Minnesota Ryan White HIV/AIDS Program
Service Area Standards: Medical Case Management

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

1. Initial assessment of service needs
2. Development of a comprehensive, individualized care plan
3. Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
4. Continuous client monitoring to assess the efficacy of the care plan
5. Re-evaluation of the care plan at least every six months with adaptations as necessary
6. Ongoing assessment of the client's and other key family members' needs and personal support systems
7. Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
8. Client-specific advocacy and/or review of utilization of services

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

Program Guidance:
Medical Case Management services have as their objective improving health care outcomes whereas Non-Medical Case Management Services have astheir objective providing guidance and assistance in improving access to needed services.
Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/AmbulatoryHealth Services. Treatment Adherence Services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

Universal Standards: All subrecipients must meet universal standards requirements in addition to service area standards for which they are funded.

Standard	Measure	Data Source
Individual Client Focused Standards		
1. Introducing Client to Medical Case Management (MCM) 1.1 Client understands what MCM is and their roles and responsibilities as well as the case manager's. 1.2 Medical Case Manager (MCM) describes medical case management including these components: • Intake • Acuity Assessment • Education • Development of goals and objectives focusing on access and retention incare. • Activities that are need based and in conjunction with the development andcoordination of an individual service plan (ISP) • Follow-up and monitoring of client progress, and • Time limited with planning for individuals changing tiers or discharge 1.3 Client is not currently receiving MCM with another provider. Verify that the client is currently not receiving this service elsewhere (if appropriate offer the option of changing providers by disenrolling 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 an ISP, and an assigned case manager.	1.1 Client understands and wants MCM services as defined in the Consent to Receive MCM Services. 1.2 Client wants and can receive MCM from the agency. 1.2 Client needs and identified barriers are addressed in the ISP and goals are achieved. 1.2 Clients with no further needs are discharged from MCM. 1.3 Client understands they may receive MCM services from one provider only.	1.1 A "consent to receive MCM services" is signed by the client and kept in the client's file. 1.2 Client goals and Acuity scores are document in the ISP. 1.2 ISP and changes in Acuity tiers are documented. 1.2 CAREWare reports, acuity assessment, and client chart. 1.3 A written "intent to switch providers" signed by the client is kept in the client's file at both the old and new provider.

Standard	Measure	Data Source
2. Complete required enrollment forms at intake 2.1 Current demographic data for each client. Demographic information as defined in CAREWare is kept current and accurate. 2.2 The acuity assessment is completed during intake to identify issues that require immediate attention and establish frequency and intensity of engagement. Complete the acuity assessment to identify needs in these nine areas that will place clients in intensive MCM: • Health insurance and benefits • HIV diagnosis • Pregnancy • HIV medications and medical treatment adherence • Housing stability and access • Trauma / mistreatment / abuse • Mental health • Chemical health • Incarceration	2.1 Client demographic information is collected and reported. 2.2 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. ISP will address all needs identified through assessment.	2.1 CAREWare. 2.2 Intake is signed, dated, and in client file.

Standard	Measure	Data Source
3. Conduct Acuity Assessment 3.1 The MCM Acuity Assessment is a detailed assessment of client's basic needs. CM conducts the Acuity Assessment with each incoming client to fully identify needs and provide goals for the Individual Service Plan (ISP). CM will start an Acuity assessment within five days of client intake and complete it within 30 days. 3.2 The Acuity Assessment is used to assess the client's needs and place clients in tiers. CM uses Acuity Assessment to guide provision of services to clients. 3.3 The CM reassesses Tier A clients' needs every three months with a face-to-face at least every six months, and Tier B clients every six months with a face-to-face occurring at least every 12 months.	3.1-3.3 Tier A clients require a face- to-face or phone contact a minimum of every three months unless the ISP requires a greater frequency; however, a face-to-face should occur at least every six months. Tier B clients require a face-to-face or phone contact a minimum of every six months; a face-to-face should occur yearly. 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.	3.1-3.3 Acuity assessment is on file. 3.1-3.3 Date of first contactis noted in client record. Acuity assessment is dated. 3.1-3.3 Dated Acuity Assessment is documented in file or electronically.

