.	☐	No other chronic medical condition (e.g., diabetes, hypertension, hyperlipidemia) requiring changes in diet.	☐	Needs referral to registered dietitian for nutritional therapy related to a chronic medical condition

Points: _____ Level: _____

Transportation

Level 1		Level 2		Level 3		Level 4	
☐	Has own or other means of transportation consistently available.	☐	Has minimal access to private transportation.	☐	No means via self/others.	☐	Lack of transportation is a serious contributing factor to current crisis
☐	Can drive self.	☐	Needs occasional assistance with finances for transportation.	☐	In area under – served by public transportation.	☐	Lack of transportation is a serious contributing factor to lack of regular medical care.
☐	Can afford private or public transportation.	☐		☐	Unaware of or needs help accessing transportation services.	☐	
☐		☐		☐		☐	

Points: _____
Level: _____

Health Insurance/Medical Care Coverage

Level 1		Level 2		Level 3		Level 4	
☐	Has insurance/medical care coverage.	☐	Assistance needed to enroll in accessing insurance (Ryan White, ADAP, Pap, etc.). No medical crisis.	☐	Assistance needed in accessing insurance or other coverage for medical costs. No medical crisis.	☐	Needs immediate assistance in accessing insurance or other coverage for medical costs due to medial crisis.
☐	Has ability to pay for care on own.	☐		☐	Assistance needed to enroll in other coverage for medical cost.	☐	No currently eligible for insurance or public benefits. Unable to access care.
☐	Enrolled in assistance (Ryan White, ADAP, Pap, etc.).	☐		☐		☐	No insurance for her child/children
☐		☐		☐		☐	

Points: _____
Level: _____

Medical/ Physical Health

Level 1		Level 2		Level 3		Level 4	
☐	Stable health with access to ongoing HIV medical care.	☐	Needs primary care referral.	☐	Poor health.	☐	Medical emergency
☐	Lab work periodically	☐	HIV care referral needed _ next available apt.	☐	HIV care referral needed – apt. ASAP	☐	End – stage of HIV disease.
☐	Asymptomatic and in medical care	☐	Short – term acute condition; receiving medical care.	☐	Needs treatment or medication for non – HIV related conditions	☐	Intensive and or complicated home care required
☐		☐	Chronic non – HIV related condition under control with medication/treatment	☐	Pregnancy / Multiple medical diagnoses/Home bound; home health needed.	☐	Hospice services or placement indicated.
		☐	HIV symptomatic with one or more conditions that impair overall health.	☐	Debilitating HIV disease symptoms/infections.		

Points: _____ Level: _____

Drug Use

Level 1		Level 2		Level 3		Level 4	
☐	No difficulties with additions including drugs, alcohol, sex, or gambling	☐	No difficulties with additions including drugs, alcohol, sex, or gambling	☐	Current addiction but is willing to seek help in overcoming addiction	☐	Current addictions; not willing to seek or resume treatment
☐	Past problems with addition; > 1 year in recovery	☐	Past problems with addiction; 6 months and < year in recovery.	☐	Major addiction impairment of significant other.	☐	Fails to realize impact of addition on life/indifference regarding consequences of substance use
☐	No need for treatment referral	☐		☐	Pregnancy	☐	Current drug use has an impact on ability to parent child/children
☐		☐		☐		☐	Pregnant and actively using

