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# SERVICE STANDARDS FOR Medical Case Management (MCM)

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*In addition to the Universal Standards, you are also expected to follow the following guidelines.*

## I. GOAL

The goal of medical case management is to assist People Living with HIV/AIDS (PLWHA) access primary medical care and medications, identify and remove barriers to medical care, and ensure adherence to a prescribed treatment plan.

## II. DESCRIPTION

Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities provided under this service category may be provided by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- 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 treatments
- Client-specific advocacy and/or review of utilization of services

In addition to providing the medically oriented activities above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

## III. KEY SERVICE COMPONENTS AND ACTIVITIES

Primary Activity - To link an HIV-positive individual to primary medical care as soon as possible. Activities include:

- Assistance and support with applying, accessing, and, adhering to core medical services.
- Assistance in enrolling in entitlement programs including the Patient Protection and Affordable Care Act (ACA), the AIDS Drug Distribution Program (ADDP), Pharmaceutical Manufacturers Patient Assistance programs, SSDI, SSI, Medicaid and Medicare assistance in accessing Primary Medical Care, Mental Health Services, Substance Abuse Treatment, Oral Health Care, Medical Nutritional Services and other Core medical services.
- Assistance in accessing medical transportation.

Secondary activities may be needed for HIV positive individuals to achieve their medical outcomes. These activities must have a direct relationship to an individual's HIV clinical outcomes. Activities include providing assistance, or referring for assistance, to apply for/access support services such as housing, food and meal programs, and HIV related legal services.

Grantees and their sub-recipients are expected to vigorously pursue enrollment into health care coverage for which their clients may be eligible (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or other private health insurance) to extend finite RWHAP grant resources to new clients and/or needed services. Grantees and sub-recipients must assure that individual clients are enrolled in health care coverage whenever possible or applicable and are informed about the ACA and the consequences for not enrolling. Please note that the RWHAP will continue to be the payer of last resort and will continue to provide those RWHAP services not covered, or partially covered, by public or private health insurance plans. (See HRSA Policy notice 13-03 Ryan White HIV/AIDS Program Client Eligibility Determinations: Considerations Post-Implementation of the Affordable Care Act)

## IV. INDICATORS/PERFORMANCE MEASURES

- Documentation of appointments scheduled and follow-up of missed appointments. The criteria should be that 80% of the appointments were kept.
- Documentation of adherence with medical care plan
- Documentation of client's adherence with required laboratory tests (CD4, Viral Load and annual laboratory tests/screenings)
- Documentation of chart review prior to each primary medical appointment
- Documentation of referrals for core and support services
- Documentation of internal case conferencing and/or administrative review
- Documentation in the clients' chart that a client is on a HAART regimen or that a HAART regimen has not been prescribed by the client's primary provider.
- A minimum of one (1) Treatment Adherence assessment/contact in the previous three to six (3-6) months

## V. SERVICE LIMITATIONS:

None

## VI. ASSESSMENT AND SERVICE PLAN

**A. Comprehensive Bio-psychosocial/medical assessment**. – The client's needs, strengths and resources are assessed, documented and summarized. This assessment should be completed within five (5) working days of initial contact. The following documentation/information is to be included:

1. Demographic information, if not completed at initial intake
2. Sex assigned at birth or gender identity

3. Date of birth/race/ethnicity
4. Information about significant other/partner/minor children
5. Information with regard to partner notification (state procedure)
6. Name and contact information about person authorized to sign for client, if necessary
7. Agency(s) where client has received services or is currently receiving services
8. Summary of medical and behavioral health history and respective treatments
9. Legal history, including current probation/parole status, if applicable
10. Assessment of risk behavior and risk reduction behavior
11. Housing/Living situation
12. Debt and money management issues
13. Employment issues (current employment/ ability to be employed)
14. Family/social support system
15. Contact information for primary care provider, dentist, pharmacy
16. Current medications (including dosages, nutritional supplements and complementary therapies)
17. Physical and social barriers to services
18. Identification of barriers to accessing medical care
19. Transportation needs
20. Present benefits/entitlements
21. Mental Health screening
22. Substance Abuse screening, including tobacco use
23. Oral Health screening
24. Nutritional screening
25. Assess HIV suppression, and steps to improve adherence, if needed

