Ryan White Part A
Quality Management

Case Management (Non-Medical)
Service Delivery Model

Broward County/Fort Lauderdale Eligible Metropolitan Area (EMA)

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Definition:
A range of client-centered services that link clients with health care, legal, psychosocial, and other social services 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). Case management services are client-centered activities through which care is coordinated through interdisciplinary team planning. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client.

Case management helps to identify appropriate providers and facilities throughout the continuum of services, while ensuring that available resources are being used in a timely and cost-effective manner in order to obtain optimum value for both the client and the reimbursement source. Other service objectives include but are not limited to the following: (1) decreasing barrier to medical and support services, (2) increasing client’s awareness of treatment options, (3) improving service and client health outcomes, (4) increasing the client’s adherence to the care plan, and (5) empowering clients to obtain self-sufficiency.

It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. In addition, Peer Education Counseling is coupled with Case Management to offer clients individual therapeutic support services by an individual who may be the same age, gender, and HIV status as the client. This person will have had experienced and resolved the same type of problems as the client.

The Peer Counselor will assist the client with as they enter and stay in care, adhere to treatment protocols, and improve their quality of life. This person shall provide client orientation to clients linked to care, assistance with meeting care plan goals and objectives, identification and removal of barriers to adherence, retention into care and helping clients in navigating the continuum of care.
### OUTCOMES, OUTCOME INDICATORS, STRATEGIES AND DATA SOURCES

<table>
<thead>
<tr>
<th>Client Outcomes</th>
<th>Outcome Indicators</th>
<th>Inputs</th>
<th>Strategies</th>
<th>Data Source</th>
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<tbody>
<tr>
<td>1. Increased access, retention and adherence to Outpatient/Ambulatory Medical Care.</td>
<td>1.1. 80% of clients are retained in Outpatient/Ambulatory Medical Care.</td>
<td>Funding, Clients, Staff, Facilities, Supplies</td>
<td>1.1.1. Collaborate with client to assess client’s needs in obtaining medical, social, community legal financial and other services.</td>
<td>1.1.1.1. Progress Notes 1.1.1.2. Action Plan</td>
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<td>1.1.2. Develop POC goals that reflect client’s medical and social needs.</td>
<td>1.1.2.1. Progress Notes 1.1.2.2. Action Plan</td>
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<td>1.1.3. Develop obtainable target dates.</td>
<td>1.1.3.1. Progress Notes 1.1.3.2. Action Plan</td>
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<td>1.1.4. Assist client in making medical appointments as needed.</td>
<td>1.1.4.1. Needs Assessment 1.1.4.2. Client appointment record 1.1.4.3. Action Plan</td>
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<td>1.1.5. Follow-up to ensure client attended medical appointments.</td>
<td>1.1.5.1. Client appointment record 1.1.5.2. Action Plan</td>
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<td>1.1.6. Educate clients on the importance of attending medical appointments.</td>
<td>1.1.6.1. Progress Notes 1.1.6.2. Action Plan</td>
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## STANDARDS FOR SERVICE DELIVERY

