# Minnesota
# Department of Human Services
# And
# Hennepin County Ryan White Program

# HIV/AIDS
# Medical Case Management Standards

# September 2013

**Minnesota Department of Human Services And**
**Hennepin County Human Services & Public Health Ryan White Program**

# HIV/AIDS MEDICAL CASE MANAGEMENT (MCM) STANDARDS
# SEPTEMBER 2013

## INTRODUCTION

These standards exist to ensure that people with HIV have access to consistent, adequate services and that the public funds which purchase these services and other HIV care are effective and cost-efficient. Additionally, MCM is time limited and need based, with clearly defined roles and expectations for both clients and case managers.

The MCM system is designed to allow many agencies to provide this service, in the belief that different types of agencies will be better able to meet the needs of diverse populations. Standards ensure that within that diverse system, no matter which agency he or she chooses, a person with HIV will be assured of getting the same basic set of services and those services will be at or above a certain minimum level of quality. Agencies will still differ from one another in that each will enhance services in ways unique to their program, but all agencies will provide the same basic services. Another reason for there being standards is, in part, as a protection for persons living with HIV who are usually in a very vulnerable position when they seek case management services.

Finally, MCM is not a "stand-alone" service, in that it functions as a gateway to many other services. One role of MCM is to facilitate the effective and efficient use of all the resources in the care system. MCM standards exist, in part, to ensure that case management services are indeed integrated with the rest of the services system and that "management" function of the service is not short-changed.

It is important to remember that standards always describe a minimum level of service. Grantees do hope that agencies work to exceed the minimum standards through grantees providing training and necessary supervision to HIV MCM case managers. As always, those agencies which fund MCM services acknowledge and congratulate those agencies and individuals who have provided excellent MCM services to Minnesotans with HIV. We look forward to our continuing partnership in creating and sustaining an outstanding system for providing high quality, compassionate, vital services that support persons with HIV as they continue to live productive lives with dignity and hope.

**HIV/AIDS Programs**
**MN Department of Human Services**
**Hennepin County Human Services and**
**Public Health Department**
**Ryan White Program**
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# HIV/AIDS MEDICAL CASE MANAGEMENT STANDARDS
# SEPTEMBER 2013

## Background:

Medical Case Management (MCM) is the backbone of the HIV services delivery system and the primary way of ensuring that people with HIV access, receive, and stay in primary medical care. The HIV services system provides several types of coordination, referral, and follow-up services that eliminate barriers and help people with HIV get connected and stay in care. MCM is the piece of this system that assesses the primary and immediate needs of people with HIV, coordinates referrals, and follows-up with critical core medical and support services to ensure people with HIV remain in medical care.

In 2001, the first written standards for Case Management were produced by the Minnesota Department of Health, AIDS/STD Prevention Services Section, under the guidance of a task force of thirteen case managers from several agencies. In 2005 and 2010, the standards were updated by Minnesota Department of Human Services (DHS), Hennepin County Ryan White Program, and staff from medical case management programs. In 2010, the Minnesota HIV Services Planning Council's Community Voice Sub-committee was also engaged for input.

## HRSA, Ryan White Program, and the Department of Human Services Medical Case Management Services Definition

**Medical Case Management services** (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments.

Key activities include

(1) initial assessment of service needs;
(2) development of a comprehensive, individualized service plan;
(3) coordination of services required to implement the plan;
(4) client monitoring to assess the efficacy of the plan; and
(5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client.

It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. These 2013 Medical Case Management Standards reflect the changed expectations and adhere to HRSA's Medical Case Management definition.

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## SECTION ONE: ENROLLMENT AND INTAKE

Intake is a time to gather and provide basic information from the client with care and compassion. It is also a pivotal moment to establish trust, confidence, and rapport with client. If there is an indication that the client may be facing imminent loss of medication or other forms of medical crisis, the intake process should be expedited and appropriate intervention should take place prior to formal enrollment. Service providers will understand that persons living with HIV/AIDS who are not accessing or utilizing HIV primary medical care can still receive other supportive services if desired.

**Introducing Client to MCM -** The first steps of the intake process is to ensure the client understands what medical case management is and that the client is currently not receiving this service elsewhere. Explain the goals, objectives, and key activities of MCM outlined in the HRSA definition above. It is extremely important to provide mandated information and obtain required consents, releases, and disclosure – see below.

