HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

Subject: Medical Case Management Service Standards for Persons Living with HIV/AIDS

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Reference: Ryan White CARE Act Part A Manual SEC. 1. Action taken by the Affected Communities Committee on May 29, 2001; the Executive Committee on June 19, 2001 and July 13, 2001; and the HIV Health Services Planning Council on July 25, 2001.

Policy: This document details the standards of medical case management required to be carried out by service providers funded by the Sacramento TGA's Ryan White CARE Program. These standards are to be applied in conjunction with other service standards for medical, psychosocial and support care for Ryan White eligible clients as developed and approved by the HIV Health Services Planning Council.

PURPOSE OF MEDICAL CASE MANAGEMENT

The Health Resources Services Administration (HRSA) defines medical case management as:

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 may be delivered 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).

Required Care Objectives include:

- First appointment within 10 days of referral to screen for eligibility (if needed) and assign a medical case manager;

- Initial assessment of the client's service needs within 30 days of the first visit;
- Development of a comprehensive, individualized care plan at the initial assessment, including client-centered goals and milestones;
- Timely and coordinated access to medically appropriate levels of healthcare and support services based on clinical and acuity status of the client;
- Routine client monitoring to determine the efficacy of the care plan;
- Re-evaluation of the care plan with the client at least every 6 months with revisions and adjustments as necessary;
- Ongoing assessment of the client's and other key family members' needs and personal support systems;
- Treatment adherence counseling to ensure that the client is ready for and adheres to HIV treatments;
- Client-specific advocacy and/or review of service utilization as appropriate; and
- Benefits counseling whereby staff assist eligible clients in obtaining access to other public and private programs for which they may be eligible including but not limited to; Medi-Cal, Medicare Part D, AIDS Drug Assistance Program (ADAP), Health Insurance Premium Payment (HIPP), Disability Insurance, Social Security, pharmaceutical manufacturers' patient assistance programs, Covered California, Housing Opportunities for Persons with AIDS (HOPWA), and/or other state or local health care and supportive services.

PRINCIPLES OF MEDICAL CASE MANAGEMENT

Medical case management is carried out in a manner that is:

- Participatory in that the medical case manager will engage the client in informed decision making to establish a client-optimized individual plan of care.

- Empowering to clients in developing constructive lifestyles and life choices that will facilitate routine medical care by eliminating barriers to care or other factors that impede optimal function of the client.

- Goal-oriented in the development of the client care plan in order to assess progress and effectiveness of medical case management.

- Flexible in response to the client's immediate, emerging, or otherwise changing needs.

- Culturally proficient in terms and contexts that are understandable and account for the client's personal situation/environment.

- Efficient in design for the purpose of optimizing client specific services based upon need.

- Cost-effective by facilitating the use of resources that will effectively prevent the client from having to access more expensive alternatives.

- Accessible through planned multiple access regardless of gender, age, sexual orientation, ethnicity, religion, educational level, language, criminal history, substance use history, or ability to pay for services.

- Proactive in will anticipatory referrals to provider services and other supportive resources that most closely match client needs.

FUNCTIONS OF MEDICAL CASE MANAGEMENT

Primary objective is to improve health care outcomes for clients afflicted with HIV or associated conditions.

Required objectives:

- Offer accurate and current information to the client;

- Assist the client in understanding the implications of the issues facing them, and of the possible outcomes and consequences of decisions;

- Present options to the client from which he/she may select a course of action;

- Offer opinion and direction when it is asked for, or when to withhold it would place the client or someone else at risk for harm; and

- Be available to support and problem solve and to not judge the client in the present or future based upon their decision(s) of the past;

- Gather and evaluate information from the client;

- In participation with the client, create a care plan that addresses basic living needs, medical treatment and compliance issues, and other

appropriate social service needs;

- Promote coordinate and collaborative communication between clients and all persons involved in the client's care.

- Educate the client on available resources and assist them in accessing those resources.

- Reinforce treatment adherence counseling to ensure readiness for the complex HIV/AIDS regiments, coordination of service and monitoring plan.