<table>
<thead>
<tr>
<th>Standard</th>
<th>Indicator</th>
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<tbody>
<tr>
<td>1. Each client receives an assessment.</td>
<td>1.1. 100% of client records will have a completed Needs Assessment.</td>
<td>1.1.1. Needs Assessment</td>
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<td>1.1.2. Designated HIV MIS System</td>
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<tr>
<td>2. Each client will be assessed to determine if he/she currently receives primary medical care.</td>
<td>2.1. 100% of client records will have documented client’s primary medical care status in the Needs Assessment.</td>
<td>2.1.1. Needs Assessment</td>
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<td>2.1.2. Designated HIV MIS System</td>
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<tr>
<td>3. Each client’s viral load and CD4 will be collected.</td>
<td>3.1. 100% of client viral loads and CD4 will be requested at least semi-annually with the intent of collecting data.</td>
<td>3.1.1.Client Chart</td>
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<td>3.1.2. Lab Report</td>
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<td>3.1.3. Designated HIV MIS System</td>
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<tr>
<td>4. Each client’s viral load and CD4 will be tracked to observe trends.</td>
<td>4.1. 100% of the collected client viral loads and CD4 will be recorded at least semi-annually.</td>
<td>4.1.1. Client Chart</td>
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<td>4.1.2. Lab Report</td>
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<td>4.1.3. Designated HIV MIS System</td>
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<tr>
<td>5. Each client will be assessed for barriers to access care, treatment adherence, adherence to medications, and culturally specific needs.</td>
<td>5.1. 100% of client Needs Assessment will have documented the barriers to access primary medical care, adherence to treatment, adherence to medications and culturally specific needs as agreed with client.</td>
<td>5.1.1. Action Plan</td>
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<td>5.1.2. Needs Assessment</td>
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<td>5.1.3. Designated HIV MIS System</td>
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<tr>
<td>6. An individual Action Plan will be developed in agreement with the client.</td>
<td>6.1. 100% of Action Plan will have client and/or caregiver’s signature.</td>
<td>6.1.1. Action Plan</td>
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<td>6.1.2. Designated HIV MIS System</td>
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<td>7. The Action Plan will be based on identified needs and will address client’s cultural needs.</td>
<td>7.1. 100% of Action Plan will address client needs identified in Needs Assessment.</td>
<td>7.1.1. Action Plan</td>
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<td>7.1.2. Designated HIV MIS System</td>
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<td>8. Each client will be assisted to develop time frames for the resolution of barriers to care identified in the Needs Assessment.</td>
<td>8.1. 100% of Action Plan documented the interventions to resolve the barriers to care.</td>
<td>8.1.1. Action Plan</td>
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<td>8.2. 100% of Action Plan documented achieves dates.</td>
<td>8.1.2. Client Progress Notes</td>
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<td>8.3. 100% of Client Progress Notes document assistance.</td>
<td>8.1.3. Designated HIV MIS System</td>
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<td>Standard</td>
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<td>9. Each client will be assisted to establish expected outcomes based on the Action Plan.</td>
<td>9.1. 100% of Action Plan document expected outcomes.</td>
<td>9.1.1. Target dates in Action Plan</td>
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<td>9.2. 100% of Progress Notes document assistance.</td>
<td>9.2.1. Progress Notes</td>
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<td>10. Each client will be assisted to remain in primary medical care and adhere to treatment.</td>
<td>10.1. 100% of Client Progress Notes document attempted assistance.</td>
<td>10.1.1. Action Plan</td>
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<td>10.2. 100% of Client Action Plans outline barriers to retention to medical care.</td>
<td>10.1.2. Client Progress Notes</td>
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<td>10.1.3. Designated HIV MIS system</td>
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<td>11. Each client receiving case management for at least 6 months during the measurement year will have two or more medical visits.</td>
<td>11.1. 95% of clients receiving case management for at least 6 months during the measurement year will have two or more medical visits.</td>
<td>11.1.1. Client Progress Notes</td>
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<td>11.1.2. Documented Provider visit</td>
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<td>11.1.3. Designated HIV MIS System</td>
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<td>12. Each client receiving case management for at least 6 months will have their case management Action Plan updated two or more times in the measurement year.</td>
<td>12.1. 95 % of clients receiving case management for at least 6 months will have their case management Action Plan updated two or more times in the measurement year.</td>
<td>12.1.1. Client Progress Notes</td>
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<td>12.1.2. Action Plan</td>
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<td>12.1.3. Designated HIV MIS system</td>
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<tr>
<td>13. Each client will be assessed for prescribed HAART therapy when CD4 count is below 500.</td>
<td>13.1. 100% of clients are assessed for HAART prescription.</td>
<td>13.1.1. Needs Assessment</td>
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<td>13.1.2. Client Progress Notes</td>
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<td>13.1.3. Designated HIV MIS system</td>
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<tr>
<td>14. Each client will be assessed for other medication use.</td>
<td>14.1. 100% of clients are assessed for medications adherence.</td>
<td>14.1.1. Needs Assessment</td>
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<td>14.1.2. Client Progress Notes</td>
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<td>14.1.3. Designated HIV MIS system</td>
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<tr>
<td>15. Conduct multi-disciplinary case staffing for appropriate clients, defined as clients identified with a decrease in CD4, increase in viral load and/or missed appointments.</td>
<td>15.1. 100% of clients identified with a decrease in CD4, increase in viral load and/or missed appointments will be assessed for a multi-disciplinary case staffing.</td>
<td>15.1.1. Action Plan</td>
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<td>15.1.2. Client Chart</td>
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<td>16. Upon a face-to-face discharge managers will review community resources with client.</td>
<td>16.1. 100% of clients’ files will document a review of community resources to access upon discharge.</td>
<td>16.1.1 Progress Notes</td>
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<td>Standard</td>
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<td>Data Source</td>
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<td>17. Upon termination of active case management services, a client case is closed and contains a closure summary documenting the case disposition and an exit interview with Case Manager &amp; Case Management Supervisor.</td>
<td>17.1. 100% of closed cases include documentation stating the reason for closure and a closure summary.</td>
<td>17.1.1. Case closure summary</td>
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<td>17.2. 100% of case closure summaries are signed off by a Case Management Supervisor.</td>
<td>17.2.1. Case closure summary</td>
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<td>17.3. 100% of Exit Interviews document client discharge</td>
<td>17.3.1. Case closure summary</td>
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<td>18. Progress notes and all program and service related documentation must be entered in Designated HIV MIS System within 3 business days of client contact.</td>
<td>18.1. 100% of progress notes will be written within 3 business days of client contact.</td>
<td>18.1.1. Progress Notes</td>
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<td>18.1.2. Designated HIV MIS System</td>
<td>18.1.2. Designated HIV MIS System</td>
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<tr>
<td>19. Each client will receive a return call within 1 business day of client’s voice message requesting a return call.</td>
<td>19.1. 80% of clients will receive a return call within 1 business day of client’s voice message requesting a return call.</td>
<td>19.1.1. Telephone Log</td>
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<td>19.1.2. Progress Log</td>
<td>19.1.2. Progress Log</td>
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PROTOCOLS