| Standard | Intervention | Measure | Data Source |
|---|---|---|---|
| **Introducing Client to Medical Case Management (MCM)** | | | |
| 1. Client understands what MCM is and his/her roles and responsibilities as well as the case manager's<br><br>2. Client is not currently receiving MCM with another provider | 1. Case Manager (CM) describes medical case management including these 7 components:<br>• Intake<br>• Mini Acuity Assessment and Acuity Scale<br>• Education<br>• Development of goals and objectives focusing on access and retention in care.<br>• Activities that are need based and in conjunction with the development and coordination of an individual service plan (ISP)<br>• Follow-up and monitoring of client progress, and<br>• Time limited with planning for individuals graduating to Self Management Tier or discharge<br><br>2. Verify that the client is currently not receiving this service elsewhere (if appropriate offer the option of changing providers by dis-enrolling and enrolling) The burden of obtaining documentation for the client lies with the new provider and involves a signed consent for services form, a completed assessment and a ISP, and an assigned case manager. | 1a. Client understands and wants MCM services as defined in the Consent to Receive MCM Services.<br><br>1b. Client wants and can receive MCM from the agency.<br><br>1c. Client goals are met and Acuity levels are improved<br><br>1d Clients with no further needs are discharged from MCM.<br><br>2. Client understand he/she may receive MCM services from one provider only. | 1a. A "consent to receive MCM services" form is signed by the client and kept in the client's file.<br><br>1b. Client goals and Acuity scores are documented in the ISP.<br><br>1c. Changes in Acuity tiers are documented in Acuity Scale<br><br>1d. CAREWare reports, acuity scale, and client chart.<br><br>2. A written "intent to switch providers" signed by the client is kept in the client's file at both the old and the new provider. |

**Identify culturally specific needs of clients –** Case managers should identify culturally specific needs of their client and to the greatest extent possible, ensure that case management services are provided in the preferred language of the client. Please note that it is best not to rely on children to interpret for family members. In accordance with Title VI of the Civil Rights Act of 1964, service providers will ensure that Limited English Proficiency (LEP) clients have access to services through the provision of timely, effective language assistance free of charge. Language assistance may be necessary to interpret and/or translate key documents, including, but not limited to, the consent for services; consent for release of medical and psychosocial information; bill of rights; service provider grievance policy; and any other similar documents that a provider might typically use in the provision of services to clients.

| Standard | Intervention | Measure | Data Source |
|---|---|---|---|
| **Culturally Specific Needs of Clients** | | | |
| 1. Client has access to appropriate interpretative services<br><br>2. Interpretive services are provided as needed<br><br>3. Policy and procedures for LEP exist and are reviewed<br><br>4. CM are trained on cultural competency | 1. Client Limited English Proficiency (LEP) needs are determined<br><br>2. Interpretive services, culturally appropriate referrals, translated materials, bilingual CM and CM trained in cultural competence will be available for all Ryan White eligible clients free of charge. If agency CM does not have the preferred language capability, use professional interpretation services or refer to agency that has the preferred language capability<br><br>3. A current policy & procedure is established for providing professional interpreter services and translation at no cost for any client with Limited English Proficiency or hearing impairment<br><br>4. All CM are trained in cultural competence | 1. Clients with LEP are identified<br><br>2. Professional interpretive services are at all meetings with LEP clients<br><br>3. Annual review of policy and procedures<br><br>4. Staff provide culturally competent services to meet the needs of Ryan White eligible clients | 1 Client's need for interpretation is documented<br><br>2a. Interpretive services are noted in meeting summary<br>2b. A list of interpretation resources is posted or readily available to CM<br><br>3. A written, dated policy and procedure is in agency files<br><br>4. CM cultural competence is demonstrated through annual site visit interviews and training attendance is documented. Client's linguistics needs are documented. Referrals are made to another CM provider when client's cultural competency needs cannot be met. |

**Determine eligibility-** Hennepin County-administered case management is available to HIV+ people living in Minnesota or in Pierce County or St. Croix County, Wisconsin who meet the following eligibility criteria. DHS-administered case management is only available to HIV positive persons living in the state of Minnesota. Case managers should determine Ryan White eligibility requirements for HIV status and income (300% of federal poverty level). A person is only eligible to receive medical case management services from only one provider at a time.

| Standard | Intervention | Measure | Data Source |
|---|---|---|---|
| **Determine eligibility criteria, procedures, and documentation** | | | |
| 1. Policy and procedure to verify HIV serostatus and income | 1 All service providers are required to have in place a procedure for verifying a client's eligibility for services based upon HIV serostatus/ AIDS diagnosis, income, and residency. | 1. CM follow and understand RW and State eligibility requirements | 1. A written, dated policy and procedure is in agency files |
| 2. Client's eligibility for services is determined and documented | 2 A person with HIV must have an annual income at or below 300% FPG and have a need for services as evidenced in acuity assessments, service plans and client's chart. For Part A, client must reside in the 13 county metro area TGA (Transitional Grant Area). For Part B the client must be a Minnesota resident. | 2. Client with HIV meets financial and residency eligibilities. | 2a. The criteria for eligibility is documented in the client's record and is to be retained in a secure location for at least three years after the client has left the service. For DHS, this is six years.<br><br>2b. Verification of income and residency eligibilities must be re-evaluated every six months and placed in the record |

**Complete Required Enrollment Forms** – At the initiation of services, clients will be informed (written and verbal) of their rights at intake including:

***Confidentiality Universal Standard-*** Give all clients assurances regarding confidentiality of information given to service providers, confidentiality in the facility, including waiting rooms and interview rooms, confidentiality regarding medical communications, maintenance and security.

