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BROWARD COUNTY
RYAN WHITE PART A PROGRAM

Non-Medical Case Management
Service Delivery Model

BROWARD COUNTY
FLORIDA
Health Care Services
Ryan White Part A Program

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I. Definitions

HRSA Definition[1]

Non-Medical Case Management (NMCM) services 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, employment, vocational, and/or other needed services. NMCM services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication).

Local Definition

NMCM services support client achievement of wellness and autonomy by facilitating social service needs of clients. NMCM is a collaborative process of assessment, planning, facilitation, and evaluation of service options for addressing clients' medical and social needs including benefits/entitlement, counseling, and referral activities assisting them to access other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services). The goals of this intervention are retention in care, sustained viral suppression, compliance with medical care and addressing any service needs.

II. Key Service Components and Activities

In addition to the NMCM Service Delivery Model (SDM), all Providers must adhere to the minimum requirements set forth in the Broward County Ryan White Part A Universal SDM. Providers must also adhere to standards and requirements set forth in the Broward County, Human Services Department, Community Partnerships Division Provider Handbook for Contracted Services Providers, individual contracts, and applicable contract adjustments. Providers must refer to their individual contract for service-specific client eligibility requirements. Providers of NMCM services are expected to comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

Peer Counseling

Peer counseling is a required component of NMCM services. Peer counseling must be offered to clients to assist with navigating the system of care and meeting clients' action plan goals and objectives. A case management supervisor must oversee all peer counseling activities. Peer counseling activities include:

- Assist clients in navigating the health care system
- Assist clients in adhering to medical appointments and treatment
- Support clients in achieving and maintaining viral suppression

[1] *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02*. Health Resources and Services Administration (HRSA)/ HIV/AIDS Bureau (HAB). [Online] October 22, 2018. https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf.

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- Support clients in making behavioral health changes that ultimately improve their general health and quality of life
- Identification of and linkage to needed services
- Assist client in reducing barriers to meet action plan goals

III. Broward Outcomes and Indicators

Table 1. Outcomes, Indicators, and Measure

Outcome	Indicator	Measure
1. Increased access, retention, and adherence to primary medical care.	1.1. 85% of clients achieve one or more action plan goals by the target resolution date. 1.2. 85% of clients are retained in primary medical care.	1.1.1. Client action plan in designated HIV Management Information System (MIS). 1.2.1. Client appointment record in designated HIV MIS.

IV. Assessment and Action Plan

Assessment

Providers must conduct an assessment of the client's barriers to primary medical care, medication adherence, and service needs within three sessions of the initial visit. The assessment must be documented using the "Client Assessment" form in the designated HIV MIS and include, at minimum, the following components:

- Medical information, including overall health, laboratory results, and prescribed medication regimen
- Pregnancy information for female clients, including pregnancy history
- Additional core service needs, including, but not limited to mental health, oral health, nutritional
- Support service needs, including financial, support groups, legal assistance, food bank, vocational, and transportation
- Risk assessment, including the client's knowledge of HIV, and STD testing, prevention and treatment
- Quality of life evaluation, including factors related to finances, culture, language, accommodations, and need for assistance with activities of daily living
- Interpersonal violence

Reassessment

A reassessment must be conducted every six months, at a minimum. A reassessment may occur more than once every six months if significant changes occur. Reassessments require the participation of the client and provider to evaluate client health and identify changes since the last assessment to determine new or ongoing needs. Activities, notations of discussions, conclusions, and recommendations must be documented during the reassessment.

Relevant Areas of Concern

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Following the completion of the assessment or reassessment, the designated HIV MIS generates a list of the clients "Relevant Areas of Concern." The provider should utilize the "Relevant Areas of Concern" list to assist the client with prioritizing areas to be addressed in the action plan.

Action Plan

Providers must work with each client to develop an action plan with goals related to the needs identified in the assessment. The action plan must be developed the same day the assessment is completed and signed and dated by the provider and client. The action plan must be individualized, culturally appropriate, and goal-oriented with measurable objectives. Providers must assist clients to develop appropriate strategies to accomplish established goals.

The action plan must be documented in the designated HIV MIS and contain, at minimum, the following components:

- The date the action plan was initiated and completed
- Case Manager and Supervisor review and date
- Life areas with identified difficulties as indicated in coordination with client
- Date client entered case management
- Date of client's first medical appointment and documentation of client's retention/ engagement in medical care while receiving case management services
- Goals must contain, at minimum, the following components:
    - Goal category (access, adherence, and retention)
    - Goal statement that is SMART (specific, measurable, attainable, realistic, and time-based)
    - Specified interventions to achieve the goal statement
    - Date goals are established
    - Target date for goal completion

Providers must maintain ongoing monitoring and communication with clients to ensure linkage to and retention in needed services. Providers must document action plan progress, assistance provided, and communication with the client in the designated HIV MIS, including phone calls, mail, face-to-face, and electronic communication. Checking lab reports (trending viral load and CD4 values and sharing trends with clients) and validating medication pick-ups at the pharmacy constitute follow-up. Supervisors, on a monthly basis, will review a sample of open client action plans to identify opportunities for improvement. All completed action plans must be reviewed by Case Management supervisors.

Action Plan Review

An action plan review must be conducted every six months, at a minimum, to assess the efficacy of the action plan. An action plan review may occur more than once every six months if significant changes occur. Any modifications or additions to the action plan made during the review must be documented. The action plan must be signed and dated by the provider and client.

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V. Standards for Service Delivery

Table 2. NMCM Standards for Service Delivery

Standard	Measure
1. Provider conducts an assessment with each client within three sessions of the initial visit and at least every six months thereafter.	1.1. Completed assessment in the designated HIV MIS.
2. Provider works with each client to develop an individualized action plan the same day the assessment is completed. The action plan is signed and dated by the provider and client.	2.1. Action plan signed and dated by the provider and client in the designated HIV MIS.
3. Provider conducts an action plan review at least every six months.	3.1. Updated action plan signed and dated by the provider and client in the designated HIV MIS.
4. Assistance provided to client and progress made toward achieving action plan goals is documented in the designated HIV MIS within three business days of meeting with the client.	4.1. Documentation of client communication, services provided, and progress made towards action plan goals in the designated HIV MIS.

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