The Case Management and Peer Counseling Protocol identify the specific ways to implement the Case Management and Peer Counseling Standards and processes essential to case management and peer counseling services. Service delivery shall be conducted with cultural competency by culturally competent service providers. Providers are also expected to comply with applicable standards and guidelines that are relevant to individual service categories (i.e., HAB Performance Measures, etc.).

Eligibility Verification
The Case Manager shall verify client’s eligibility is established by reviewing the certification in the designated HIV MIS System. Case Manager (or other authorized individual such as Peer Educator), shall perform an eligibility and financial assessment at each visit in addition to reviewing client’s eligibility certification in the designated HIV MIS System. Case Manager (or designee) will review client’s eligibility for all funding streams and services for which client may qualify. Case Manager will follow-up with referrals as appropriate. The purpose of the assessment is to ensure 1) client’s access to all services client may be eligible for and 2) the status of Ryan White as payer of last resort.

Needs Assessment
The Case Manager shall assess client needs by completing all sections of the Needs Assessment document and/or designated HIV MIS System. The Case Manager shall complete the Needs Assessment within three (3) sessions from the time of initial visit.

Additionally, client’s progression of HIV will be indicated under HIV Disease Progression in the Needs Assessment in designated HIV MIS System.

Action Plan

- **Individualized Plan of Care (POC)**
  The Case Manager in conjunction with the client shall complete an individualized Action Plan that incorporates the specific needs of the client. Action Plan includes the needs that can be met in the time frame agreed with the client. The Case Manager completes the Action Plan the same day the Needs Assessment is completed.

- **Time frames**
  The Case Manager shall assist the client to set client driven, realistic time frames to resolve the barriers for access to primary medical care identified in the Needs Assessment. Time frames shall be documented in the Target Date field in the Action Plan.

- **Addressing Cultural Needs**
  The Case Manager shall ensure client cultural needs are addressed in Action Plan by including those agreed with the client in the Action Plan.

- **Addressing Client Needs**
  The Case Manager shall use the Needs Assessment data in the development of the Action Plan. The Case Manager, in conjunction with the client, shall prioritize the client needs to be addressed in the Action Plan.

- **Resolutions to Barriers**
  The Case Manager shall assist the client in determining appropriate strategies to resolve barriers to access primary medical care. The resolutions shall be client driven. The strategies shall be documented in the column Interventions.
Goals
The Case Manager shall assist the client to define both medical and social service goals for the needs identified in the Action Plan. The expected results/benefits shall be documented in the Action Plan. The Case Manager shall document the specific assistance provided to the client in the Progress Notes.

In making sure that the client meets their objectives and defined case plan goals in their action plans the Peer Counselor will document efforts to assist the client by documenting with a progress note in the client record.

Client Participation

Once barriers are addressed and goals are achieved, the client is considered self-sufficient and case management is no longer needed. The client should be discharged from services.

Referral Process
Purpose
To standardize the process used to provide clients with information, and referrals when appropriate, within the Ryan White system of care and to other third party providers.

Procedure
Referring Case Manager shall assess client needs by completing a Needs Assessment. The analysis of the Needs Assessment shall assist the Case Manager in determining the referrals needed.

An Action Plan shall be developed by the referring Case Manager based on the identified needs. Referrals shall be documented in the Action Plan and the Progress Notes.

Referring Case Manager or Peer Counselor shall provide client with information of available Ryan White and Non-Ryan White services. This shall be documented in Progress Notes.

Referring Case Manager or Peer Counselor shall follow-up and document the results of the referral in the Progress Notes.