***Confidentiality rights***- A signed, current release of information form will be in the client's file before sharing confidential, identifiable client information with a third party.

***Duty to Warn-*** Client will be informed of the case manager's mandated reporting requirements. Information about "Duty to Warn", "Vulnerable Adults" and "Child Maltreatment" will be included in the informed consent form.

At intake, all clients receiving Ryan White-funded services in a non-clinic setting must be offered a copy of the standards for the specific service received (including the universal standards). All DHS funded programs should provide client with a copy of standards upon client's request. The following forms must be completed and, where noted, signed by the client, and recorded in CAREWare and/or retained in client's written files. Contact Contract Managers for template forms if needed.

| Standard | Intervention | Measure | Data Source |
|---|---|---|---|
| **Complete required enrollment forms** | | | |
| **Intake**:<br>1. Current demographic data for each client.<br><br>2. The mini acuity assessment will be completed during intake to identify issues that require immediate attention and establish frequency and intensity of engagement. | 1. Demographic information as defined in Form I of CAREWare is kept current and accurate.<br><br>2. Complete the mini acuity assessment to identify needs in these 10 areas that will place clients in intensive MCM:<br>• Homelessness<br>• Peri-incarceration<br>• Pregnancy without prenatal care<br>• CD4 count below 200 AND a viral load above 400<br>• New diagnosis of HIV<br>• Untreated mental illness<br>• New to antiretroviral therapy<br>• Not in care/re-engaging in care<br>• Non-adherence to HIV medication<br>• Chemical health/substance use | 1. Client demographic information is collected and reported.<br><br>2. MCM Intake should take place as soon as possible and within five business days of referral or initial client contact. If MCM intake is not completed within five business days, coordinate referral for client and notify contract manager. ISP will prioritize and address crises. | 1. Form I of CAREWare<br><br>2. Intake is signed, dated, and in client file. |
| **Informed Consent**:<br>1. Client consents to receive services and understands the goals, objectives, and key activities of MCM. | 1. The Informed Consent to Participate in Case Management form must describe the services offered by the service provider (including client responsibilities and case manager responsibilities and limitations). Client will also be informed of the case manager's mandated reporting requirements. Information about "Duty to Warn", "Vulnerable Adults" and "Child Maltreatment" will be included in the informed consent form. | 1. The informed consent form will be reviewed with clients, in their own language, signed and dated either by the client or a legal representative and will be retained in the client's file. The client will be given a copy of the signed consent form. | 1. A current, signed, Consent Form is in client's file |
| **Release of Information**:<br>1. To facilitate communication between providers and to ensure that clients are accessing care | 1. To coordinate referrals and follow-ups, the client record must contain a signed release of medical and psychosocial information before the CM can share confidential, identifiable client information with a third party. The release form must contain information for the client, including | 1. The Release of Information form has been reviewed with client, the date of coverage and who information can be released to identified, | 1. Signed and dated release of information form is in client files. Update the form annually. |

| Standard | Intervention | Measure | Data Source |
|---|---|---|---|
| | the kinds of information that will be shared and with whom the information will be shared. | and the form, signed and dated.<br>The client will receive a copy of the release form. | Client contacts documented in client record and in client's file/service plan |
| **PLWH/A Bill of Rights and/or Patient Bill of Rights**<br>1. All clients receiving Ryan White-funded services must be offered a copy | ***The PLWH/A Bill of rights covers:***<br>1. All clients have the right to be treated respectfully by MCM staff. Clients also have a mutual responsibility to work cooperatively and agreeably.<br>A Client's Rights and Responsibilities should:<br>• Ensure that client's decisions and needs drive the MCM process;<br>• Ensure a fair process of case review if the client believes he/she has been mistreated, poorly serviced or wrongly discharged from MCM services;<br>• Clarify the client's responsibilities which help facilitate communication and service delivery. | 1. The CM will go over the Bill of Rights with the client. Agencies must develop and post the client's bill of rights and responsibilities in a conspicuous location in the agency. The client must be offered a copy of the bill of rights and responsibilities at the time eligibility was determined. | 1. A signed, statement that client was explained and offered a copy of his/her Bill of Rights is in the client's file.<br>Posted Bill of Rights will be verified during annual site visits and/or audits. Need to adhere to agency's policies. |
| **Grievance Policy and Procedure**<br>1. A written, dated grievance policy and procedure<br>2. Every client receives and understands the grievance policy and procedure prior to receiving services<br>3. CM follow the policy when a grievance comes in | 1. Agencies have a written grievance policy and procedure.<br>2. Clients receive a written explanation of the agency's grievance policy and the procedure for registering a grievance with the funder(s) at the time of intake.<br>3. Reasonable time frames for responding to grievances, established in the written policy, are adhered to. A summary is written for every formally registered grievance and appeal. The summary will include a statement of the specifics of the case, the procedure which was followed, the participants in the procedure, actions taken, all relevant dates and the outcome of the process. | 1. Agencies have a written, dated grievance policy and procedure<br>2. CM explain the grievance policy and procedure to new clients who sign and date it<br>3. Service Provider respond to all grievances and informs grantee when a grievance occurs and the outcome | 1. A copy of the Agency's written grievance/ appeal process will be submitted to the State of Minnesota's or Hennepin County Ryan White Program designated representative within 3 months of contracting with the State of Minnesota or Hennepin County Ryan White Program. |

