Medical Case Management - (including Treatment Adherence) Service Delivery Model

Approved by the Planning Council - 2-4-2010

SERVICE CATEGORY: MEDICAL CASE MANAGEMENT (INCLUDING TREATMENT ADHERENCE)

Goal: To facilitate access to and retention in Primary Medical Care and any indicated support services necessary to promote engagement and optimal utilization of PMC for individuals living with HIV/AIDS.

Service Definitiion: A range of client-centered services that links clients with health care, psychosocial and other services to ensure timely, coordinated access to medically appropriate levels of health and support services, continuity of care, ongoing assessment of the client's and other family members' needs and personal support systems, and inpatient Medical Case Management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropritate, from an inpatient facility. Key activities include (1) initial comprehensive assessment of the client's needs and personal support systems; (2) development of a comprehensive, individualized service plan; (3) coordination of the services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and revision of the plan as necessry over the life of the client. May include client-specific advocacy and/or review of utilization of services.

Medical Case Management embraces a medical focus on the clinical services of HIV primary care, and ensures that an HIV+ patient is enrolled into and is retained in HIV Primary Medical Care services. The Medical Case Manager ensures that the HIV+ patient receives associated services such as oral health, nutritional assessments, substance use and mental health interventions, treatment adherence support, and prevention education. In addition, Medical Case Management services must include initial comprehensive assessment of the clients' needs and personal support systems and enroll clients in all relevant federal, state, and local entitlement programs (e.g., Medicare, Medicaid, SSI, etc...) to ensure that Part A funding is used only as a payer of last resort. In the absence of a designated Case Manager, the Medical Case Managers will also necessarily coordinate referrals into social support services such as housing assistance and will confirm those social support referrals.

The level of Medical Case Management needed by individual clients is determined by the initial intake assessment. To the extent necessary based on the acuity of needs, Medical Case Management services includes the coordination of inpatient and outpatient care, referrals to specialists, follow-up referrals and missed appointments, and regular care conferencing between clinical care providers, community-based care providers, and interdisciplinary care teams.

The objectives of the Standards of Care for Medical Case Management are to ensure that:

- Services are available to all eligible consumers;
- Referrals for other services are made based on appropriateness and availability;
- Clients are enrolled in the continuum of care with an emphasis on continuous engagement and retention in PMC; and
- Medical Case Management services are recognized as an essential "core service" in the TGA.

Medical Case Management service providers are expected to comply with the Universal Standards of Care, as well as these additional standards. The service specific Standards of Care for Medical Case Management services provide additional requirements on the following components of service provision:

STANDARDS	INDICATOR	DATA SOURCE	MEASURES

STANDARDS	INDICATOR	DATA SOURCE	MEASURES
Agency employs/contracts with staff with the skills and experience appropriate to the provision of Medical Case Management services.	Medical Case Management staff and Supervisors will receive, at least, twelve (12) hours of HIV specific continuing education on a yearly basis One (1) hour of annual training on cultural diversity sensitivity for each Case Manager.	• Credentials and resume in employee's file. • Records of completion of continuing education in employee's file.	Percent of achievement.
Newly hired Medical Case Managers will have applicable skills and qualifications.	A Master's or Bachelor's degree in social work, counseling, human service or related discipline or RN; or a Master's or Bachelor's Degree in a Human Services **related** field and 2 years Medical Case Management experience. Applicable work experience. Completion of a four (4) hour introductory training on HIV and Medical Case Management within ninety (90) days of employment	• Credentials and resume in employee's file. • Records of completion of continuing education in employee's file.	Percent of achievement.
Newly hired or promoted Medical Case Manager Supervisors will have, at least, the minimum qualifications described above for Medical Case Managers plus two years of Medical Case Management experience or other experience relevant to the position (e.g. volunteer management experience).	A Master's or Bachelor's degree in social work, counseling, human service or related discipline or RN; or a Master's or Bachelor's Degree in non-Human Services field and 2 years Medical Case Management experience. Applicable work experience. 3.3 Completion of a four (4) hour introductory training on HIV and Medical Case Management within ninety (90) days of employment.	• Credentials and resume in employee's file. • Records of completion of continuing education in employee's file.	Percent of achievement.
4a. Agencies comply with the Virginia Department of Health HIV/AIDS Medical Case Management Standards and Guidelines,	Establish a baseline for uniform quality in HIV/AIDS Medical Cas e Management services. Assure accessibility and	• Adapted Virginia Department of Health HIV/AIDS Medical Case Management Standards.	Percent of achievement.

