Medical Case Management, including Treatment Adherence Services

Health Resources & Services Administration (HRSA) Definition: 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 includes all 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 6 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 (same for Referral for Health Care & Support Services) have as their 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/Ambulatory Health 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 Outpatient/Ambulatory Health Services category.

NOTE: For the Orlando Service Area, the Telehealth defined by HRSA is considered live (Synchornous) videoconferencing, Store-and-forward (asynchronous) videoconferencing, remote patient monitoring (RPM), or Mobile health (mHealth).

Medical Case Management (MCM) within the Orlando EMA, (the RWHAP Part A–funded service category) shall be synonymous with Intensive Case Management (ICM) services.

Eligibility: Clients accessing Medical Case Management or Intensive Case Management shall meet the eligibility standards as described in the System Wide Service Standards.

1.0 Policies and Procedures

The agencies shall have Policies and Procedures to ensure the services are accessible to all eligible clients. The agency policy and procedures will ensure compliance with the following standards.

1.0 Agency Policies and Procedures

	STANDARDS		MEASURES
1.1	The agency shall maintain information about each MCM/ICM caseload, which includes, at a minimum: • Assigned MCM/ICM • Number of cases per full-time equivalent (FTE) • The acuity of each client ***NOTE: Caseloads for ICM shall not exceed 35.***	1.1	Documentation in the approved electronic data management system.
1.2	All Ryan White MCM (funded through RWHAP Part B) must meet at least one of the following staff qualifications: • Bachelor's degree in a social science or health discipline • An individual with a bachelor's degree in disciplines other than social science must have at	1.2	Appropriate degrees, licensure and/or certification in personnel file

	least six (6) months direct case management experience • Florida licensed registered nurse with at least one year of case management experience • An individual with a master's degree other than a social science or health can substitute their degree for six (6) months of direct case management experience ***NOTE: This requirement may be waived by the Lead Agency. Subrecipients are encouraged to use competency-based recruitment and hiring practices. Waivers can be requested prior to the interview process.***	
1.2a	All Intensive Case Managers (funded through RWHAP Part A) must meet at least one of the following staff qualifications: • Bachelor's degree in a social science or health discipline **and** 6 months of direct care case management experience • An individual with a bachelor's degree in disciplines other than social science must have at least one (1) year direct care case management experience • Florida licensed registered nurse with at least one year of case management experience • An individual with a master's degree other than a social science or health can substitute their degree for six (6) months of direct case management experience ***NOTE: This requirement may be waived by the Recipient. Subrecipients***	1.2a. Appropriate degrees, licensure and/or certification in personnel file

	are encouraged to use competency-based recruitment and hiring practices. Waivers can be requested prior to the interview process.	
1.3	All MCM/ICM Supervisors must meet the following requirement: • Master's Degree in the fields of mental health, social work, counseling, social science or nursing ***NOTE: This requirement may be waived by the Recipient/Lead Agency. Subrecipients are encouraged to use competency-based recruitment and hiring practices. Waivers can be requested prior to the interview process.***	1.3 Appropriate degrees, licensure and/or certification in personnel file
1.4	MCM/ICM and MCM Supervisors shall complete fifteen (15) hours of training annually. Topics include: • HIV 101/500 within three (3) months of hire • HIV/AIDS 501 courses within one (1) year of hire • Establishing rapport and a professional relationship with the client • Methods of engaging individuals • Special issues relating to working with the PWH population • Confidentiality/HIPAA and professional ethics • Knowledge of public assistance programs and benefits • The agency's emergency plan, disaster relief resources, and planning and procedures • The AETC Case Manager modules within three (3) months of hire: ***Modules available at:***	1.4 Documentation of the following will be in the personnel file: • Proficiency certification within one (1) year, AETC certificate within 3 months of hire • Eligibility training certificate within 30 days of hire • HIV 101 within three (3) months of hire • 501 certificate dated within one (1) year of hire • Proof of attendance, certificate or other documentation including training subject matter, date(s) of attendance and hours in agency training record • Training certificate

	https://www.seaetc.com/modules ***Note: Training shall also include, but not be limited to, cultural sensitivity issues, case management issues, bio-psychosocial issues surrounding the HIV disease, and any other training proposed by the Recipient.***	
1.5	MCM/ ICM Supervisors shall have an additional six (6) hours of leadership training. Leadership training topics shall include, but not be limited to the following: • Cultural competency for clients and staff • Ethics in managing staff • Research • Clinical quality management to include developing staff performance improvement plans for client needs	1.5 Documentation (i.e. training certificates) of the training shall be in the employee training record
1.6	All licensed professionals shall be responsible for maintaining their licensure per Florida State Requirements, where applicable.	1.6 Copies of licenses will be in personnel file, where applicable.
1.7	MCM/ICM shall be assigned within two (2) working days of a request for service or receipt of a referral.	1.7 The record shall reflect the name of the assigned MCM/ICM and date of assignment.

