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 to make informed decisions, planning for care, and accessing services to meet their long-term service and support goals. Additionally, for some individuals case management (long-term or short-term) is necessary to monitor, follow up, and reevaluate need on services and resources specified in the individual's plan.

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 40:1.

There are three service categories:

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, supportive decision making 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 is necessary to monitor, follow up, and reevaluate needs, services and resources specified in the individual's plan. An average caseload for a Case Manager is 25:1.

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 Eligibility for ongoing case management must meet one or more of the 3 priorities listed below:

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

[1] Cognitive Impairment is defined: when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life. Cognitive impairments range from mild to severe.

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

3. Those who meet the first priority above and 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 – continue providing person-centered practices and planning through monitoring services, follow up, and reevaluate clients needs on services and resources specified in the individual's plan.

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 public programming that include case management and there is a waitlist; the case manager must attempt to find an interim service.

2.3 Service Enhancements: Nevada Care Connection partners may offer these additional services as resources allow.

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. The Veterans Choice Program– Additional funding is available for some partners to offer this program. ADSD will provide training and technical assistance to eligible partners for this service. This service is offered to Veteran's who are screened and deemed eligible by the VA

Medical center. This program offers Veterans and their caregivers' access to long-term services and supports to continue living at home and remain a part of their community. Veterans in this program have choice and control over the goods and servcies that best meets their needs through Resource Navigation and Case management.

2.3.c. 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.

2.4 Home visits may be conducted during initial Resource and Service Navigation as needed or through the case management services, as required. Subrecipient must have policies in place related to home visit safety.

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 report suspected abuse to the appropriate agency within 24 hours.

4. Documentation Requirements:

4.1 For every identified consumer/client/caregiver; collect and document each contact with the following information: date of contact, RSN/CM initials, brief summary of pertinent information, topics discussed; including any follow up conducted, noting any other parties present during any phone/ in-person contact.

All data is to be entered into the management information system designated and provided by ADSD for each NVCC service as instructed in section 5.1.

4.1.a A chronology and summary of client's problem or need; actions taken to assist the client, including information and referral provided, assessments completed, applications completed, types of services provided, evaluation of the clients support system, and any necessary documentation collected;

4.1.b. follow-up activities related to the verification of services received by clients; and

4.1.c. Warm hand-off to Case manager and/or agency when appropriate.

4.2 Utilize the Intake Form made available by ADSD.

4.3 Utilize the Resource and Service Navigation Tool. Which is a standardized, multi-dimensional assessment tool to be used to focus on strengths-based assessment to develop a service plan. This includes but not limited to client's desired outcome goals, physical health, cognitive health, and/or support systems, home environment, and financial resources.

4.4 Utilize the Plan of Services template. That includes A description of the client's vision of quality of life, to include his or her desires and priorities.

4.5 For Case Management: Documentation include section 4.

4.5.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.

4.5.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 need to be scheduled and completed no later than the 15th of the following month.

4.5.c. A reassessment must be conducted and documented at least every six months to assess any changes since the last assessment. This

includes but not limited to client's desired outcome goals, physical health, cognitive health, and/or support systems, home environment, and financial resources.

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 3 months. The purpose of monitoring is to determine the appropriateness, quality of the service and the status of the client's condition.

4.3.e. The case file must maintain notes as applicable in 4.1 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 and annually thereafter.

6.3 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.

6.4 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.

6.5 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 or NWD staff to administer to individuals served. This supersedes the performance indicator survey requirement in the ADSD General Service Specifications.

8. Outreach and Education

8.1 All outreach materials that includes but not limited to: social media, presentations, printed material, etc. must be approved by NWD staff before utilization each fiscal year to ensure outreach messaging stays consistent statewide.

8.2 Outreach must be 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 information and education.

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” or shared 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 and targeted audience.

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

1. Tabling and in-service presentations may not account for travel time to and from each event.

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