Points: _____
Level: _____

HIV Treatment and Adherence							
Level 1		**Level 2**		**Level 3**		**Level 4**	
☐	Has attend to all HIV medical appointments in the last 12 months.	☐	Adherent to medications as prescribed in the last 6 but may have missed an appointment	☐	Has missed one or two (non-consecutive) HIV medical appointment in the last six months but has been seen by member of medical team	☐	Has missed two or more consecutive medical appointments in the last six months
☐	Is virally suppressed and or has not OI in the last year.	☐	Keep majority of medical appointments.	☐	Doesn't understand medications and or adverse side effects reported	☐	Refuses/declines to take medications and or inability to take meds as schedule.
☐	Express no issues with side effect	☐	Has detectable VL but is on ARVs	☐	Has detectable VL and CD4 <350 and refuses ARVs	☐	Has detectable VL and CD4 under 200 and refuses ARVs
☐	Can name or describe current medications.	☐	Has reschedule multiple appointment within the last 12 months	☐	Has been hospitalized in the last 6 months.	☐	Require professional assistance to take meds and keep appoint.
☐	Rarely or never misses a doses of prescribed medications	☐	Misses doses monthly, or on occasion	☐	New to care or diagnosed in the last 6 months.	☐	Has been hospitalized in last 30 days
☐	Has not history of hospitalization in the last 12 months		Has not hx. of OIs in last 6 months or is on treatment for OIs	☐	Misses doses weekly	☐	Misses doses daily
☐	New to care		Has had not hospitalizations in last six months	☐	Moderate adverse side effects that occasionally impact adherence	☐	Experiences significant adverse side effects that impact adherence
						Points: _____ Level: _____	

Mental Health

Level 1		Level 2		Level 3		Level 4	
☐	No history of mental health, illness, psychological disorder or psychotropic medications.	☐ ☐	Level of client /family stress is high. Needs emotional support to avert crisis. Needs counseling referral	☐ ☐	Severe stress or family crisis; needs mental health assessment Experiencing an acute episode and /or crises.	☐ ☐ ☐	Danger to self or others Needs immediate psychiatric assessment/evaluation
☐	No need for counseling referrals	☐	History of mental health disorder/treatment in client and /or family.	☐ ☐	Requires significant emotional support Depression, not functioning.	☐	Active chaos or problems due to violence or abuse
☐		☐	In mental health treatment and compliant	☐ ☐	In treatment but not adherent Recent hospitalization	☐	Requires therapy, not accessing it.
☐		☐ ☐	Depressed, functioning Needs counseling referral	☐ ☐	Significant trouble getting along with others. Pregnancy	☐	Pregnant and not on mental health mediation.

Points: _____
Level: _____

Drug Use

Level 1		Level 2		Level 3		Level 4	
☐	No difficulties with additions including drugs, alcohol, sex, or gambling	☐	No difficulties with additions including drugs, alcohol, sex, or gambling	☐	Current addiction but is willing to seek help in overcoming addiction	☐	Current addictions; not willing to seek or resume treatment
☐	Past problems with addition; > 1 year in recovery	☐	Past problems with addiction; 6 months and < year in recovery.	☐	Major addiction impairment of significant other.	☐	Fails to realize impact of addition on life/indifference regarding consequences of substance use
☐	No need for treatment referral	☐		☐	Pregnancy	☐	Current drug use has an impact on ability to parent child/children
☐		☐		☐		☐	Pregnant and actively using

Points: _____
Level: _____

Personal Support

Level 1		Level 2		Level 3		Level 4	
☐	Strong support from family, friends, and peers.	☐	Strong support system, however client is requesting additional support.	☐	No stable support system in place	☐	Imminent danger of being in crises.
☐	No support needed	☐	Has few family member/friends in local area.	☐	Only support is provided by professional caregivers	☐	Acute situation where client is unable to cope without professional support within a particular situation/time frame.
☐		☐	Gaps exist in support system	☐	Pregnancy	☐	
☐		☐	Family, friends, and peers often unavailable when crises occurs.	☐		☐	

Points: _____
Level: _____

Domestic Violence/ Trauma

Level 1		Level 2		Level 3		Level 4	
☐	Emotionally dependable and physically available relatives and friends to support client.	☐	Family and /or significant others often unavailable when crises occurs.	☐	Agency9ies) involved due to signs of potential abuse (emotional, sexual, and physical).	☐	Acute situation where client is unable to cope without professional support within a particular situation/time frame.
☐	No history of abuse or domestic violence	☐	History of past relationship	☐	Violent episodes currently occurring.	☐	Medical and /or legal intervention has occurred.
☐		☐		☐	Pregnancy	☐	Life-threatening violence and/or abuse chronically and presently occurring.
☐		☐		☐		☐	Unsafe home environment

