Norfolk TGA Ryan White Part A
MEDICAL CASE MANAGEMENT (MCM)
SERVICE STANDARD

SERVICE CATEGORY DEFINITION

Medical Case Management (MCM):

Medical Case Managers 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 includes all types of case management encounters (e.g. face-to-face, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- 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 benefit 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 Marketplace/Exchanges). Medical Case Managers may be social workers, nurses or any similar professional with related health and human service experience. Medical Case Managers focus on medical and behavioral needs of clients (mental health, substance use, HIV risk reduction and self-management skills building) and access to needed supportive services to assist the client to successfully adhere to their HIV treatment program.

Medical Case Management includes all provisions listed above and requires a patient whose acuity level requires the case manager also manage their medical care, schedule and monitor medical appointments, lab work, medication treatment adherence, other indicated services

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including dietician, mental health and substance abuse screenings/treatment and other supports.

CLIENT INTAKE AND ELIGIBILITY

All Subrecipient's are required to have a client intake and eligibility policy on file. It is the responsibility of the Subrecipient to determine and document client eligibility status, as outlined in the Ryan White Part A—Norfolk TGA Eligibility Policy in accordance with HRSA/HAB regulations. Eligibility must be completed at least once every six months.

Eligible clients must:

- Live in the Norfolk TGA (Chesapeake, Norfolk, Virginia Beach, Portsmouth, Suffolk, Hampton, Newport News, Poquoson, Williamsburg, York County, James City County, Gloucester County, Matthews County, Isle of Wight and Currituck County, North Carolina)
- Have an HIV/AIDS diagnosis
- Have a household income that is at or below 400% of the federal poverty level
- Be uninsured or underinsured

Services will be provided to all Ryan White Part A qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

PERSONNEL QUALIFICATIONS

Medical Case Managers may be social workers, nurses or any similar professional with related health and human service experience. Medical Case Managers focus on medical and behavioral needs of clients (mental health, substance use, HIV risk reduction and self-management skills building) and access to needed supportive services to assist the client to successfully adhere to their HIV treatment program.

Medical Case Managers participating on a multidisciplinary team work in partnership with the other professionals to assess the needs of the client, the client's family, and support systems to develop an individualized client Service Plan. Medical Case Managers also arrange, coordinate, monitor, evaluate, and advocate for a comprehensive package of services to meet the specific client's complex needs.

The minimum education and/or experience requirements for Medical Case Managers are:

1. Bachelor of Social Work (BSW); Masters of Social Work (MSW), or other related health or human service degree from an accredited college or university, or;
2. Current Virginia licensed registered nurse (RN) with additional Association of Nurses in AIDS Care (ANAC) Certification preferred, or;
3. Related experience for a period of two years, regardless of academic preparation.
4. If licensed, a copy of the most current Virginia license must be kept in the Medical Case Manager's personnel file.
5. All Medical Case Managers must complete a minimum training regimen within one year of their hire date that includes:
   a. HIV case management standards,
   b. Training in HIV 101 to include HIV disease processes, treatment, testing, legal ramifications to include confidentiality, counseling/referral, and prevention,
   c. Cultural competency and
   d. ADAP/Insurance training.

***If newly hired and have previously completed the required training(s), staff are not required to repeat it. Documentation of completion of required trainings must be kept in the personnel file**.*

6. All Medical Case Managers, except Virginia Licensed Clinical Social Worker (LCSW) or nationally Certified Case Manager (CCM) must complete a VDH-approved basic case management training program within one year of their hire date.
7. Documentation of completion of this training must be kept in the Medical Case Manager's personnel file. VHARCC offers a variety of trainings and consultation services. More information can be found at: http://www.VHARCC.com

8. All Medical Case Managers must complete at least 12 hours of continuing education in HIV/AIDS each year. Case manager supervisors will identify appropriate continuing education opportunities. Documentation of completion of continuing education must be kept in the Medical Case Manager's personnel file. See appendix for an illustrative documentation form.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of medical case management is to provide care planning and coordination services needed for people living with HIV/AIDS, ensuring access to core and support services that will enable medical adherence and stability for each individual client.