Status of Referral
Referring Case Manager, peer and provider that receives the referral shall communicate to update each other on the status of the referral.

No Show
Referring Case Manager or Peer Counselor shall contact “no show” clients to assess potential barriers and/or conditions leading to “no show”.

Referring Case Manager or Peer Counselor and client shall determine future steps to resolve the situations that triggered the “no show”.

Referring Case Manager or Peer Counselor shall establish coordination with the agency that received the initial referral to re-activate it after client consents.

Case Manager or Peer Counselor shall document all client follow-up (phone calls, mail, face-to-face and/or electronic communication) on Progress Notes as soon as information is collected.

Case Manager or Peer Counselor shall access outreach services if client remains unreachable after 6
months of not showing for outpatient/ambulatory medical care or case management appointments.
Access to Primary Medical Care
The Case Manager or Peer Counselor shall assist the client to get primary medical care, if he/she is not in care, using information provided in the Needs Assessment. The Case Manager or Peer Counselor shall discuss with the client the reasons for accessing primary medical care and with client participation determine how the Case Manager can help him/her access primary medical care. The Case Manager or Peer Counselor shall discuss with the client what needs to happen so he/she can start primary medical care. The Case Manager or Peer Counselor shall coordinate a primary medical care appointment for consenting client within 2 weeks of client contact with Case Manager.

The Case Manager or Peer Counselor shall detail the assistance provided in the Progress Notes including any coordination conducted to get the client in primary medical care.

Retention in Primary Medical Care
The Case Manager or Peer Counselor shall assist client to remain in primary medical care. The Case Manager or Peer Counselor shall assess possible barriers to continue in primary medical care and assist in their removal.

The Case Manager or Peer Counselor shall detail the assistance provided in the Progress Notes. The Case Manager or Peer Counselor shall document any coordination conducted to assist client to remain in primary medical care.

Adherence to Treatment
The Case Manager or Peer Counselor shall assist the client to adhere to treatment using information provided in the discussion of retention in primary medical care documented in the Progress Notes. The Case Manager or Peer Counselor shall discuss with the client the reasons for not adhering to medical treatment and with the client participation determine how the Case Manager can help to have him/her to adhere. The Case Manager or Peer Counselor shall discuss with the client strategies to improve adherence treatment. The Case Manager or Peer Counselor shall detail the assistance provided in the Progress Notes. The Case Manager or Peer Counselor shall document any coordination conducted to assist client to adhere to treatment.

Case Management and Peer Counselor Monitoring
The Case Manager and Peer Counselor will collect, plot, analyze and monitor and review with client his/her CD4 and viral loads at a minimum biannually. Each client will be assessed to determine whether multidisciplinary case staffing is warranted upon receipt and analysis of lab results. The Peer Counselor will provide clients with services such as face-to-face, phone contact, home visits, and medical eligibility screenings.

Follow-up
The Case Manager or Peer Counselor shall provide follow-up based on the client Action Plan. Ongoing monitoring and follow-up with the client serves to confirm the completion of referrals, acquisition of services, maintenance of services, and adherence to primary medical care, HIV prevention and risk reduction, and other support services. The Case Manager and Peer Counselor shall follow-up the progress of the Action Plan and adherence to treatment and medications. The Case Manager and Peer Counselor shall document the follow-up in the Progress Notes, including phone calls, mail, face-to-face and/or electronic communication. Checking lab reports (trending viral loads and CD-4 values and sharing trends with clients) and validating medication pick-ups at the pharmacy constitute follow-up. The Case Manager and the Peer Counselor shall take every possible interaction with the client as a window of opportunity to assess and/or reinforce access, retention and adherence to treatment.

Documentation
The Case Manager and the Peer Counselor shall document within three business days any coordination and/or intervention with the client and/or on behalf of the client. The Progress Notes make up the major source of documentation.
Reassessment
The Case Manager shall conduct: a) continuous client monitoring to assess the efficacy of the Action Plan and b) Periodic re-evaluation and adaptation of the plan at least every 6 months, as necessary. The Case Manager shall document the reassessment in the Progress Notes. The Case Manager shall revise and update the Action Plan at reassessment.

If the client chooses to receive services from a different provider, the Case Manager shall ask if the client desires to have the record transferred once he/she has selected another provider. The Case Manager shall document the reasons for client’s refusal of services. If the client does not express a reason, the Case Manager shall document this.

Continuous Quality Improvement
Case management shall conduct chart reviews at least quarterly to ensure appropriate documentation of all services, including referrals, follow-up and reassessment.

