MEDICAL CASE MANAGEMENT

I. DEFINITION OF SERVICE

Support for **Medical Case Management Services (including treatment adherence)** to ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, provided by trained professionals, including both medically credentialed and other health care staff who are part of the clinical care team, through all types of encounters including face-to-face, phone contact, and any other form of communication.

Activities include at least the following:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Coordination of services required to implement the plan
- Continuous client monitoring to assess the efficacy of the plan and to ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, provided by trained professionals, including both medically credentialed and other health care staff who are part of the clinical care team, through all types of encounters including face-to-face, phone contact, and any other form of communication.
- Continuous client monitoring to assess the efficacy of the plan of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for, and adherence to, HIV/AIDS treatments
- Client-specific advocacy and/or review of utilization of services
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Documentation that:

- Service providers are trained professionals, either medically credentialed persons or other health care staff who are part of the clinical care team
- The following activities are being carried out for clients as necessary:
    1. Initial assessment of service needs
    2. Development of a comprehensive, individualized care plan
    3. Coordination of services required to implement the plan
    4. Continuous client monitoring to assess the efficacy of the plan
    5. Periodic re-evaluation and adaptation of the plan at least every 6 months, during the enrollment of the client
- Documentation in program and client records of case management services and encounters, credentialed persons or other health care staff who are part of the clinical care team.
- Documentation in program &client records of case management encounters and advocacy.

II. DESCRIPTION OF SERVICE

SERVICE	PERFORMANCE MEASURE/METHOD	MONITORING STANDARD	LIMITATIONS
Support for Medical Case Management Services (including treatment adherence) to ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, provided by trained professionals, including both medically credentialed and other health care staff who are part of the clinical care team, through all types of encounters including face-to-face, phone contact, and other forms of communication	Documentation that service providers are trained professionals, either medically credentialed persons or other health care staff who are part of the clinical care team	Provide written assurances and maintain documentation showing the medical case management services are provided by trained professionals who are either medically credentialed or trained health care staff and operate as part of the clinical care team The minimum requirements are: • A bachelor's (preferred) in social work from an accredited program; OR • An associates degree (preferred) in social work from an accredited program (one year of paid experience will substitute for the degree); OR • One (1) year of paid experience in direct service to HIV target population.	
Activities that include at least the following: • Initial assessment of service needs • Development of a comprehensive, individualized care plan • Coordination of services required to implement the plan • Continuous client monitoring to assess the efficacy of the plan • Periodic re-evaluation and adaptation of the plan at least every 6 months, as necessary	Documentation that the following activities are being carried out for clients as necessary: • Initial assessment of service needs • Development of a comprehensive, individualized care plan • Coordination of services required to implement the plan • Continuous client monitoring to assess the efficacy of the plan • Periodic re-evaluation and adaptation of the plan at least every 6 months, during the enrollment of the client	Maintain client charts that include the required elements for compliance with contractual and Ryan White programmatic requirements, including required case management activities and such as services and activities, the type of contact, and the duration and frequency of the encounter	

SERVICE	PERFORMANCE MEASURE/METHOD	MONITORING STANDARD	LIMITATIONS
Service components that may include: • A range of client-centered services that link clients with health care, psychosocial, and other 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) • Coordination and follow up of medical treatments • Ongoing assessment of the client's and other key family members' needs and personal support systems • Treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments • Client-specific advocacy and/or review of utilization of services	Documentation in the program and client records of case management services and encounters, including: • Types of services provided • Types of encounters/communication • Duration and frequency of the encounters Documentation in client records of services provided, such as: • Client-centered services that link clients with health care, psychosocial, and other services and assist them to access other public and private programs for which they may be eligible • Coordination and follow up of medical treatments • Ongoing assessment of client's and other key family members' needs and personal support systems • Treatment adherence counseling • Client-specific advocacy	Maintain client charts that include the required elements for compliance with contractual and Ryan White programmatic requirements, including required case management activities and such as services and activities, the type of contact, and the duration and frequency of the encounter	

IV. MCM SERVICE COMPONENTS

Program outcome:

- 80% of clients will maintain Medical Care after accessing Case Management services as reported every 6 months 80% of clients retained in HIV medical care
- 90% of clients virally suppressed.