2.0 Client Initial Comprehensive Assessment and Care Plan

MCM/ICM shall conduct a face-to-face or Telehealth (as defined by HRSA) comprehensive assessment of each client, which shall be documented in the client's record in the approved electronic database management system. The comprehensive assessment shall include the client's barriers (perceived and actual) to access and retention in care and to medication adherence.

The care plan shall outline incremental steps in reaching a goal and who is responsible for each activity. The activities shall be measurable with timeframes for the completion of each activity, similar to SMART (Specific, Measurable, Actionable,

Reasonable, Timely) objectives. Outcomes of the care plan activities shall be noted in the MCM/ICM record.

2.0 Client Initial Comprehensive Assessment and Care Plan:

	STANDARDS		MEASURES
2.1	***Initial Comprehensive Needs Assessment***: An initial client assessment shall be initiated within five (5) working days of contact with the client. An initial comprehensive assessment shall be completed for all clients within 30 days of the first appointment to access MCM/ICM services and includes at a minimum: • Client health history, health status, and health-related needs; • Behavioral health (including mental health, substance use) • Social; • Financial; • Health literacy; • Cultural issues; • Acuity level; and • Other needs.	2.1	The client record shall contain the initial client assessment forms dated within five (5) days of referral or date of service requested. Intake progress notes shall reflect the date of referral or service requested and date of intake. A copy of the completed comprehensive assessment is documented within 30 days of the first appointment and shall be maintained in the approved electronic database management system.
2.2	(Part A) ICM shall demonstrate at a minimum, 2 face-to-face contacts **and** 2 additional contacts monthly with each client. (Part B) MCM shall demonstrate at least 1 face-to-face contact quarterly (every 3 months) and 2 additional contacts monthly with each client.	2.2	(Part A) Documentation of the number of face-to-face and other client contacts every month included in the approved electronic database management system. (Part B) Documentation of the number of face-to-face and other client contacts included in the approved electronic database management system.
2.3	***Acuity Level***: MCM/ICM clients will have a documented initial acuity assessment completed once the client is assigned.	2.3	Documentation of the Acuity Assessment completed in the approved electronic database management system.

	Thereafter an Acuity Assessment shall be completed at least every 6 months and/or as needed. To receive on-going MCM services, the client must have an acuity level of 2 and be an eligible recipient of Part B funded services. To receive ongoing ICM services, the client must not be virally suppressed, have other cormorbidities and/or other extensive needs that require a higher level of case management services.		Documentation of completed acuity level using an approved acuity scale with the comprehensive assessment and documented in the approved electronic database management system. Documentation of MCM acuity level 2 noted in the approved electronic database management system. Documentation of an updated Acuity Assessment at least every six (6) months, to ensure acuity is still an appropriate level for the client's needs completed in the electronic database management system

2.4	***Care Plan:*** An individual care plan shall be developed with the participation of the client within 30 days of the comprehensive needs assessment. The care plan shall be based on prioritized identified needs, acuity level, and shall address client's cultural needs. The care plan should include at a minimum:
	• Problem Statement (Need)
	• Goal(s) – suggest no more than 3 goals for ICM, one of which shall be attainment of viral suppression
	• Intervention
	  ○ Task(s)
	  ○ Referral(s)
	  ○ Service Deliveries
	• Individuals responsible for the activity (MCM/ICM, client,
		2.4	Documentation of the individual care plan developed with the client within 30-days of the comprehensive assessment in the approved electronic database management system.
			
			Documentation of ongoing care plan reviews, case notes reflecting the stated need and the progress/lack of progress towards meeting the goal are identified in the approved electronic database management system.

	other team member and/or family) • Anticipated timeframe for each task MCM/ICM shall conduct reviews and adaptation of the care plan at least monthly, throughout the client's enrollment with MCM/ICM services. The care plan shall be updated, revised or amended at least monthly in response to goals or changes in client's life. Tasks, referrals, and services should be updated as they are identified or completed. Each client shall be assisted with establishing expected outcomes within the care plan. For ICM, changes in frequency of contacts (increased or decreased) shall be based on the client's rate of achieving viral suppression.		Documentation reflects review of the care plan at least monthly in the approved electronic database management system.
2.5	***Progress Notes***: MCM/ICM are responsible for monitoring and documenting the client's progress in meeting established goals of the care plan. All progress note shall be electronically signed with the MCM/ICM full legal name and title. All progress notes shall be entered in the approved standard progress note format. The entries must be dated with title and credentials within 72 business hours after date of activity. For clients receiving ICM services the reason(s) for increased or	2.5	A progress note must be completed on a client for each contact to include adherence (medical, medication, and care plan) and health outcomes in the approved electronic database management system. Progress notes shall reflect all required elements in the approved electronic database management system.