EDUCATION REQUIREMENTS FOR DESIGNATIONAS MEDICAL CASE MANAGER

Minimum Qualifications

Possession of any health or human services bachelor's degree from an accredited college or university in social work, counseling, psychology, gerontology or licensing/certification as a Nurse Practitioner (NP), Physician Assistant, Public Health Nurse, Registered Nurse or Clinical Pharmacist.

Experience in specialty case management meeting the criteria described below may be substituted for credentialing.

- Full time work in case management activities with direct consumer interaction for a period of no less than three (3) years under the supervision of a health or human services professional

- Individuals without active credentialing or license in their field must receive clinical oversight and supervision by a licensed clinician monthly or more frequently as appropriate.

Training

All staff designated as a Medical Case Manager and those staff providing affiliate case management services must complete an initial training session specific to providing and coordinating service to HIV afflicted individuals Training is be completed within 60 days of hire covering at minimum the following topics:

- General HIV knowledge, such as transmission, care, and prevention
- Privacy requirements and HIPAA regulations

- Navigation of the local HIV system of care including ADAP and HOPWA
- Basic case management skills
- Regional health and human services availability within the TGA
- Trauma Informed Care
- Optional topics may include Motivational Interviewing

The above required training does not preclude a contracted Ryan White employer from determining or otherwise administering additional employer-based training to the provider's work force as appropriate and necessary or attendance at ongoing Medical Case Management training opportunities organized by the Recipient.

MEDICAL CASE MANAGEMENT PROCESS

Medical Case Management must be delivered in a manner that mitigates barriers to accessing effective care while maximizing available resources to support positive health outcomes for enrolled or potential clients. All Medical Case Management services must include, the functions identified in the Purpose of Medical Case Management Required Care Objectives found in this document.

Process standards are identified and addressed in the following areas:

- Intake
- Assessment
- Reassessment
- Care Plan Development
- Care Plan Implementation
- Care Plan Follow-up and Monitoring
- Transfer and Discharge
- Evaluation of Client Satisfaction

Intake

All Medical Case Management services shall be provided in a culturally and/or linguistically competent manner, which is respectful to the client's cultural health beliefs, practices and preferred language.

Each prospective client who requests or is referred for medical case management services will be evaluated through a face-to-face interaction designed to gather information for immediate and future service needs and facilitate informed client decision-making. The service request/referral will

be screened for basic admission criteria and assesses whether the client is in a crisis situation and/or requires immediate direct service referral. If immediate intervention is needed, a referral will be expedited to an appropriate entity.

Required intake activity processes are outlined below:

- the Ryan White Program Intake form will be completed in its entirety
- the client will be assessed with an Acuity scale which will be dated and signed by the medical case manager. The acuity scale will be updated every six months for medical case management clients
- the client's Informed Consent to Participate in the medical case management program shall be obtained
- the client will be informed of their right to confidentiality and information privacy procedures
- the client will be informed of the Release of Information Form, and will be asked to provide consent to the appropriate release of information to other pertinent entities
- release of information form must be updated annually.
- the client will be informed of, and agree to the Client's Rights and Responsibilities form
- the client will be informed of the agencies' as well as the Ryan White Program's Grievance Procedure
- the client will be informed of the role and purpose of medical case management
- anticipating basic eligibility, the client may proceed to formal assessment, or be referred to another case management agency (if the client would be better served based upon their particular need for medical or non-medical case management services)
- create a client file and archive all relevant documents and forms

Eligibility

Eligibility requirements for Ryan White services can be found in SSC 05 – Eligibility and Fees for Ryan White Part A/B Services. Clients who are receiving Targeted Case Management through the county (a Medi-Cal services) are still eligible for Non-Medical Case Management from the Ryan White Program as the Targeted Case Management services do not meet the minimum standards of Non-Medical Case Management as defined in this standard. It is recommended that the Ryan White funded case manager coordinate services with the Targeted Case Management case manager to avoid duplication of efforts and confusion for the client.