| Standard | Intervention | Measure | Data Source |
|---|---|---|---|
| | | | 2. A signed, dated copy of the explanation of the grievance policy and procedure will be kept in the client's file.<br><br>3a. Service provider sends grant manager a written notification when a grievance is filed<br><br>3b. Copies of these summaries will be retained for at least 5 years and will be available to the State upon request |
| 1. Provide client with Notice of Privacy Practices (NPP) | 1. Provide client information on data collection, reporting, confidentiality and secured date policy, and mandatory reporting requirements. | 1. Written NPP. May be included in consent form. | 1. Signed & Dated copy is in client files |

**The Mini Acuity Assessment (see Appendix __)**
**The Mini Acuity Assessment** is administered with every client as part of the initial intake to identify and address crisis needs. It can be a companion document for the Acuity Scale and provides information for the development of the individual service plan (ISP). If client reports suicidal or homicidal thoughts/intents, an **IMMEDIATE REFERRAL** is required.

**Conduct the MCM 2013 Acuity Scale (see Appendix __)**
The MCM 2013 Acuity Scale, developed as part of the HIV Medical Case Management Guidelines by the District of Columbia in 2010, is replacing the two tools (the Comprehensive Assessments and the Acuity Scale). There are 4 tiers in this Acuity Scale: Tier 3 Intensive Management; Tier 2 Moderate Management; Tier 1 Basic Management; and Tier SM (Self-Management).

The Acuity Scale is an objective tool used to establish the frequency and intensity of engagement a client requires when receiving MCM services. It should be a client centered process; one that focuses on the needs and interests of the client with consistent and continuous access to medical care being a top priority. It should also include support services needs of clients in areas such as housing, social network and psychosocial support, nutrition, mental health services, substance abuse, transportation, legal, and prevention. This is a continuing and evolving process rather than an activity that could be initiated and completed in a single session. Periodic reassessments occur as defined by the needs of the client and the new four Tiers model. Total points identify the Tier (Tier 3-SM) of service and the client needs for this case management period.

| Standard | Intervention | Measure | Data Source |
|---|---|---|---|
| **Conduct the Mini Acuity Assessment** | | | |
| 1. The Mini Acuity Assessment is used in conjunction with the Intake form and the 2013 Acuity Scale | 1. Agencies use the Mini Acuity Assessment with incoming clients to identify and address any crisis needs | 1. Use the Mini Acuity Assessment with every client on the first day<br><br>2. CM uses the Mini Acuity Assessment to guide provision of emergency services to clients | 1. Mini Acuity Assessment Template is on file<br><br>2. Date of first contact will be noted in client record. Mini Acuity Assessment will be dated.<br><br>3. Dated Mini Acuity Assessment is documented in file or electronically |
| **Conduct Acuity Scale** | | | |
| 1. The 2013 MCM Acuity Scale is a detailed assessment of client's basic needs<br><br>2. CM conduct Acuity Scale assessments with each new client<br><br>3. CM reassess Tier I, II, and III clients' needs every 6 months. Self-managed tier clients will be re-assessed annually. | 1. Agencies use the 2013 Acuity Scale<br><br>2. CM conducts an the Acuity Scale with incoming clients to fully identify needs and provide goals for the Individual Service Plan (ISP).<br><br>3a. The Acuity Scale is used to place clients in Tiers<br><br>3b. The Acuity Scale is used to reassess Tier I, II, and III clients' needs every 6 months. Self-managed tier clients will be reassessed annually. | 1. Tier I, II, and III clients require a face-to-face Acuity Scale assessment at least once every 6 months. Self-managed tier clients require a face-to-face Acuity Scale assessment annually. If there is a major change in Tier (such as the client presents a number of new and critical issues) a face-to-face assessment is required.<br><br>2. CM will start an Acuity Scale /assessment within 5 days of client intake and complete it within 30 days.<br><br>3. CM uses Acuity Scale to guide provision of services to clients | 1. Acuity Scale Template is on file<br><br>2. Date of first contact will be noted in client record. Acuity Scale assessment will be dated.<br><br>3. Dated Acuity Scale is documented in file or electronically |

