STATE OF NEVADA
AGING AND DISABILITY SERVICES DIVISION

SERVICE SPECIFICATIONS
ACCESS TO SERVICES:
NEVADA CARE CONNECTION

Any exceptions to these Service Specifications must be requested in writing and approved by the Deputy Administrator of the Aging and Disability Services Division.

PURPOSE:

To promote quality of service, the Aging and Disability Services Division (ADSD) has established service specifications that contain general guidelines. The service specifications that each grantee must follow consist of GENERAL REQUIREMENTS and SERVICE-SPECIFIC REQUIREMENTS established for each type of funded service.

SERVICE DEFINITION:

This service provides person-centered counseling and planning to support individuals in knowing their options, planning for care, and accessing services to meet their goals. Additionally, for some individuals case management (long-term or short-term) is necessary to monitor and follow up on services specified in the individual's plan, ensuring the services are being provided in accordance with the individual's plan and they are able to access new services as their needs change.

SERVICES AND UNIT MEASURES:

The following service categories and unit measures must be used to document the amount of service provided:

Resource and Service Navigation: a service that offers person-centered counseling to help individuals identify needs and goals, explore their options, and develop a plan to meet their long-term care goals. This service helps individuals navigate the LTSS system while considering the resources available to them. An average caseload for a Resource Navigator is 80:1.

There are three service types within this category:

1. Information & Referral – includes providing information only, to a consumer/caregiver, or referring the consumer/caregiver to another agency for services.

2. Assessment – includes a comprehensive assessment of the consumer/caregiver's needs, preferences, values and existing supports that results in a person-centered service plan.

3. Eligibility & Access – includes assisting a consumer in pre-determining possible eligibility for public programs, application assistance, or document gathering.

One unit of service equals ¼ hour of time assisting a consumer/caregiver with long-term services and supports planning and access.

Case Management: a service that helps individuals maintain services and supports. Case management services are targeted to individuals who have a higher level of need to monitor and follow up on services specified in the individual's plan, ensuring the services are being provided in accordance with the individual's plan. An average caseload for a Case Manager is 50:1.

One unit of service equals ¼ hours of time of case management.

GENERAL REQUIREMENTS:

The Nevada Care Connection Operations Manual developed by ADSD shall be used for all program definitions, instructions and requirements.

Case managers may also be Licensed Social Workers and would therefore need to meet the requirements of NRS Chapter 641B, Social Workers.

SPECIFICATIONS:

1. Eligibility

    1.1 Any consumer planning for or needing access to long-term support services including older adults, people with disabilities, caregivers, and anyone else planning for future long-term care needs.

    1.2 During Resource and Service Navigation, the need for case management is identified and discussed; eligibility for ongoing case management meets one or more of the 3 priorities listed below:

        1. Consumers who have dementia or other cognitive and functional impairments that hinders their ability to maintain long term supportive services and lives alone.

        2. Those who meet the first priority listed above and also live in rural/ frontier Nevada.

        3. Consumers that have had difficulty maintaining services within the past 6 months.

2. Required Services:

Nevada Care Connection partners may provide direct service in one or more of the following Service Programs:

2.1 Resource & Service Navigation – comprehensive, interactive decision support process that examines a consumer's needs, preferences, values, and strengths, which results in a person-centered service plan. Priority is given to consumers who are at or below 300% of the federal poverty level, family caregivers, and consumers who are experiencing a life change.

2.2 Case Management - monitor and follow up on services specified in the individual's plan and ensuring the services are being provided in accordance with the individual's plan. Assists the individual in adjusting their service plan and accessing new services as needs change.

2.2.a. The designated case manager must act as an advocate on behalf of the client/client's family with agencies and service providers.

2.2.b. In the event an individual qualifies for CBC programming and that program has a waiting list, the case manager must attempt to find an interim service.

2.3 Service Enhancements:

2.3.a. Transportation to facilitate the client's application for needed services may be provided as part of the Nevada Care Connection service.

1. The grantee must verify that staff maintain a valid Nevada Driver's License and automobile insurance per NRS 485.185. All drivers must submit a copy of their driving record from the Department of Motor Vehicles, prior to hiring and annually, thereafter. Copies of the driving records of each driver must be maintained on file.

2.3.b. Home visits may be conducted during initial Resource and Service Navigation or periodically through the case management services. Subrecipient must have policies in place related to home visit safety.

2.4 Optional Services – Nevada Care Connection partners may offer these additional services as resources allow.

2.4.a. Veterans Benefit Counseling – Navigators and Case Managements may receive additional training through the Nevada Care Connection Certification program to provide information to veterans about benefits that may be available to state and federal Veteran Services programs.

Additional funding is also available for some partners to offer the Veteran Directed Care program. ADSD will provide assistance and training to eligible partners for this service.

2.4.b. Care Transitions – a temporary service offered to stabilize consumers in their homes after an acute care hospital stay. This service program is also used to provide nursing home diversion/transition services to consumers at risk of or currently in a skilled nursing facility placement. Priority is given to consumers who have had multiple hospital readmissions in a six-month time period.

3. Service Prohibitions:

3.1 In addition to the Service Prohibitions in ADSD's General Service Specifications, staff shall not influence consumer choice.