Clinical Quality Improvement outcome goals for medical case management are:

- 100% of all client files include documentation of a completed comprehensive care plan.
- 80% of clients receiving medical case management services are actively engaged in medical care as documented by a medical visit in each six (6) month period in a two-year measure and in the second half of a single year measure.
- 80% of clients receiving medical case management services are prescribed Antiretroviral Therapy (ART) in the measurement year.
- 80% of clients receiving medical case management services are virally suppressed as documented by a viral load of less than 200 copies/mL at last test.

SERVICE STANDARDS, MEASURES, AND GOALS

	Standard	Measure	Goal
1.	Services are provided by trained professionals.	Documentation of minimum education and/or experience requirements for Medical Case Managers.	100%
2.	Clients have a completed comprehensive individual care plan.	Documentation of completed comprehensive individual care plan is included in the file of all clients receiving services in the measurement year.	100%
3.	New medical case management clients receive an initial assessment of service needs.	Documentation of initial assessment of service needs is included in the file of all clients entering service in the measurement year.	100%
4.	Clients will have an acuity scale completed and documented, reflecting their current acuity level.	Documentation of acuity scale is included in the file of all clients in the measurement year.	100%
5.	Clients receive coordinated referrals and information for services required to implement the care plan	Documentation of referrals and service coordination are noted in the file for clients receiving services in the measurement year.	100%
6.	Clients have their individual care plans updated two or more times, at least three months apart.	Documentation that the individual care plan is updated at least two times, three months apart, for clients receiving services for a span longer than six months in the measurement year.	80%
7.	Clients are continuously monitored to assess the efficacy of their individual care plan.	Documentation of continuous monitoring to assess the efficacy of the care plan is evident in the client chart	80%

8.	Clients are linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the measurement year as documented by the medical case manager.	80%
9.	Clients are retained in medical care	Documentation that the client had at least one medical visit in each six-month period of a 24-month measurement period with a minimum of 60 days between visits as documented by the medical case manager.	80%
10.	Clients have no gaps in medical care.	Documentation that the client had a medical visit in the first and second halves of a 12-month measurement period as documented by the medical case manager.	80%
11.	Clients are on Antiretroviral Therapy (ART).	Documentation that client was prescribed ART in the 12-month measurement year as documented by the medical case manager.	80%
12.	A discharge summary (for all reasons) must be placed in each client's file within 30 days of discharge date.	Discharge Summary in client file within 30 days of discharge date.	100%
13.	Clients lost to care have documented attempts of contact prior to discharge.	If client is "lost-to-care" (cannot be located), the subrecipient will: a. make and document a minimum of 3 follow-up attempts over a 3-month period after first attempt. b. A certified letter must be mailed to the client's last known mailing address within five business days after the last phone attempt notifying the client of pending inactivation within 30 days from the date on the letter if the client does not make an appointment to re-screen. c. Subrecipient refers client to EIS services.	100%

14.	Clients are virally suppressed.	Documentation that the client has a viral load <200 copies/mL at last test as documented by the medical case manager.	80%

CLIENTS RIGHTS AND RESPONSIBILITIES

Subrecipient's providing services are required to have a statement of client rights and responsibilities posted and/or accessible to the client. Each Subrecipient will take all necessary actions to ensure that services are provided in accordance with the client rights and responsibilities statement and that each client understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Subrecipient's providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of clients Personal Health Information (PHI). Subrecipient's must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the clients record. Information on all clients receiving Ryan White Part A funded services must be entered in the HRSA sponsored, Norfolk Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Subrecipient's providing services must adhere to the National Standards on Culturally and Linguistically Appropriate Services.

CLIENT GRIEVANCE PROCESS

Each Subrecipient must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the clients record.

CASE CLOSURE PROTOCOL

Each Subrecipient providing services should have a case closure protocol on file. The reason for case closure must be properly documented in each client's file. If a client chooses to receive services from another provider the Subrecipient must honor the request from the client.