Assessment

Required assessment process and criteria:

- initial Medical Case Management face-to-face appointments must occur no later than 10 calendar days from the date of referral
- service agency must have in place a process to ensure timely follow-up of no show clients preferably within 24hours
- clients ineligible for Medical Case Management must be referred to an appropriate alternate support service through a warm hand off process
- the Medical Case Manager must complete an in-person psychosocial needs assessment within 30 days of the start of Medical Case Management
- assessment base line will encompass client functional status, strength/weaknesses inventory, stressor points and available resources and future resource needs
- every attempt should be made to develop a complete history for the purpose of care planning recognizing that the client has the right to refuse disclosure and may request deferment of certain information gathering

Assessment content should address:

- Primary care connection;
- Connection with other care providers (e.g. dentist, specialists, key social services)
- Current health status / medical history, including last and next medical appointment, most recent CD4 and VL, and any reasons for terminating care (if applicable);
- Oral health and vision needs
- Current medications / adherence;
- Immediate health concerns;
- Substance use history;
- Mental health / psychiatric history;
- Level of HIV health literacy;
- Awareness of safer sex practices;
- Sexual orientation and gender identity;
- Sexual history;
- Treatment adherence history, including assessment of ability to be retained in care;
- Self-management skills and history;
- Prevention and risk reduction issues;
- History of incarceration
- Family composition;
- Living situation;
- Languages spoken;
- History and risk of abuse, neglect, and exploitation;
- Social community supports;
- Transportation needs;
- Legal issues
- Financial / program entitlement;
- Emergency financial assistance needs and history;
- Nutritional status assessment;
- Partner Services needs;
- Cultural issues, including ethnic, spiritual, etc.; and,
- Summary of unmet needs.

CARE PLAN DEVELOPMENT AND IMPLEMENTATION

Required process and components of care plan formulation:

- development is based on an approved acuity scale
- includes any CD4 count and/or viral load tests during the measurement year
- all medical provider visits will be documented as part of the care plan progress note and those visits client self-reported will be verified by the medical case manager inclusive of date through direct contact with the provider, transcript of case conference notes or other corroborating documentation as appropriate.
- individualized holistic with emphasis on medical needs
- includes realistic, measurable goals that are time framed and consistent with ongoing inter-professional assessment
- intervention responsibility is identified be it provider, vendor, facility or service
- is participatory with the client and reflects client concurrence with initial plan and all updates thereafter
- multiagency or inter-professional collaboration is identified and coordinated
- care plan is documented in an approved format that can be of varying medium i.e., paper chart, EMR, ARIES etc.
- care plan is authenticated by both client and medical case manager by date and signature upon initial implementation and minimally every 6 months or upon each update (change) thereafter
- periodic reassessment is expected to detect changes in health status of the client but in no case shall reassessment extend beyond a 6 month period within the measurement year
- regardless of periodic reassessment the required measurement year 6 month interval reassessment will be comprehensive encompassing all parameters required during the initial medical case management assessment and will be documented as such

- **care plan must be updated, at a minimum, every six months during the measurement year**, unless the client initiated services within six months prior to the end of the measurement year (example: The Sacramento TGA fiscal year is March through February. If a client entered services in December, only the initial care plan would be feasible during the measurement year of March – February)

- Case conferencing required components

    - formal case conferences must be held at least once per quarter for all clients to coordinate care among providers from different services, fields, and disciplines

    - case conferencing should be done through a formal meeting with a multidisciplinary team that is appropriate to the needs of the client.

    - for clients experiencing significant changes or unexpected absence from care, more frequent case conferences may be necessary

    - during case conferencing, a review of the care plan and an evaluation of the services the client is receiving should be performed, as well as discussion of the client's current status (coordinating care, troubleshooting problems with maintaining the client in care, strategies to re-engage client in care, etc.)

    - the client and/or their legal representative must be given the opportunity to provide input to the Medical Case Manager about their care plan for discussion at the case conference

    - appropriate documentation must also be kept in the client chart or record including: names and titles of those attending the case conference, key information discussed, and whether the client or legal representative had input into the conference and the outcomes

- Treatment adherence counseling requirements

    - monitor client treatment employing client self-report, pill counts, electronic pill bottle caps, diaries, adherence watches and other reminder systems, lab reports, etc.