## SECTION TWO: COORDINATION AND FOLLOW-UP

**The Individual Service Plan (ISP)** should reflect the client's needs identified in the acuity scale. **The priority is always to get clients into or maintain primary medical care.** It is critical that the ISP be developed in collaboration with client, taking into account his/her priorities and perception of needs. The approach should also be strength based. This means building on clients' strength and accomplishments rather than focusing on short comings or relapses. And finally, the ISP should be updated as needs or addresses and new goals are identified. Case managers have found this tool useful for tracking client's progress.

| Standard | Intervention | Measure | Data Source |
|---|---|---|---|
| **Develop the Individual Service Plan** | | | |
| 1. An Individual Service Plan (ISP) is developed which provides steps for client and CM to follow to address client needs<br><br>2. ISP is completed with clients within 30 days of the acuity scale. ISP will prioritize primary care access, retention, and treatment.<br><br>3. ISP will be reviewed and updated at least 30 within 30 days of an acuity scale reassessment. | 1. Agencies have a standard form for an ISP and the ISP includes documentation of the following:<br>• Identified needs(s) or issue(s) to address.<br>• Process/steps to resolve the identified issues.<br>• Timeframe to accomplish the steps<br>• Person(s) responsible for taking action.<br>• Outcome of the actions taken.<br>• the mechanism to check in on progress<br><br>2. CM develops an ISP jointly with client—assist client with identifying and prioritizing needs. Outline steps to accomplish goals.<br><br>3. ISP will be updated as defined by the agreed upon timeframe. Revised or new ISPs will be written within 30 days of an acuity scale re-assessment. | 1. A standard ISP form is used by all agency CMs<br><br>2. The ISP will be completed within 30 days of an acuity scale (exceptions will be documented). The CM and the client will indicate agreement to the plan by signing and dating the ISP.<br><br>3. The ISP will be reviewed and updated, as defined by the agreed upon timeframe or at minimum, every six months. ISP will be signed at least every six months. | 1. A ISP Template is on file<br><br>2. A signed and dated ISP is in the client's record.<br><br>3. ISPs and review dates will be recorded on the written ISP. |

**Conduct Re-Assessments –** the case manager needs to assess clients' medical, both HIV and non-HIV related, needs at minimum of every six months for Tier 3, 2, 1, and annually for SM clients (and more frequently as needed such as when a client presents a significant number of new and critical issues). This includes a reassessment of clients' understanding of health issues related to HIV, resources available to clients, and continuity/ regularity and access to medical and dental care as well as compliance with treatment. Service providers will ensure that persons living with HIV/AIDS and not accessing or utilizing HIV primary medical care could still receive other supportive services if desired. Access to other HIV supportive services is not conditional upon access to or utilization of HIV primary medical care.

| Standard | Intervention | Measure | Data Source |
|---|---|---|---|
| **Conduct reassessments** | | | |
| 1. At minimum every 6 months for Tiers III, II, and I clients and annually for Tier SM clients or whenever a client presents a significant number of new and critical issues. | 1. At a minimum, reassessment should include<br>• Confirmation of client's HIV care, medical provider's name, date of last clinic visit.<br>• Updated income verification<br>• Completed mini acuity assessment and acuity scale<br>• Discussion and documentation of VL and CD4 counts. | 1. All Tier III, II, and I clients should be reassessed every six months at minimum. All SM clients should be reassessed annually at minimum. | 1. Dated reassessments are in client chart/file. |

**SUMMARY OF FREQUENCY OF CONTACT** (All contacts will be noted in the client's file.)

| | **Frequency of Contact** | **Frequency of Assessment** |
|---|---|---|

| | Phone contact | Face-to-face | Mini-Acuity Assessment | Complete Acuity Scale | ISP | Reassessment |
|---|---|---|---|---|---|---|
| **Tier 3** | Once a month | every 2 months | within 5 days of referral | within 30 Days of intake | within 45 days of intake | every six months |
| **Tier 2** | every 3 months | every 6 months | within 5 days of referral | within 30 Days of intake | within 45 days of intake | every six months |
| **Tier 1** | every 6 months | every 6 months | within 5 days of referral | within 30 Days of intake | within 45 days of intake | every six months |
| **Tier SM** | Every 6 months | annually | within 5 days of referral | within 30 Days of intake | within 45 days of intake | annually |

**Ensure Coordination and Follow-up –** Medical case management is an ongoing "management" process, one that includes reassessments and follow-up. Coordination and follow-up are key components of medical case management**.** As appropriate, case managers will facilitate referrals by obtaining releases of information so they can provide information about client's needs to another service provider. The goal of the referral is to secure needed care and services and it is important that the case manager follow-up to make sure the client successfully accesses these.