Standard	Measure	Data Source
4. Develop the Individual Service Plan 4.1 An Individual Service Plan (ISP) is developed which provides steps for client and CM to follow and address client needs identified within the acuity assessment. Agencies have a standard form for an ISP and the ISP includes documentation ofthe following: • Identified needs(s) and issue(s) to address • All needs identified in acuity assessment will be addressed in the ISP. (If client is not ready, notation of discussion with client must be included.) • Process/steps to resolve the identified issues • Timeframe to accomplish the steps • Person(s) responsible for taking action. • Number/frequency of face to face and phone contact with the client for theduration of the service plan • Outcome of the actions taken to check in on progress 4.2 ISP is completed with clients within 30 days of the acuity assessment. ISP will prioritize primary care access, retention, and treatment. CM develops an ISP jointly with client— assist client with identifying and prioritizing needs. Outline steps to accomplish goals. 4.3 ISP will be reviewed and updated at least within 30 days of an acuity reassessment. 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.	4.1 A standard ISP form is used by all agency CMs. 4.2 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. 4.3 The ISP will be reviewed and updated, as defined by the agreed upon timeframe or, at minimum, every rolling six-month period of time. ISP will be signed at least every six months.	4.1 An ISP Template is on file. 4.1-4.3 A signed and dated ISP is in the client's record. 4.2-4.3 ISPs and review dateswill be recorded on the written ISP.

Standard	Measure	Data Source
5. Conduct Reassessments 5.1 CM conducts a reassessment at minimum every six months for Tier A clients and annually for Tier B clients or whenever a client presents a significant number of new and critical issues. At a minimum, reassessment should include: • Confirmation of client's HIV care, medical provider's name, date of last clinic visit. • Completed acuity assessment. • Discussion and documentation of VL and CD4 counts. **Contact Frequency - Phone or Face-to-Face** **Tier A**: A minimum phone or face-to-face every three months unless the ISP requires a greater frequency; however, a face to face should occur at least every six months. Tier A: client needs require intensive through basic case management. **Tier B:** A minimum phone or face-to-face every six months; a face-to-face should occur yearly. Tier B: client needs only periodic assistance (current scale 'self-managed').	5.1 All Tier A clients should be reassessed every six months at minimum. All Tier B clients should be reassessed annually at minimum. **Complete Acuity Assessment** **Tier A**: Initial assessment should be started within five days of initial client contact and completed within 30 days of intake. **Tier B**: Initial assessment should be started within five days of initial client contact and completed within 30 days of intake **ISP** **Tier A**: Within 45 days of intake. **Tier B**: Within 45 days of intake.	5.1 Dated reassessments are in client chart/file. • **Tier A**: Every six months • **Tier B**: Annually

Standard	Measure	Data Source
6. Referral and Follow-up 6.1 A referral will be made if a client has not accessed or utilized HIV primary medical care within the past six 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.	6.1 Ensure that the client is accessing or has accessed medical care in the previous six-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.	6.1 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.
7. Education 7.1 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: • Signs and symptoms of HIV disease and HIV progression • Meaning and use of routine medical tests (i.e., viral load HIV test, CD4) • Medication adherence • Managing medication side effects	7.1 The provision of information, including dissemination about medical and behavioral health or preparation and distribution of materials in the context of medical and behavioral health.	7.1 HIV Education will be documented in the client's file as indicated by the client's presenting needs. 7.1 Document in the client's file any dissemination of information about methods to reduce spread of HIV
8. Risk Reduction 8.1 Client and CM identifies a need for prevention education or supplies. When identified as a need, and agreed 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.	8.1 CM identifies need through assessment. 8.1 Prevention education and supplies are provided to the clientas needed is identified.	8.1 Need is documented in files. 8.1 Document response in ISP or case notes.

Standard	Measure	Data Source
9. Termination, Discharge or Graduation to Self-Management 9.1 Termination or Discharge should occur to manage resources and ensure coordination of care for active clients. A client's case will be closed within two weeks after a decision has been made to discharge the client due to the following situations: • Client wishes to terminate services • Client refuses services • Client has met the goals in the ISP and no other relevant needs can be identified • Client moves out of state for more than three months • Client has been physically threatening or verbally abusive • Client is lost to care or does not engage in services in a six-month period of time • Client is incarcerated for greater than six months	9.1 For cases being closed due to client request, clients need to provide a signed request to stop services 9.1 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.	9.1 Closure letters will be included in the client's file. 9.1 The appropriate criteria will be noted in the 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.
10. Transfer 10.1 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 managers.	10.1 Agency understands current protocol for clients accessing MCM services from one provider only. 10.1 CM uses standard protocol to transfer or enroll clients to another provider.	10.1 Adopt and sign policy on one service provider per client. 10.1 A dated and signed MCM provider transfer form.
11. Incarceration 11.1 Coordinate with correctional facilities to ensure continuity of care for clients who are incarcerated. These individuals need intense medical case management immediately after release from incarceration to assess if their meds are running out and link them with a primary provider.	11.1 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.	11.1 Client's needs are clearly documented in client files including time needed to secure stable housing upon release.

