Hartford Ryan White Part A Program
Medical Case Management Services Standard of Care

Important: Prior to reading service-specific standards, please read that HRSA/HAB National Monitoring Standards---Universal, HRSA/HAB National Monitoring Standard—Part A, and Universal Standards outlined in this document.

Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV/HCV care continuum. An interdisciplinary team that includes other specialty care providers may prescribe activities. These services can be access via the **traditionally** or a **triage** models. Where necessary the medical case manager can travel outside of their organization to provide services. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other form of communication). Key activities include.

- Initial assessment of service needs
- Development of a comprehensive, individualized service plan
- Coordination of services required to implement the plan
- Coordination a follow up of medical treatments
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptation as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support system
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV/HCV treatments
- Client-specific advocacy and/or review of utilization of services
- Provide benefits counseling to eligible clients (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Program, Pharmaceutical Manufacturer's Patient Assistance Program, other state or local health care and supportive services, and insurance plans through the health insurance marketplaces/exchanges)

Service components that may include:

- **Performance Measures:**
- Refer to summary of Clinical Performance Measures Part A and Hep-C

STANDARD	MEASURE
1. Staff Requirements	
• The minimum education requirement for medical case managers is a Registered Nurse(RN), **a Licensed Practical Nurse (LPN), Ba**chelor of Social Work (BSW), or other related health or human services degree from and accredited college or university *(Medical case managers who were hired prior to 2015 may substitute related direct client service experience under the supervision of a human services professional for a period of 2 years of full time work regardless of academic preparation)*	• A copy of the diploma/credential If medical case manager is hired prior to 2015 and does not meet the minimum education requirements, documentation of 2 years of related direct client service experience under supervision is required

• The minimum education requirement for medical case management supervisors is a Licensed Practical Nurse (LPN), Registered Nurse (RN), Bachelor of Social Work (BSW), or other related health or human service degree(s) from an accredited college or university. • All medical case managers must have completed the training for medical case management, including annual participation in HIV/HCV prevention and care related trainings and or meetings for a minimum of 10 hours for the fiscal year. • Direct supervisors of medical case managers must obtain the training for medical case managers, including annual participation of HIV/HCV prevention and care related trainings.	• A copy of diploma/credential • The training certifications/records for appropriated support • The training certifications/records for appropriate staff
2. Assessment –Traditional	
• All clients who request or are referred for HIV/HCV MCM services will be contacted within 2 business days* after a referral has been received. • A face– to- face assessment with a client must be made and the initial intake must be completed **within** ten (10) business days* of referral. **TREATMENT ADHERENCE**: Medication list and potential barriers to treatment adherence ***Circumstances that necessitate a deviation from this time frame must be documented in the client's progress note.**	• Documentation in client record of completed assessments forms, and signed and dated progress notes within (5) business days* • Documentation in CAREWare must be completed within (5) business days* from intake • Documentation of current list of medication dosages and frequencies • Documentation of barriers to treatment adherence
3. Care Plan	

• Medical case managers, in collaboration with their clients develop and implement the service plan that addresses client's medical and psychosocial needs **within** (10) business days of initial intake.
• The service plan
  ○ A description of the need(s)
  ○ Action steps to resolve the need(s)
	• Documentation in client records of completed service plan within specific timeframes
	• Completed and signed service plan form

○ Timeframes to resolve the need(s) ○ Documentation of who will complete action steps ○ Dated signature of the client and medical case manager	
4. Care Plan Monitoring	
• Conduct on going 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 in care for the client monthly.	• Documentation in client's record of care plan monitoring
• The medical case manager must maintain ongoing contact and follow-up with clients based on **acuity level** and care plan needs	• Documentation in client records of ongoing contact with medical providers and other referred service providers
• The medical case manager not in a medical setting must have attended at least one huddle/meeting with the client's medical provider within the year	• MOU between medical sites and community base organizations
• The medical case manager must maintain regular contact and follow-up with clients' core or supportive services provider	• Documentation of outcomes in client record
• The medical case manager must address clients' barriers to access necessary resources and achieving care plan goals on an ongoing basis	• Documented updates in client's progress notes addresses the needs indicated in the care plan.
• The medical case manager must provide ongoing education to clients on identified treatment adherence needs. At minimum, the medical case manager must address: ○ HIV/HCV 101 (including CD4 viral load and HCV Virology response) ○ Insurance and health system navigation ○ Medical care and treatment adherence (including readiness to start or continue HIV/HCV medications) ○ The medical case manager must review and update the care plan at minimum every 6 months or with any changes in acuity level.	• Documentation in client records of education sessions that include, at minimum, the identified topics • Updated documentation of medications Documentation of medication adherence supportive devices offered