Responsibilities of Case Managers
Ryan White Part A Case Managers shall provide services to clients as indicated below:
- Discuss client confidentiality, rights and responsibilities, grievance process, other providers of the same service
- Complete Needs Assessment
- Complete POC
- Monitor service delivery and client adherence to POC
- Follow-up POC
- Re-assess Needs Assessment and POC
- Promote medical adherence, including medication
- Facilitate access to primary medical care, medications, home health care, specialty care
- Facilitate referral to ancillary medical services, (i.e. oral health, physical therapy, home health care, complementary therapies)
- Coordinate medical referrals
- Monitor referral status
- Coordinate medical care needs
- Ensure all non-Ryan White Part A medical clients’ verified Viral Loads, CD4 counts are available and entered into designated HIV MIS system
- Refer to disease management programs non-adherent clients
- Identify, refer, follow-up social support service needs identified in the POC
- Coordinate client care with all appropriate parties
- Document all interventions
- Assist client with Prescription Assistance Program (PAP) referrals (as identified in HIV MIS system)

Responsibilities of Peer Counselors
Ryan White Part A Peer Counselors shall provide services to clients as indicated below:
- Discuss client confidentiality, rights and responsibilities, grievance process, other providers of the same service
- Monitor service delivery and client adherence to POC
- Follow-up POC
- Promote medical adherence, including medication
- Facilitate access to primary medical care, medications, home health care, specialty care
- Facilitate referral to ancillary medical services, (i.e. oral health, physical therapy, home health care, complementary therapies)
- Coordinate medical referrals
• Monitor referral status
• Coordinate medical care needs
• Refer to disease management programs non-adherent clients
• Identify, refer, follow-up social support service needs identified in the POC
• Coordinate client care with all appropriate parties
• Document all interventions
• Assist client with Prescription Assistance Program (PAP) referrals (as identified in HIV MIS system)
• Assist Case Manager in care coordination

**Payer of last resort**
An applicant may not be eligible for services from Ryan White Part A Program if the applicant is already receiving or is eligible for the same benefits/services from other programs. The services provided by Ryan White may be utilized for HIV related services only when no other source of payment exists.

An applicant cannot be receiving services or be eligible to participate in local, state, or federal programs where the same type service is provided or available. This requirement does not preclude an individual from receiving allowable services not provided or available by other local, state, or federal programs, or pending determination of eligibility from other local, state or federal programs. Ryan White Part A services is the payer of last resort. All community resources should be explored with clients prior to obtaining and receiving Ryan White Part A services.

**Professional Requirements and Training**

**Peer Counselor**

Education Requirements:
• High School Diploma or Equivalent

Requirement:
• Must be a consumer of services and have at least one-years’ experience in the HIV/AIDS service delivery system.

Other experience that would be helpful to assist consumers:
• Knowledge of community resources and support groups
• Knowledge of target population
• Knowledge of HIV disease and treatment

Skills:
• Written documentation
• Adherence assessment and reinforcement
• Time management

Additional requirement based on the type of setting and/or project:
• Knowledge of substance abuse
• Knowledge of women’s health
• Knowledge of medical issues

Training of the Peer Counselor:
• HIV Basic Training
• Annual HIV Update

Additional requirement:
• Mandatory Case Management Seminars and/or training sessions required by Grantee
- Cultural and linguistic competence
Case Manager

Education Requirements:
- Earned Bachelor or graduate degree from an accredited institution with a major in either social work, nursing or social services field with a minimum of one year case management experience.

Other Requirements:
- Knowledge of community resources
- Knowledge of target population
- Knowledge of HIV disease and treatment
- Cultural and linguistic competence
- Experience in care coordination

Skills:
- Client assessment
- Written documentation
- Adherence assessment and reinforcement
- Time management

Additional requirement based on the type of setting and/or project:
- Knowledge of substance abuse
- Knowledge of women’s health
- Knowledge of medical issues

Training of the Case Manager:
- HIV Basic Training
- Annual HIV Update
- Case Manager must have a minimum of 8 hours of training annually on medically-related topics

Case Management Supervisors

In addition to the Case Manager requirements:
- Master’s degree from an accredited institution in health/human services preferred or Bachelors with a minimum of 3 years case management experience
- Earned Bachelor or graduate degree from an accredited institution with a major in either social work, nursing or social services field with a minimum of one year case management experience
- A minimum of one year supervisory experience in a health or social services setting
- Knowledge of program goals, outcomes, indicators, protocols, quality improvement evaluation, staff training and development
- Experience with chart review
- Experience with assessment of staff performance

Training:
- Updates on management issues and/or skills
- Other appropriate to the position