Standard	Measure	Data Source
12. Medical Case Manager Competencies and Qualifications 12.1 Professional CM will have current state licensure (if applicable) and: • An undergraduate or graduate degree in social work, nursing, public heath, human services, or • At least two-years' experience providing social services responsible for a case load, or • At least one-year experience providing HIV services in a position that included providing the direct service skills listed above 12.2 Case Managers will have knowledge of: • Signs and symptoms of HIV disease and HIV progression • Meaning and use of routine medical tests (i.e., viral load testing) • Medication adherence • Managing medication side effects HIV transmission and transmission prevention • HIV Risk Assessment and Risk Reduction 12.3 Case Managers will have competencies in the following areas: • Psycho-social assessment of client's interdisciplinary care coordination monitoring of health/social service delivery to maximizeefficiency/cost effectiveness • Knowledge of the resources available to target populations • Development and utilization of client-centered ISPs • Data privacy and confidentiality cultural and social indicators impacting disease management for unique client populations 12.4 All new case managers will complete the annual MCM training provided by DHS (or equivalent with prior approval).	12.1 Professional staff possess current state licensure. if applicable 12.1-12.2 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. 12.2-12.4 Case managers will complete the HIV MCM certification training provided by the state as well as all required trainings by DHS and Hennepin County Ryan White program. 12.3-12.4 Within three months of employment, a case manager will be knowledgeable on HIV/AIDS as listed. 12.4 Programs are staffed with personnel with knowledge of HIV and experience to provide medical case management.	12.1-12.2 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. 12.3-12.4 Program file contains documentation of training completion and ongoing education. 12.3-12.4 Program file contains documentation of competencies requirements and how these are met by case manager.

Standard	Measure	Data Source
13. Routine Supervision 13.1 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. 13.2 Formal supervision of program staff should occur at least monthly.	13.1-13.2 Program Supervision is provided by a qualified person. 13.1-13.2 Supervision is provided on a regular, formal basis.	13.1-13.2 Program file contains documentation of program supervisor qualifications including education, work experience, and relevant certification or licensure where applicable. 13.1-13.2 Records on formal supervision sessions are maintained for two years.

Standard	Measure	Data Source
Program Focused Standards		
14. Clinical Consultant Services 14.1 A licensed clinical consultant will provide guidance to MCM staff. 14.2 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. 14.3 Clinical Consultant services include: • CM discusses observations of challenges experienced by clientsand/or CM at meeting agreed upon goals and objectives. • CM consults with clinical consultant regarding possible mental health services referrals.	14.1 Qualifications for a clinical consultant: a licensed mental health professional with a graduate degree in one of the behavioral sciences or related fields 14.1-14.3 Documentation of staffing of individual clients.	14.1 Program file contains copies of current licensure of clinical consultant. 14.1-14.3 Provider record has dated and signed documentation of staffing with clinical consultant. 14.1-14.3 Hours of clinical consultation documented in program quarterly reports to recipient.
15. Ongoing Training and Continuing Education 15.1 Case managers will complete the core HIV case management training provided by the state, as well as all required trainings by DHSand Hennepin County Ryan White Program: • Case managers who have already completed the core training will complete 12 hours of continuing education annually. Continuing education sessions will be provided by recipients. Any recipient-sponsored training sessions, annually, will meet the continuing education standards • A case manager may use other professionally accredited (nursing or social work) continuing education hours to meet the standard (with recipients'' approval)	15.1 Certificate of attendance or equivalent documentation.	15.1 Continuing education sessions will be reported in quarterly reports and documentation will be reviewed during annual site visits and/or audits.

Standard	Measure	Data Source
16. Case Loads 16.1 Case Load is based on program average of 50 cases per funded FTE. 16.2 Ensure a client is not waitlisted: • 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 recipient. Negotiated changes from this standard will be based on demonstrating that a significant portion of the program clients served are Tier A clients. • Providers are expected to coordinate appropriate referrals to other MCM providers when they've reached their funded capacity and notify their contract manager. Referral and coordination processes in place to avoid waitlists when programs have reached their capacity. Contract managers must be notified.	16.1 Program tracks average FTE case load. 16.2 Referrals are coordinated if the next available appointment is longer than five business days.	16.1 Document caseloads in quarterly reports, central database, and reviewed during site visits and audits. 16.2 Quarterly reports and communications with contract manager.
17. Monitoring and Documentation Systems 17.1 Supervisor and peers will conduct internal chart audits for standards compliance.	17.1 Demonstration of compliance.	17.1 Documentation of internal chart reviews.

ADDENDUM

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 medicalcrisis, 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 are 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. Itis extremely important to provide mandated information and obtain required consents, releases, and disclosure – see below.

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

The Acuity Assessment 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 tiers model. Total points identify the goals and intensity of service, and the client needs for this case management period.

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 their 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 orrelapses. 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.

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 A, and annually for Tier B 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.

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.

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.