Points: _____
Level: _____

Dental

Level 1		Level 2		Level 3		Level 4	
☐ ☐	Currently in dental care Reports practicing daily oral hygiene	☐	Has not seen a dentist within 6 months	☐	Reports problems with teeth, gums, and mouth	☐ ☐	Current or severe pain reported. Reports significant difficulty eating
☐	Has seen a dentist within the past 6 months	☐	Has dentures and requested dental follow-up	☐	Episodic issues reported with the mouth and pain	☐	Reports severe or major problems with teeth, gums, and mouth
☐	No complaints of pain	☐	Reports not practicing daily oral hygiene	☐	Reports difficulty eating	☐	Few or no teeth

Points: _____
Level: _____

Legal

Level 1		Level 2		Level 3		Level 4	
☐	No recent or current legal problems	☐	Wants assistance completing standard legal documents.	☐ ☐	Present involvement in civil or criminal matters Incarcerated	☐	Immediate crisis involving legal matters (e.g. legal altercation with landlord/employers, civil & criminal matters, immigration and family/spouse).
☐	Legal documents completed	☐	Possible recent or current legal problems	☐	Unaware of standard legal documents which may be necessary	☐	Recent release from jail

Points: _____
Level: _____

Risk Reduction

Level 1	Level 2	Level 3	Level 4

☐	Abstaining from risky behavior by safer practices	☐	Occasional risk behavior	☐	Moderate risk behavior	☐	Significant risk behavior
☐	Good understanding of risks	☐	Fair understanding of risk	☐	Poor understanding of risks	☐	Little or no understanding of risk
☐	Understands the importance of preventing the spread of HIV	☐		☐	Mild/moderate A&D, MH, or relationship barrier to safe behavior	☐	Significant A&D, MH, or relationship barrier to safe behavior
☐	Understands the importance of avoiding re-infection	☐		☐		☐	No understanding of prevention methods or how to avoid re-infection
							Points: _____ **Level: _____**

Cultural Beliefs

Level 1		Level 2		Level 3		Level 4	
☐	Understands service system and is able to navigate it.	☐	Needs interpretation services for medical /case management services	☐	Needs interpretation services to access additional services	☐	Cultural factors significantly impair client and/or family's ability to effectively access and utilize services
☐	Language is not a barrier to accessing services (including sign language)	☐	Family needs education and/or interpretation to provide support to the client	☐	Family's lack of understanding is barrier to care	☐	Crisis intervention is necessary
☐	No cultural barriers to accessing services	☐	Few cultural barriers to accessing services	☐	Non-disclosure of HIV to family is barrier to care	☐	Many cultural barriers to accessing services
☐		☐		☐	Some cultural barrier to accessing services	☐	
							Points: _____ **Level: _____**

Emergency Financial Assistance

CASE MANAGEMENT NON-MEDICAL

Level 1		Level 2		Level 3		Level 4	
☐	Never needs financial assistance	☐	Financial assistance needed 1-2 times a year	☐	Financial assistance needed 3-6 times per year	☐	Financial assistance needed 6+ times per year
☐	Able to access services which they are eligible without assistance	☐	Information needed to follow up with applying for financial assistance	☐	Difficulty maintaining sufficient income to meet basic needs.	☐	Financial crisis, in need of immediate assistance.
☐	Live within financial means	☐		☐	Assistance needed with budgeting and financial planning	☐	
							Points: _____ **Level: _____**

Level 1 Self-Management 16-17 points

Level 2 Supportive 18-22 points

Level 3 Intermediate 23-37 points

Level 4 Intensive 38-64 points

Case manager's Name _____ CM Initial ____ Date _____

Case manager's Name _____ CM Initial ____ Date _____