STANDARDS	INDICATOR	DATA SOURCE	MEASURES
(including definitions for supportive and comprehensive treatment) regarding placement of clients into level of Medical Case Management. 4b. Limited case management in Part A will be defined as: **Annual eligibility and referral to requested service.**	availability to Medical Case Management in all HIV/AIDS services.		
Services are made available to all individuals who meet program eligibility requirements.	Documented eligibility criteria on the referral form include the following: • HIV-positive. • Residence in the Norfolk TG A. • Income no greater than 300% of the Federal Poverty Level.	• Ryan White Eligibility Determination Form.	Percent of achievement.
Clients' eligibility will be reviewed annually.	Documentation of annual updat e in client's chart.	• Client chart.	Percent of achievement.
Each client will be given an overview of Ryan White Part A services.	Client chart will contain a signed form indicating that the client has received an overview of Ryan White services.	• Ryan White Part A Provider List of Services.	Percent of achievement.
8. Each client will be assessed to determine if he/she currently receives primary medical care and assisted with establishing linkages to primary medical care, if care is not currently received.	8.1 Medical Case Management shall coordinate a Primary Medical Care appointment for consenting client within one (1) week of client consent to be referred to medical care.	• Progress Notes. • Service Plan.	Percent of achievement.
9. MCM Client Record/Progress Notes evidence a medical focus, and include assessment of need for core medical and support services; HIV/AIDS status, updated lists of current medications, treatment adherence assessments/interventions, laboratory monitoring values and other medically relevant documentation, including dia gnosis of new OIs and other health	9.1 Documentation in the Progress Notes/Client Record includes all indicated items.	• Client Record	Percent of achievement

STANDARDS	INDICATOR	DATA SOURCE	MEASURES
10. Client progress will be monitored and documented according to the leve l of intensity of need for Medical Case Management and will be transitioned to a higher or lower intensity of Medic al Case Management services to reflect their acuity scale/service need level.	10.1 Documentation, both dated and signed by the Medical Case Manager, is maintained in the Progress Notes.	• Progress Notes	• Percent of achievement
11. Medical Case Management providers routinely coordinate all necessary services along the Continuum of Care to include other sources of Medical Case Management.	11.1 Coordination activities include frequent contact with other providers and Case Managers and are documented in the Client Contact Notes.	• Progress Notes.	Percent of achievement.
12. Agency has policy for client crisis intervention services that ensures all onsite emergencies are addressed immediately and effectively.	12.1. Administrative Policy and Procedure Manual addresses crisis intervention protocol for incidents that occur on site. 12.2. Program staff is trained on agency crisis policy and how to respond to crisis.	• Agency Policy and Procedure Manual.	Percent of achievement.

STANDARDS	INDICATOR	DATA SOURCE	MEASURES
13. If MCM cannot confirm client's maintenance and/or active participation in PMC and the MCM cannot successfully contact client to establish service activity, a referral to Outreach/Case Finding is appropriate. **MCM must demonstrate an attempt to contact client with a minimum of 3 client contacts (2 by telephone and 1 by letter, if possible)** (Applicable to Comprehensive and Supportive Services).	13.1 Documented lack of PMC participation in the client record, along with documented efforts to unsuccessfully reach/re-engage client. Confirmed referral to Outreach is documented in the client record. Example means to identify "at risk" or Out of Care: – "No-show" for PMC appointments. - Erratic appointment compliance – Confirmation or suspicion of active - Substance abuse and/or undertreated Mental Health issues; homelessness, or other existing issues that complicate one's opportunity to remain optimally in care. Example responses once client is identified "at risk" - 24 hour prior to appointment remind er phone calls. - Contact 'no-shows' within 48 hours following failure to appear to reschedule missed appointment (caveat: frequently changed phone #s/addresses) - Once client has missed appointment and contact is not verified to confirm why they missed, referral can be made to Targeted Outreach provider for services based on MCM assessment.	• Client Record • Progress Notes	
14. Upon termination of active Medical Case Management services, a client case is closed and contains a closure summary documenting the case disposition.	14.1. Closed cases include documentation stating the reason for closure and a closure summary. 14.2. Supervisor signs off on closure summary indicating approval.	• Client Progress. CAREWare data.	Percent of achievement.

Approved by the Planning Council - 2-4-2010