**B. Development of a comprehensive individualized care plan**

1. Set realistic, measurable and mutually acceptable goals based on bio/psychosocial/medical assessment
2. Identify actions needed to attain each goal
3. Identify timelines for achieving goals
4. Describe how outcomes will be measured
5. Develop a treatment adherence plan

**C. Implementation of an individualized care plan**

1. Schedule appointment for medical visit
2. Schedule appointment for lab tests
3. Referral for Core Services in CHAMP
4. Contact provider(s) to set up appointment(s)
5. Referral for Support Services in CHAMP
6. Contact provider(s) to set up appointment(s)
7. Arrange for transportation, if required
8. Follow up to remind client of appointment(s)
9. Reschedule missed appointment(s)

**D. Monitor client to assess the efficiency of care plan**

1. Maintain contact with client in the manner client prefers. Depending on client need; this contact should be a minimum of every three (3) months
2. Discuss treatment adherence issues experienced by client
3. Address emergency situations as they arise
4. Adjust Care Plan, if necessary

5. Utilize CHAMP to reduce duplication of services
6. Follow up to make sure diagnostic/medical and sub-specialty appointments are kept
7. Review client file and test results before medical visit
8. Meet with client after medical visit to make sure that he/she understands instructions/medications
9. Internal Case Conference including medical case manager and primary clinician at least every 6 months (following medical visit and/or annual screening tests)
10. A medically stable HIV patient should be seen by a clinician every 6 months or as directed by the clinician

### E. Reassessment of Care Plan

1. Review original medical care plan and progress notes with the client at a minimum of every six (6) months.
2. Evaluate the appropriateness and effectiveness of the medical plan.
3. Update personal data if necessary.
4. Identify significant changes in the client's clinical, psychological, or functional status.
5. Review entitlements.
6. Obtain signed initial and updated individualized treatment plans.
7. Update progress notes detailing each contact with, or on behalf of, the client. These notes should include date of contact and name of person providing the service.
8. Obtain signed "Consent to release information" form. This form must be specific and time limited.
9. Document any emergent medical or psychiatric emergency room visit or hospitalization
10. Identify goals that have been reached within the established timeframes.
11. Assess whether barriers to medical care have been addressed/removed/improved and document.
12. Asses adherence to primary care visits
13. Assess treatment adherence
14. Update individualized care plan, as necessary.
15. Case Closure/Discharge/ Case Transfer - see Universal Service Standard

### DOCUMENTATION

Written documentation is kept for each client, which includes:

1. Client's name and unique identifier number
2. Name and contact info of client's Medical Case Manager
3. Proof of HIV+ status
4. Printout of CHAMP Referral Ticket
5. Initial needs assessment
6. Signed initialed and updated individualized care plan
7. Evidence of consent for services
8. Progress notes detailing each contact with or on behalf of the client - these notes should include date of contact and names of person providing the service
9. Evidence of the client's understanding of his/her rights and responsibilities
10. Signed "Consent to release information" form - this form must be specific and time limited
11. Status of client if they are no longer receiving services

## VII. ENGAGEMENT AND RETENTION OF CLIENTS

Please refer to Universal Service Standards

## VIII. PERSONNEL QUALIFICATIONS AND TRAINING

*Either medically credentialed professionals or other health care provider who are part of the clinical care team.*

Qualifications/Training

1. Education: Minimum of Associate's degree, BS/BA preferred, in health or human services-related field (preferred) or 5 years of medically-related experience.
2. HIV experience/training preferred.
3. Medical Case Manager must complete the Ryan White Medical Case Management Certification program.
4. Ongoing education/training of a minimum of six (6) hours per year in related subjects.
5. The agency will provide new hires with training regarding confidentiality, stigma, health education and risk reduction, health literacy, client rights, and the agency's grievance procedure.
6. The agency will conduct an annual staff evaluation/review.

## IX. Program Guidance [HIV/AIDS Bureau Policy 16-02]

Activities provided under the Medical Case Management service category have as their objective improving health care outcomes whereas those provided under the Non-Medical Case Management service category have as their objective providing guidance and assistance in improving access to needed services.

Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.