Indicators:

- Case/Care plan details client's short and long-term goals with associated tasks to achieve them. Case/care plan is updated every 6 months.
- Clients are successfully linked to Primary Medical Care as evidenced by initial visit and then documentation of visit every 6 months.
- The number of client charts with accurate risk/exposure group via documentation of updated risk factors twice a year.

Service Unit(s): Face to Face Clinic (Office); Visit or Face to Face (Home);

1. Administration Core MCM	Source of Data	Outcome Measure & Goal	Numerator/Denominator
1.1 All provider agencies who offer medical case management services must have a client record system that collects and maintains information about client demographics, assessments, services plans, treatment/ services provided, client response to services, updates, treatment goals, etc., that conforms to the information required by the funding Part.	Agency system	100% of agencies have a comprehensive client record system that meet requirements for each Part.	**Numerator:** # agencies with a client record system **Denominator:** # agencies funded by Part A
1.2 Contents of the client record shall be protected within the parameters of State and federal laws. Record retention expectation is seven years.	Agency policies & procedures, Record Location	100% have client records in a secure location and retained for a minimum of 7 years.	**Numerator:** # agencies with protected client records **Denominator:** # of agencies
1.3 Client's right to privacy will be safeguarded and respected in accordance with federal and state laws, including private interview area. Communication made on the client's behalf (including face- to-face information sharing) should safeguard the client's right to privacy Professional relationship with the client is evidenced by a signed rights and responsibilities of client as documented in the client file.	Client record, Conf. Form, R&R, ROI, Policies & procedures	100% of signed HIPAA compliant confidentiality form, client rights and responsibilities form, and client release of information form updated annually	**Numerator:** # client records with signed, updated confidentiality, R&R, and ROI forms updated annually **Denominator:** # of client records

1.4 *All Agencies shall maintain a grievance procedure, which provides for the objective review of client grievances and alleged violations of universal and service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so.*	Agency Policies & Procedures Grievance Log	Agency, federal and state policies & procedures on privacy are available to staff, client and routinely updated. 100% client grievances addressed, resolved and an action plan developed	**Numerator:** # client records with signed grievance procedure acknowledgements form updated annually **Denominator**: # of clients records **Numerator:** # of clients who file grievance **Denominator:** # of clients with addressed grievance with action plan
1.5 Define role expectations and tasks of the MCM with signed job descriptions clearly defining roles of staff members with HIPAA acknowledgement forms signed in MCM HR file.	Staff files	100% of job descriptions and confidentiality agreements are signed by staff	**Numerator:** # of agencies with signed HIPAA statements of all staff , signed job descriptions with clearly defined roles in staff HR files **Denominator:** # of staff by agency

2. MCM Roles & Responsibilities	**Source of Data**	**Outcome Measure & Goal**	**Numerator/Denominator**
2.1 Conduct an intake that includes all necessary information to link and retain RW eligible clients to care. This includes an initial assessment of needs, client strengths and deficits.	Client Record: Assessment	100% of client records contain initial client assessment	**Numerator:** # of records with initial client assessment **Denominator:** # of client records
2.2 Conduct ongoing care planning, including re-evaluation and updating as evidenced by an ongoing assessment of client's medical and psychosocial needs to the extent that the assessment supports access to and retention of care for the client.	Client Record: Assessment of medical and psychosocial needs	100% of client records contain eligibility & support services assessment access every 6 months	**Numerator**: # client records with eligibility & support services assessment every 6 months **Denominator:** All client records
2.3 Monitor client's progress to meeting established goals of care.	Client Record	100% of client records contain established goals and updated care plan and progress notes	**Numerator:** # of client records with goals and updated care plan and progress notes **Denominator:** All client records

2. MCM Roles & Responsibilities	Source of Data	Outcome Measure & Goal	Numerator/Denominator
2.4 Coordinate referrals and track linkages and outcomes of clients to other core medical and support services to support access to and retention in care.	Client Record: Referral log Progress notes	100% of clients needing referrals are successfully linked 100% of documented referrals in data base and/or progress notes	**Numerator:** # of clients successfully linked with referred services **Denominator:** All client referrals **Numerator:** # of client records with referrals **Denominator:** All client records
2.5 Actively participate in team meetings or case conferences (for clients) to sustain retention in care &/or to improve client quality of life as evidenced by updated information in the client chart.	Client Record, Conference/ Meeting notes	100% of MCMs document case conferences or team meeting participation	**Numerator:** # of MCMs with documented case conference/team meeting participation **Denominator**: # of MCMs
2.6 Participate in training as mandated by Parts A, B, C, D baseline for new MCMs and annually. See Training Components (7.0).	Staff file/ letter or certificate of attendance	100% of MCM participate in mandated training relegated by RW program	**Numerator:** # of staff files documenting mandated training **Denominator:** All staff files