| Standard | Intervention | Measure | Data Source |
|---|---|---|---|
| **Referral and Follow-up** | | | |
| 1. Standards are the same for all Tiers | 1. A referral will be made if a client has not accessed or utilized HIV primary medical care within the past 6 months. Within three months of the referral, the case manager will follow up with the client, or provider to which they were referred either in person, by telephone or in writing. Service providers will have in place a procedure for verifying a client's health insurance status. | 1. Ensure that the client is accessing or has accessed medical care in the previous 6-month period. If it is determined that a client does not have access to health insurance, an appropriate referral must be made and documented in the client's file. | 1. Referrals made and the outcome of those referrals will be noted in client's file. The determination of health insurance status forms part of the client's permanent record and is to be retained in a secure location for at least six years. |

**SECTION THREE: HEALTH EDUCATION AND RISK REDUCTION (HE/RR)**

| Standard | Intervention | Measure | Data Source |
|---|---|---|---|
| **Education** | | | |
| Standards are the same for all tiers. | For new clients and/or clients with identified HE/RR needs through assessments and/or ISP , HIV and health care education may include the following:<br>• signs and symptoms of HIV disease<br>• HIV progression<br>• meaning and use of routine medical tests (ie. viral load HIV test, CD4)<br>• medication adherence<br>• managing medication side effects | The provision of information, including dissemination about medical and behavioral health or preparation/distribution of materials in the context of medical and behavioral health. | HIV Education will be documented in the client's file as indicated by the client's presenting needs<br><br>Document in the client's file any dissemination of information about methods to reduce spread of HIV |
| **Risk Reduction** | | | |
| | 1. Client and CM identifies a need for prevention education or supplies<br>2. When identified as a need, and agreed | 1. CM identifies need through assessment<br><br>2. Prevention | 1. Need is documented in files |

| Standard | Intervention | Measure | Data Source |
|---|---|---|---|
| | upon by client, risk reduction education, prevention supplies (condoms, sharps box, needle exchange), partner testing and referral will be provided to the client and documented. | education and supplies are provided to the client as needed is identified | 2. Document response in ISP or case notes |

## SECTION FOUR: TERMINATION, DISCHARGE PLANNING, INCARCERATION

**Termination of Medical Case Management Services/Discharge Planning** is an important component of medical case management. There are legitimate reasons for terminating medical case management services with a client, but keep in mind that termination should never be assumed. For example, clients may be very difficult to locate because they are recently homeless or in transition. Remember to close the client in the data collection system within thirty days of case termination.

| Standard | Intervention | Measure | Data Source |
|---|---|---|---|
| **Termination, Discharge or Graduation to Self-Management** | | | |
| Termination or Discharge should occur to manage resources and ensure coordination of care for active clients | 1. A client's case will be closed within 2 weeks receiving notification of the following situations:<br>• Client wishes to terminate services<br>• Death of client<br>• Client refuses services<br>• Client has been deported<br>• Client has met the goals in the ISP and no other relevant needs can be identified<br>• Client moves out of state for > 3 months<br>• Client has been physically threatening or verbally abusive<br>• Client no longer meets program eligibility requirements<br>• Client does not participate in client responsibilities of case management (i.e. signing release forms, participating in planning, etc.)<br>• Client is incarcerated for greater than 6 month or client is lost to the provider for greater than six months<br><br>* Standard is the same for all tiers. | 1. For cases being closed due to client request, clients need to provide a signed request to stop services<br><br>2. For cases being closed by the agency (not due to client request), client will receive a written notice of closing two weeks prior to the closing to allow time for client to challenge the decision to close. | 1. A notification to close or copies of closure letters (originals in original envelope in the case of returned mail) will be included in the client's file.<br><br>2. The appropriate criteria will be noted in the client file client's file or closing summary. A brief closing summary stating the reason for closing, the final status of ISP and any other relevant information will be included in the client file. |
| **Transfer**<br>Ensure coordination and continuity of care for clients | When client transfers to another provider ensure that the transition is smooth and client does not experience any lapse in medical services. The agency has a system in place to assist a client with changing providers and/or case manager | 1. Agency understands current protocol for clients accessing MCM services from one provider only | 1. Adopt and sign policy on one service provider per client<br><br>2. A dated and |

| Standard | Intervention | Measure | Data Source |
|---|---|---|---|
| | | 2. CM uses standard protocol to transfer or enroll clients to other providers | signed MCM provider transfer form |
| **Incarceration** Coordinate with correctional facilities to ensure continuity of care for clients | These individuals need intense medical case management immediately after release from incarceration to assess if their meds are running out, link them with a primary provider. | 1. Client in Federal, State, and County Facilities may be enrolled and in MCM six months prior to release, unless additional time is needed to assist client with securing stable housing upon release. | Client's needs are clearly documented in client files including time needed to secure stable housing upon release. |