	decreased frequency of contacts must be documented in the progress notes.		
2.6	***Viral Suppression/Treatment Adherence***: MCM/ICM to assess the client's treatment adherence needs and provide education as soon as clients enter MCM/ICM services and should continue as long as a client receives MCM/ICM services. The following criteria are recommendations that can help MCM/ICM staff and clients examine the client's current and historical adherence to both medical care and treatment regimens: • **Medication Adherence:** Relates to current level of adherence to ARV medication regimen and client's ability to take medications as prescribed. MCM/ICM staff will use any available treatment adherence tool to promote adherence. **Appointments:** Relates to current level of completion of appointments for core medical services and understanding the importance of regular attendance at medical and non-medical appointments in order to achieve positive health outcomes. • **Knowledge of HIV Medications:** Relates to client's understanding of prescribed ARV regimen, the role of medications in achieving positive health	2.6	Documentation of education about the goals of ARV therapy in the approved electronic database management system. Documentation of medication adherence counseling with education documented in the approved electronic database management system.

	outcomes and techniques to manage side effects. • **Treatment Support:** Relates to client's relationship with family, friends, and/or community support systems, which may either promote or hinder client adherence to treatment protocols		
2.7	***Referrals:*** MCM/ICM shall complete referrals based on the comprehensive needs assessment and the acuity assessment. MCM/ICM shall facilitate oral health referrals for clients. MCM/ICM shall determine the need for medical transportation and facilitate the appropriate conveyance. MCM/ICM shall determine the need for food services and facilitate access to the appropriate method. MCM/ICM shall coordinate and track linkage and outcomes of clients referred to other core medical, support services, partner services, and prevention to support identification of those unaware of their HIV status.	2.7	All completed client referral forms shall be maintained in the approved electronic database management system. Oral Health purchase orders and treatment plan shall be documented in the approved electronic database management system. All bus passes and door-to-door vouchers shall be recorded in the approved electronic database management system. All food vouchers and/or food cards shall be recorded in the approved electronic database management system. Documentation including forms and progress notes regarding linkage and outcomes of referrals in the approved electronic database management system.
2.8	MCM/ICM shall facilitate distribution of nutritional supplements in accordance with a nutritional care	2.8	Nutritional care plan and services shall be documented in the approved electronic database management system.

	plan approved by a licensed dietitian.	

3.0 Additional Case Management Activities

Care Coordination includes communication, information sharing, and collaboration, and occurs regularly between medical case management and other staff serving the patient within the agency and among other agencies in the community. Coordination activities may include directly arranging access; reducing barriers to obtaining services; establishing linkages and confirming service acquisition.

3.0 Additional Case management Activities

	STANDARDS		MEASURES
3.1	MCM shall actively participate in multidisciplinary team meetings and/or case conferences for the clients to sustain retention in care and/or improve the client's quality of life as needed.	3.1	Documentation of team meetings and/or case conferencing or team meetings shall be entered in the approved electronic database management system.
3.1a	ICM shall establish monthly team meetings or case conferences with client's medical and other providers to sustain retention in care and/or improve the client's quality of life as needed.	3.1a	Documentation of team meetings and/or case conferences shall be entered in the approved electronic database management system.
3.2	MCM/ICM shall verify each client receives medically necessary services.	3.2	Progress notes document efforts to coordinate services with other service providers in the approved electronic database management system..

4.0 Discharge/Graduation

Clients who are no longer engaged in HIV treatment and care services OR have achieved self-sufficiency should have their cases closed based on the criteria and protocol outlined in the agency's MCM/ICM Policies and Procedures Manual.

4.0 Discharge/Graduation

	STANDARDS		MEASURES
4.1	Upon termination of active MCM/ICM services, a client's case shall be closed within 30 days of last contact or third documented attempted contact. The record shall contain a discharge summary documenting the case disposition and offer of an exit interview.	4.1	Upon discharge clients will receive a transition plan that outlines available resources and instructions for follow-up. Documentation of discharge shall be in the approved electronic database management system.
4.2	All attempts to contact the client and notification about case closure shall be communicated to the MCM Supervisor. Referral to Early Intervention Specialist (EIS) shall be completed after the MCM/ICM is unable to contact the client thirty (30) days after the expired eligibility or after three (3) documented attempted contacts.	4.2	Attempts to contact client about case closure is communicated with the MCM/ICM Supervisor and completion of an EIS referral shall be documented in the approved electronic database management system
4.3	Cases may be closed when the client: • Has achieved all goals listed on the Care Plan • Has become ineligible for services • Is deceased • Decides to discontinue the MCM/ICM services • The MCM/ICM is unable to contact the client thirty (30) days after the expired eligibility or three (3) documented attempts to contact • Is found to be improperly utilizing the service and/or is asked to leave the agency.	4.3	Documentation of case closure in the approved electronic database management system.

4.4	Clients who have successfully achieved all goals in the care plan shall be graduated from MCM/ICM services. Graduation criteria include: • Client completed all medical case management goals • Client is no longer in need of MCM services (e.g. client is capable of resolving needs independent of medical case management assistance). • Client has maintained viral suppression for 12 or more months.	4.4	Documentation of the client's graduation from MCM/ICM services is entered in the approved electronic database management system.
4.5	All discharged or graduated clients shall be offered an exit interview via one of the following: • Face-to-face visit; • Telephone • Written communication ***Note: When the Case Manager is not able to conduct an exit interview, reason must be documented in the record***	4.5	Documentation of an exit interview being offered shall be recorded in the approved electronic database management system.