3. Eligibility for and Assessment of Service Delivery Needs	Source of Data	Outcome Measure & Goal	Numerator/Denominator
3.1 The MCM determines financial eligibility for all services, which is equal to or below 300% Federal Poverty Level. This must be updated every 6 months. Medical Case Management services are exempt from this FPL requirement.	Client record: Eligibility Worksheet	100% of records contain financial eligibility documentation with updates every 6 months	**Numerator:** # records with financial eligibility and updates every 6 months **Denominator:** All records at agency
3.2 All Ryan White services not covered by Title XIX or another medical insurer must have documentation to indicate the service(s) provided are not allowable under the health plan.	Client record	100% of records show documentation of services not covered by other insurers	**Numerator:** # of records document services not covered by other insurers **Denominator:** All client records
3.3 The MCM must secure documentation of the client HIV status prior to providing services as evidenced by HIV antibody test, Western Blot, detectable viral load, or letter from a MD, PA, or APRN.	Client Record: HIV Antibody, Western Blot, Viral Load, Letter	100% of records show documentation of client's HIV status, updated every 3 months	**Numerator:** # of records with documentation of client HIV status **Denominator:** All client records
3.4 The medical case manager will conduct a face-to-face assessment of the client's needs, which will be documented in the client record and in Data collection system as applicable (CAREWare). The assessment must include: • Client demographics, eligibility documentation, client emergency contact information, insurance information if applicable, client's Primary medical provider, Last and next medical appointments, name and address of pharmacy, and HIV Status • Functional assessment of HIV knowledge/health literacy • Biopsychosocial assessment • Brief assessment of oral healthcare status, mental health screening, substance use screening, HIV medication adherence screening, and documentation of HIV medical treatment adherence (CD4/VL labs 3 months apart and/or 2 or more medical visits documented by either the Primary Medical provider[1] or the clients' HIV care provider)	Client Record	100% of records show documentation of face-to-face assessment as indicated	**Numerator:** # of records with documentation of assessment **Denominator:** All client records

[1] Primary medical provider visit MUST contain discussion of the HIV diagnosis to "count" in the 2 medical visits per measurement year; the HAB measure clearly indicates a prescribing provider as "…a healthcare professional who is certified in their jurisdiction to prescribe ARV therapy".

• Documented language proficiency and preference • Referrals to core and support services based on assessment needs • Documented barriers to accessing services (both real and perceived) • Assessment of clients housing status. • Health education/Risk reduction assessment.			
3.5 The assessment must be completed with the client as evidenced by documentation in the assessment form and a completed service (care) plan signed by the MCM and client	Client Record: Care Plan	100% of records have documentation of care plan review with the client	**Numerator:** # of records documenting completed care plan review **Denominator:** All client records
3.6 All clients who request or are referred for HIV medical case management services will be contacted within 2 business days after a referral has been received. Every effort should be made to meet with a client within 10 business days and complete the intake information	Client record	100% of clients are contacted within 2 days post referral 100% of clients are contacted within 10 business days to complete intake information	**Numerator:** # of clients contacted within 2 days post referral **Denominator:** # clients linked to MCM **Numerator:** # of clients who have complete intake 10 business days post referral **Denominator**: # clients linked to MCM