3.2 When an organization has existing programs or services that may overlap or connect with Nevada Care Connection services, they must establish procedures for delineating between Nevada Care Connection services and existing service delivery in close coordination with the ADSD No Wrong Door (NWD) Coordinator.

3.3 Staff shall not visit clients after the grantee's business hours without the supervisor's approval.

3.4 Staff shall not operate as the client's legal guardian or executor.

3.5 Staff shall not investigate suspected vulnerable adult abuse but must refer suspected abuse to the appropriate agency within 24 hours.

4. Documentation Requirements:

4.1 For every identified consumer/client/caregiver; collect and document individual's information, as made available, and the topics discussed, including any follow up conducted, and enter into the management information system designated and provided by ADSD.

4.1.a Utilize the level 1 Intake Assessment made available by ADSD.

4.2 For Resource and Service Navigation:

4.2.a. Utilize the Resource and Service Navigation Tool.

4.2.b. Utilize the Plan of Services template.

4.2.c. Maintain an individual case record, using a management information system designated and provided by the ADSD that documents the following:

1. A standardized, multi-dimensional assessment of the client must be completed during the resource and service navigation process and must document:
2. A summary of the client's problem or need;
3. An evaluation of the client's support system;
4. A description of the client's vision of quality of life, to include his or her desires and priorities, and their relationship to identified deficits in physical/mental health and ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs); and
5. A description of the client's home environment and financial resources;
6. A chronology and summary of actions taken to assist the client, including information and referral provided, assessments completed, applications completed, types of services provided, and any necessary documentation collected;
7. Follow-up activities related to the verification of services received by clients; and
8. Warm hand-off to Case manager when appropriate.

4.3 For Case Management:

4.3.a. The Case manager to make initial contact with client within 3 days from the day the case is received to introduction, review service plan and follow-up questions in initial contact with client. Client in home assessment of the residence must be completed within 30 days.

4.3.b Schedule your first face to face home visit with this client during this initial contact.

1. Any new case assigned between the 1st and the 15th of the month requires a face to face contact be conducted by the end of the month.
2. If a new case is assigned in the second half of the month (16th-end), a face to face needs to be scheduled the following month, to be completed no later than the 15th of the following month.

4.3.c. A reassessment must be conducted at least every six months to assess any changes in the client's desired outcome goals, physical health, mental health, and/or support systems. The reassessment must include the following:

1. A description of the client's ability to perform ADLs and IADLs;
2. An evaluation of the services provided and the progress toward the outcome goals established in the client's service plan;
3. An assessment of the client's mental/physical condition and support system;
4. An assessment of the services needed; and
5. A summary of any changes to the client's condition since the last assessment, if any.

4.3.d. The service plan must be monitored monthly by phone or in person. A home visit or a visit in an adult day care setting is required no less than every six months. The purpose of monitoring is to determine the appropriateness and quality of the service and the status of the client's condition. Case notes document each contact with, or on behalf of, the client, including referrals, applications and forms completed, and outcomes. Narrative notes must also include date of entry, brief summary of pertinent information, initials, and title of person making the entry.

4.3.e. The case file must maintain notes as applicable in 4.2.a Specification above.

5. Operating Procedures:

5.1 The Nevada Care Connection Operations Manual will be used to define operations at each site.

5.2 The program will participate in the development, updating, implementation and adherence of the Nevada Care Connection Operations Manual by attending partner meetings.

5.3 The program will have staff designated for the roles of Intake, Resource and Service Navigation, Case Management and Program Oversight.

5.4 The program will implement strategies to increase capacity in coordination with the Division which may include match (cash or in-kind), volunteer programs and other such strategies.

6. Training:

    6.1 All new Staff and volunteers must complete the Nevada Care Connection Certification trainings offered or identified by the Division within 6 months of employment.

    6.2 Staff and volunteers must receive five additional hours of training related to long-term services and supports, person-centered planning or future planning each grant year.

    6.3 Upon employment and a minimum of every other year thereafter, staff and volunteers will receive training in crisis management and suicide prevention to include crisis assessment, identifying resources, service acquisition, and follow-up.

    6.4 Any person providing case management services who is not licensed in accordance with NRS 641B, et sec., must receive at least 10 hours of training annually in areas related to case management.

7. Quality Improvement:

    7.1 A quality improvement survey will be provided by the Division for partners to administer to individuals served. This supersedes the performance indicator survey requirement in the ADSD General Service Specifications.

8. Outreach and Education

    8.1 Review and work with NWD coordinator on all outreach material: Social media, presentations, printed material, etc. to ensure outreach messaging stays consistent statewide.

    8.2 Outreach specific to Nevada Care Connection which includes educating the community (general public and partners) of NVCC services and building partnerships with state and community stakeholders to expand NVCC outreach.

    8.3 Maintain an outreach record, using a management information system designated and provided by the ADSD that documents the following:

        1. Tabling events: Number of individuals that were provided flyers, brochures, or briefly provided Nevada Care Connection information.

        2. Social Media outreach: Number of people that “liked” the post and/or number of people reached with post.

        3. In Service presentation: Number of individuals who attended the Nevada Care Connection in-service presentation.

8.4 One unit of service equals ¼ hour of time for any outreach event.

1. Tabling and In-service presentations may include travel time to and from each event toward time counted.

2. Social Media – For every 3 social media posts through any platform will be considered equivalent to one unit of service.