- determine who has the primary responsibility for giving medication, and shall provide HIV and adherence education to family members or caregivers as applicable

- refer clients to additional treatment adherence services as needed

- assess for barriers to adherence in each case (housing instability, alcohol and drug use, mental health issues, financial factors, attitudes toward medicines, etc.)

- communicate any adherence barriers to the client's medical care providers and work to address the barriers, updating the care plan as needed

- monitor laboratory values as appropriate

The medical case manager shall document all medical visits including any CD4 count and/or viral load tests during the measurement year.

QUALITY ASSURANCE AND SUPERVISION

All agencies providing Medical Case Management must have a quality assurance plan in place describing a supervisory review to critique documentation of client needs and if those needs were addressed.

Required Standards:

- a representative sample of at least 10 percent of charts of active Medical Case Management clients must have a supervisor review annually

- all clients who are discharged from Medical Case Management must also have a supervisor review within 3 months of that discharge

- reviews must be documented in the client chart with supervisor signature, date of review, and associated findings

- the review process must be conducted by a licensed provider

- in lieu of an internal licensed provider the agency must have in place a process in which an external licensed provider is utilized for the required review

- Provider reviewers may not perform a review of their own clients' chart(s).

CASELOAD

Medical Case Managers are expected to main a caseload of between 40 and 65 clients per 1.0 full time employee (FTE) at any given time depending on the acuity of clients.

Monitoring

Caseload – Agencies must submit their written policies and procedures for caseload review and redistribution when warranted, to adhere to caseload standards.

DOCUMENTATION STANDARDS

Client Record:

- all Medical Case Management activities, including but not limited to all contacts and attempted contacts with or on behalf of clients and coordination with referral agencies, must be recorded in the client record within 48 hours and entered into ARIES within two (2) weeks as appropriate.

- all documentation of activities must be legible, signed, and dated by the Medical Case Manager or authenticated in the an electronic manner consistent with an electronic health record or other record system

Memoranda of Understanding (MOUs), Releases of Information, or other standardized agreements may be necessary to ensure participation in the multidisciplinary team by all necessary staff.

Monitor Treatment Adherence: Lab reports, particularly viral suppression status, are an integral part of understanding a client's adherence to medications and medical care. The Medical Case Manager must determine which method(s) may be helpful for a particular client.

TRANSFER AND DISCHARGE

The agency shall maintain a systematic process addressing transfer of the client to another program or medical case manager.

Conditions for appropriate transfer, discharge or case closure include:

- client achieves self sufficiency
- loss of financial eligibility
- client and/or client's legal guardian requests that the case be closed
- client is found not to be HIV+
- client relocates outside of service area
- client lost to follow-up defined as a minimum of three (3) good faith attempts within a 90-day period to contact the client, with no response from the client or his/her representative
- client refuses to participate in care planning, engagement in required responsibilities or exercise of reasonable self-care management
- falsification of required information/documentation
- client behavior patterns that are threatening, abusive or disrupting to the effective, safe and reasonable provision of service or create eminent potential harm to agency personnel

Standards for client transfer, discharge or closure include:

- matters related to transfer, discharge or closure are discussed through in-person interaction with the client or client's representative
- circumstances necessitating service termination outside of routine transfer, discharge or closure require consultation and concurrence with appropriate agency management
- involuntary termination of service requires implementation of an established agency protocol that minimally includes the following components
    - client notification process and complete with timelines
    - notice of appeals process
    - exploration of alternative care that is coordinated with the receiving service
    - process for intermittent suspension of service

- documentation of the reason for transfer, discharge, or closure describes discussion with the client and options for other service provision when applicable (preferably face-to-face) and includes a service transition plan

GRIEVANCE PROCESS

Client conflict or care management disagreement resulting in medical case management services termination will be addressed through the agency's specific grievance procedure.

If a resolution is not mutually resolved between the client and agency, then the case will be reviewed by the Recipient and a written response sent to all parties involved (e.g. agency, client) within twenty (20) working days with a disposition. If an extension is needed, a letter shall notify all parties involved of an extension for an additional ten (10) working days. Final disposition shall occur no later than thirty (30) working days following the initial filing with the Recipient.

Adopted:  Date: 06/22/22

Richard Benavidez, Chair