4. Care Plan	**Source of Data**	**Outcome Measure & Goal**	**Numerator/Denominator**
4.1 The MCM develops and coordinates a Care Plan with the client based on assessments,level with input from the client's healthcare team to ensure the identified medical and support service needs are addressed.	Client Record: Care Plan	100% of clients have a comprehensive Care Plan	**Numerator:** # of clients with Care Plan **Denominator:** All client records
4.2 MCMs ensure that all client needs are identified by assessments and prioritized so that the most important services for clients are made available as soon as possible.	Client Record	100% of client assessments are identified and prioritized	**Numerator:** # of assessments that identify and prioritize client needs **Denominator:** All client records
4.3 A Care Plan should be developed within 10 business days of the first face-to-face meeting with the client.	Client Record	100% of clients have a developed care plan with 10 business days of intake	**Numerator:** # of records with developed Care Plan within 10 business days of intake **Denominator:** All client records
4.4 Care Plan are reassessed every 4-6 months.	Client Record	100% of client records show Care Plan review of services every 4-6 months	**Numerator:** # of records documenting services review every 4-6 months **Denominator:** All client records
4.5 The Care Plan should be signed and dated by the MCM that developed the Plan and by the client. The client's signature confirms understanding of the Plan (lack of signature needs documented reason in the Progress Note)	Client Record	100% of care plans signed/dated by MCM and clients. Those not signed by client have documentation in progress note.	**Numerator:** # of care plans signed/dated by MCM and client **Denominator:** All care plans

5. Progress Notes	**Source of Data**	**Outcome Measure & Goal**	**Numerator/Denominator**
5.1 A progress note must be completed on a client no less than every 3 months if stable (includes adherence and medical progress), and/or at least monthly as needed.	Client Record: Progress Notes	100% of client records will have progress notes updated every 2-3 months and/or at least monthly as needed.	**Numerator:** # of client records with progress notes updated every 2-3 months **Denominator:** All client records
5.2 The MCM must document in client records the progress on meeting the goals addressed in the Care Plan.	Client Record	100% of client records have documented client progress on stated goals	**Numerator:** # of client records with progress on meeting goals **Denominator:** All client records
5.3 The MCM completing progress note entry must sign his/her full legal name, title, credentials and date within 5 days after an interaction with the client.	Client Record	100% of progress notes completed within 5 days of client interaction containing name, title, credentials, and date	**Numerator** # of client records with progress notes containing name, title, credentials and date within 5 days of client interaction **Denominator:** All client records
5.4 The MCM document efforts to contact the client as needed (e.g., to update client information, reassess Care Plan, assess completion of referral, etc.)	Client Record	100% of client records have evidence of efforts to contact client	**Numerator:** # of client records with documented efforts to contact client **Denominator:** All client records
6. Training Components			
6.1 Medical Case Managers must receive minimum training requirements per Parts A, B, C, D .1 HIPAA .2 Managing HIV Disease .3 Core Medical Services .4 Client Assessments (including risk categories) .5 Enrollment & Eligibility .6 Cultural Competency (gender, language, sexual orientation, etc.) .7 Categories described in 3.4 (e.g., mental health, substance abuse, entitlements and legal issues, housing)	Agency Staff Records/ Training Manuals/ Record of Attendance	100% of medical case managers receive required training by Part.	**Numerator:** # of medical case managers receiving mandated training (by part) e.g., within 6 mos. or 1 year of hire **Denominator:** All case managers

3.4 Face-to-face Assessment Components include at a minimum:

- Last/Next Medical Appointment
- Name of Medical Provider
- Pharmacy
- Viral Load and CD4 results
- Support Systems including Religious Affiliations
- Strengths & Limitations
- Biopsychosocial Support Needs
- Barriers to Access & Retention in Care
- Functional HIV Knowledge/Health Literacy
- Need for Referrals to Core Medical/Support Services
- Access to Pharmaceuticals
- Correctional History
- Legal Issues
- Follow-up after Hospital Discharge
- Follow-up after Emergency Care
- Risk Reduction Counseling
- **Use Assessment:**
- Oral Health
- HIV Medication Adherence
- Mental Health
- Substance Use
- Nutritional Health
- Housing Assessment
- Primary Care & Health Maintenance (evidence of medical treatment compliance such as 2 medical visits with HIV care provider at least 3 months apart, and/or CD4/VL labs at least 3 months apart)

V. DATA REPORTING

Part A service providers are responsible for documenting and keeping accurate records of Ryan White Program Data/Client information, units of service, and client health outcomes.

Reporting units of service are a component of each agency's approved workplan. Please refer to the most current workplan, including any amendments, for guidance regarding units of service.

Summaries of service statistics by priority will be made available to the Planning Council by the Grantee for priority setting, resource allocation and evaluation purposes.