5. Reassessment	
• The medical case manager must complete a reassessment every six (6) months (financial assessment should be completed annually unless the clients financial status changes within the fiscal year)	• Documentation in client record of a reassessment at specified timeframes
6. Documentation	
• The medical case manager must document any and all efforts to work with client and provide services, such that signed, dated progress notes and units of services align with CAREWare	• Documentation in client records of progress notes that correspond to the units of service
7. Discharge	
• The medical case manager must consult with supervisor to decide when a client is to be discharged • After a decision has been made to discharge client, the medical case manager must complete a discharge summary within 10 business days. • The medical case manager must ensure a discharge summary that includes: o Reason for discharge o Client-centered discharge plan o Referrals provided (i.e. EIS) o Notification of core medical and support services providers o Letter of discharge status sent to client o Dated signature of the medical case manager o The medical case management supervisor must review and sign the discharge summary	• Documentation in client records of discharge summary within specified timeframes • Completed and signed Discharge Summary form • Documentation in client records or discharge summary with relevant signatures

Performance Measures:

1. 90% of clients with an HIV/HCV+ diagnosis that received Medical Case Management Services who had at least one HIV medical care visit in each 12-month period of the 24-month measurement period

2. 90% of clients with an HIV/HCV+ diagnosis that received Medical Case Management services (including treatment adherence) whose last viral load in the measurement year is <200 copies/mL

3. 92% of clients with an HIV/HCV+ diagnosis that received Medical Case Management Services (including treatment adherence) who are prescribed ART in the 12-month measurement period

Service Unit(s) definitions:

Face-to-face encounters, phone consultation

CAREWare Data Reporting:

Part A services sub-recipient are responsible for documenting and keeping accurate records of Ryan white program data/client information, units of services, and client health outcome

Triage Medical Case Management

Is defined as the sorting of patients according to their urgency in need for care and or supportive services. In the Hartford TGA. This process will entail determining whether or not someone is in need of short term assistance, (triage) or ongoing, long term assistance and monitoring of medical condition as a consumer would receive in the medical case management system. Triage is to include no more than 90 days with an HIV+ client. Clients may be referred by agencies in the continuum of care, community agencies, or self-referred.

STANDARD	MEASURE
1. Area of Functioning: HIV Care Adherence	
• **Acuity Level Assessed**	• Acuity level is identified and HIV Care adherence scale is completed and in the client's record
2. Triage Service Assessment	
• **A Brief face-to-face assessment evaluating the client's level of psychosocial functioning, including but not limited to: history of the client's present condition, problem solving and coping skills, interpersonal efficacy, current resources and support systems, immediate needs, and possible obstacles to obtaining services.** • **CAREWare demographics tab must be completed of assessment, (substitute as intake).**	• Documentation of the brief client assessment needs form (**BCAN**) is completed and in client's record and signed and dated progress notes within (5) business days* • Documentation in CAREWare must be completed within (5) business days* from assessment.
3. Triage Care Plan Development	
• **Medical case managers, in collaboration with their clients develop and implement the service plan that addresses client's medical and psychosocial needs** • **The service plan** ○ **A description of the need(s)**	• Documentation in client records of completed service plan within 2 business days. • Completed and signed service plan form in client record.

○ **Action steps to resolve the need(s)** ○ **Timeframes to resolve the need(s)** ○ **Documentation of who will complete action steps** ○ **Dated signature of the client and medical case manager** ○ **The medical case manager must address clients' barriers to access necessary resources and achieving care plan goals on an ongoing basis**	• Documented outcomes in client's progress notes addresses the needs indicated in the care plan.
4. Documentation	
• **The medical case manager must document any and all efforts to work with client and provide services, such that signed, dated progress notes and units of services align with CAREWare**	• Documentation in client records of progress notes that correspond to the units of service
5. Discharge from Triage Services	
• **The medical case manager must ensure the discharge process is clearly explained to the client to includes:** ○ **Reason for discharge** ○ **Provide information on re-accessing services on a as needed basis**	• Documentation in client records or discharge summary

Performance Measure: 1. 90% of clients with an HIV/HCV+ diagnosis that received Medical Case Management services (including treatment adherence) whose last viral load in the measurement year is <200 copies/mL

2. 92% of clients with an HIV/HCV+ diagnosis that received Medical Case Management Services (including treatment adherence) who are prescribed ART in the 12-month measurement period