SERVICE CATEGORY DEFINITION

Medical Case Management (MCM):

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

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.

PERSONNEL QUALIFICATIONS

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.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

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.

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, as necessary

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

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

Program outcome:

- 80% of clients will maintain Medical Care after accessing Case Management services as reported every 6 months % of clients entering care
- 80% of clients retained in care
- 80% 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)

SERVICE STANDARDS, MEASURES, AND GOALS

	Standard	Measure	Goal
1.	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.	Job descriptions and confidentiality agreements are signed by staff	100%
	MCM ROLES AND RESPONSIBILITES:		
2.	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 records contain initial client assessment	100%
3.	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. Professional relationship with the client is evidenced by a signed rights and responsibilities of client as documented in the client file.	Client records contain confirmation of clients' accessing medical care at least every 6 months and client records contain eligibility & support services assessment access every 6 months	100%
4.	Monitor client's progress to meeting established goals of care.	Client records contain established goals and updated care plan and progress notes	100%

5.	Coordinate referrals and track linkages and outcomes of clients to other core medical and support services to support access to and retention in care.	Clients needing referrals are successfully linked and documented referrals are in data base and/or progress notes	100%
6.	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.	MCMs document case conferences or team meeting participation	100%
7.	Participate in training as mandated by Parts A, B, C, D baseline for new MCMs and annually. See Training Components	MCM participate in mandated training relegated by RW program.	100%
	ELIGIBILITY FOR AND ASSESSMENT OF SERVICE DELIVERY NEEDS		
8.	The MCM determines financial eligibility for services, which is equal to or below 300% Federal Poverty Level. This must be updated every 6 months	Records contain financial eligibility documentation with updates every 6 months	100%
9.	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.	Records show documentation of services not covered by other insurers	100%
10.	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.	Records show documentation of client's HIV status, updated every 3 months	100%

11.	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) • 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 situation. • Health education/Risk reduction assessment.	Records show documentation of face-to-face assessment as indicated	100%

12.	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	The assessment must be completed with t evidenced by documentation in the assessment form and a completed service (care) plan signed by the MCM and client	100%
	[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".		
	CARE PLAN		
13.	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.	Clients have a comprehensive Care Plan	100%
14.	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 assessments are identified and prioritized	100%
15.	A Care Plan should be developed within 10 business days of the first face-to-face meeting with the client.	Clients have a developed care plan with 10 business days of intake	100%
16.	Care Plan are reassessed every 4-6 months.	Client records show care plan review of Services every 4-6 months	100%

17.	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)	Care plans signed/dated by MCM clients. Those not signed by client documentation progress note.	100%
PROGRESS NOTES			
18.	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 records will have progress notes updated every 2-3 months and/or at least monthly as needed.	100%
19.	The MCM must document in client records the progress on meeting the goals addressed in the Care Plan.	Client records have documented client progress on stated goals	100%
20.	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.	Progress notes completed within 5 days of client interaction containing name, title, credentials, and date	100%
21.	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 records have evidence of efforts to contact client	100%
TRAINING COMPONENTS			

22.	Medical Case Managers must receive minimum training requirements per Parts A, B, C, D • HIPAA • Managing HIV Disease • Core Medical Services • Client Assessments (including risk categories) • Enrollment & Eligibility • Cultural Competency (gender, language, sexual orientation, etc.) • Categories described in 3.4 (e.g., mental health, substance abuse, entitlements and legal issues, housing) information, reassess Care Plan, assess completion of referral, etc.)	Medical case managers receive required training by Part.	100%

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
- 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)

CLIENT RECORDS, RIGHTS AND RESPONSIBLITIES, PRIVACY AND CONFIDENTIALITY

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. 100% of signed HIPAA compliant confidentiality form, client rights and responsibilities form, and client release of information form updated annually. Contents of the client record shall be protected within the parameters of State and federal laws. Record retention expectation is seven years. 100% have client records in a secure location and retained for a minimum of 7 years. 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. 100% of agencies have a comprehensive client record system that meet requirements for each Part.

CLIENT GRIEVANCE PROCESS

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, 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.

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.