**SECTION FIVE: AGENCY STANDARDS**

| Standard | Intervention | Measure | Data Source |
|---|---|---|---|
| **Medical Case Manager Competencies & Qualifications** | | | |
| 1. Medial Case Managers will be qualified for the positions | 1. Professional CM will have current state licensure and<br>• an undergraduate or graduate degree in social work, nursing, or public heath, human services *or*<br>• at least two years experience providing social services responsible for a case load *or*<br>• at least one year experience providing HIV services in a position that included providing the direct service skills listed above.<br>(DHS will offer variance to case managers. Requests for variance are subject to the discretion of DHS).<br><br>2. Case Managers will have knowledge of<br>• Signs and symptoms of HIV disease and HIV progression<br>• Meaning and use of routine medical tests (i.e. viral load testing)<br>• Medication adherence<br>• Managing medication side effects<br>• HIV transmission and transmission | 1. The competencies for every case manager will be retained by each agency from the time of hire until at least one year after a case manager leaves the position.<br><br>Professional staff possess current state licensure<br><br>2. Case managers will complete the HIV Medical Case Management certification training provided by the state as well as all required trainings by DHS and Hennepin County Ryan White program. | 1. Program file contains documentation of all current direct service CM including education, work experience, skills assessment, and relevant certification or licensure where applicable and background check.<br><br>2. Program file contains documentation of training completion and ongoing education. |

| Standard | Intervention | Measure | Data Source |
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| | prevention<br>• HIV Risk Assessment and Risk Reduction<br><br>3. Case Managers will have competencies in the following areas:<br>• psycho-social assessment of clients<br>• interdisciplinary care coordination<br>• monitoring of health/social service delivery to maximize efficiency/cost effectiveness<br>• knowledge of the resources available to target populations<br>• development and utilization of client-centered ISPs<br>• data privacy and confidentiality<br>• cultural and social indicators impacting disease management for unique client populations<br><br>4. All new case managers will complete the annual MCM training provided by DHS. | Within 3 months of employment, a case manager will be knowledgeable on HIV/AIDS as listed.<br><br>3. Programs are staffed with personnel with knowledge of HIV and experience to provide medical case management. | 3. Program file contains documentation of competencies requirements and how these are met by case manager. |
| **Routine Supervision** | | | |
| 1. Routine Supervisor will be qualified for the position. | 1. Program Supervisors will have an undergraduate or graduate degree in social work, nursing, or psychology *and* at least three years experience providing social services responsible for a case load *or* at least two years experience providing HIV services in a position that included providing the direct service skills listed above.<br><br>2. Formal supervision of program staff should occur at least monthly.<br>DHS will offer variance to supervisors upon request from agency. | 1. Program Supervision is provided by a qualified person<br><br>2. Supervision is provided on a regular, formal basis | 1. Program file contains documentation of program supervisor qualifications including education, work experience, and relevant certification or licensure where applicable.<br><br>2. Records on formal supervision sessions are maintained for two years. |

| Standard | Intervention | Measure | Data Source |
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| **Clinical Consultant Services** | | | |
| 1. A licensed clinical consultant will provide guidance to MCM staff. | 1. Program maintains a service agreement with a qualified clinical consultant to provide clinical supervision either in a group supervision setting at least once a month or in a one-to-one setting at least quarterly.<br><br>2. Clinical Consultant services include: Discuss CM observations of challenges experienced by clients and/or CM at meeting agreed upon goals and objectives. Consult with clinical consultant regarding possible mental health services referrals. | 1. Qualifications for a clinical consultant: a licensed mental health professional with a graduate degree in one of the behavioral sciences or related fields<br><br>2. Documentation of staffing of individual clients.<br>. | Program file contains copies of current licensure of clinical consultant.<br><br>2a. Provider record has dated and signed documentation of staffing with clinical consultant.<br><br>2b. Hours of clinical consultation documented in program quarterly reports to grantee. |
| **New Employee Orientation** | | | |
| 1. New employees will be trained on Ryan White services, client eligibility requirements, and MCM standards. | 1. Service providers will have an orientation program for new employees/volunteers who will be working with Ryan White eligible clients. The orientation program will include at minimum, a discussion of Ryan White funding eligibility, confidentiality and the universal standards. Orientation will be provided on topics relevant to HIV/AIDS and service specific standards. | 1. Documentation of new employees' participation in orientation and content of training. | 1. Documentation of new employee orientation content and attendance will be reviewed during annual site visits and/or audits. |
| **Ongoing Training and Continuing Education** | | | |
| 1. On-going Training/ Continuing Education | 1. Case managers will complete the core HIV case management training provided by the state, as well as all required trainings by DHS and Hennepin County Ryan White Program.<br>2. Case managers who have already completed the core training will complete 12 hours of continuing education annually. Continuing education sessions will be provided by grantees. Any grantees-sponsored training sessions, annually, will meet the continuing education standards.<br>3. A case manager may use other professionally accredited (nursing or social work) continuing education hours | 1-3. Certificate of attendance or equivalent documentation. | 1-3. Continuing education sessions will be reported in quarterly reports and documentation will be reviewed during annual site visits and/or audits. |

| Standard | Intervention | Measure | Data Source |
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| | to meet the standard (with grantees' approval). | | |
| **Case Loads** | | | |
| 1. Case Load is on average, agency wide 50 cases per funded FTE.<br><br>2. Ensure a client is not waitlisted. | 1. The contracted case load is 50 cases per funded FTE at any one time (per contract period) on average *agency wide*, unless a lower number is negotiated with the Grantee. Negotiated changes from this standard will be based on demonstrating that a significant portion of the program clients served require more time than a typical Tier III client.<br><br>2. Providers are expected to coordinate appropriate referrals to other MCM providers when they've reached their funded capacity and notify their contract manager. | 1. Program tracks average FTE case load.<br><br>2. Referrals are coordinated if the next available appointment is longer than 5 business days. | 1. Document case loads in quarterly reports, central database, and reviewed during site visits and audits<br><br>2. Quarterly reports and communications with contract manager |
| **Monitoring and Documentation Systems** | | | |
| 1. Client information is stored and protected.<br><br>2. Internal chart reviews are conducted at minimum annually to ensure compliance with MCM Standards. | 1a. Records of services to clients must be stored in a secure filing system.<br><br>1b. Computerized records must be password protected and backed up at least weekly. Backed up records will be kept in a safe and secure (off-site) location. Service providers must document when and by whom files are removed from a secure filing system.<br><br>2. Supervisor and peers will conduct internal chart audits for standards compliance. | 1. Agency Procedures and demonstration of Client Data protection systems in place<br><br>2. Demonstration of compliance. | 1a. For each client, a separate file must be maintained, or there is rationale as to why this did not occur.<br>1b. Systems verified during annual site visits and/or audits. Document in client record and report on centralized database<br>2. Documentation of internal chart reviews. |

**Quality Assurance/Quality improvement**
Service providers will participate in Quality Assurance programs for Medical Case Management. Service providers will assess the quality, appropriateness and effectiveness of services through peer review, record review, utilization review, and client satisfaction surveys, among other mechanisms. If needed, an Action Plan will be formulated to document corrective actions and improvement in outcomes.

| Standard | Intervention | Measure | Data Source |
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| **Quality Assurance/Quality Improvement** | | | |
| Agencies will meet the Universal Standards for Ryan White Funded Programs | 1. Agencies develop a plan for QA/QI<br>2. Agency implements stated QA/QI Plan for current period | 1. QA/QI Plan will be submitted by due dates specified in contract.<br><br>2. Action plan in response to corrective action and improvement of outcomes will be submitted by agreed upon due date. | 1. Current written Agency QS/QI Plan<br><br>2. Current QA/QI efforts documented showing CM involvement |

## APPENDIX A
## DEFINITIONS

**Acuity Scale**—The MCM Acuity Scale is used to determine a client's MCM related needs. It is an objective tool used to establish the frequency and intensity of engagement a client requires when receiving MCM services.

**Assessment—** Process by which a case manager collects, analyzes, and prioritizes information which identifies client needs, resources, and strengths for purposes of developing a service plan.

**Client File** — A collection of printed and/or computerized information regarding a client using services currently or in the recent past.

**Confidentiality** — The process of keeping private information private. Information given by a client to a service provider will be protected and will not be released to a third party without the explicit written permission of the client or his/her representative.

**Coordination with medical care** — Health care services related to the treatment of HIV/AIDS infection and HIV/AIDS associated complications, as well as the maintenance of health status. Coordination includes referrals and follow-ups to ensure client access services and/or barriers are addressed.

**Criteria** —Definition of specific, measurable outcomes expected from a Standard.

**Culturally Appropriate Care** — The ability of service providers and others to accommodate language, values, beliefs and behaviors of individuals and groups they serve.

**Demographic Information** — Descriptive information about a client--including, but not limited to, age, race/ethnicity and gender. This information provides a profile of people receiving services from a specific agency.

**Grievance** — A verbal or written complaint or concern regarding a practice or policy of an individual or organization per the organization's policy.

**Health Education/Risk Reduction** — Activities which include information dissemination about methods to reduce the spread of HIV; HIV disease progression; and the benefits of medical and psychosocial support services. This activity does not include medication or treatment information, which is part of Adherence activities.

**Individual Service Plan (ISP)** — Created by identifying client needs based on information collected during assessment/reassessment; a written plan that directs the activities of the client and the case manager. The ISP delineates the medical case management goals and objectives that support the client's access to and retention in primary care and the continuum of health and support services required to manage their disease.

**Reassessment** — Conducted to determine the client's case management status and the need for revisions in the care plan. Acuity scale may be used in lieu of 6 month reassessment for Tier III clients. Comprehensive re-assessment required for all three tiers.

**Referrals** — The act of directing a client to a service in-person or through telephone, written or other type of communication.

**Quality Assurance/Improvement** —A method of program/service evaluation, which is designed to assure that the highest quality of services are provided to the client.

**Standard** — Authoritative statements by which a profession describes the responsibilities of its practitioners.

**Unit of Service—** 15 minutes of activities performed on behalf of a unique client = 1 unit of service