Memphis TGA Ryan White Part A & MAI Medical Case Management Standards of Care

PURPOSE

The purpose of the Ryan White Part A and Minority AIDS Initiative (MAI) Medical Case Management Standards of Care is to ensure that uniformity of service exists in the Memphis Transitional Grant Area (TGA) such that the consumers of a service receive the same quality of service regardless of where or by whom the service is provided. Standards will be used as contract requirements, in program monitoring, and in quality management. If an agency is unable to meet a particular standard, the agency must document why the standard was unable to be met and explain the steps it is taking to meet that standard.

The purpose of Medical Case Management is to assist persons living with HIV/AIDS (PLWHA) by identifying and addressing barriers that limit a person's ability to connect to care and then link with needed services and to support the coordination and follow up of a person's medical care so that they can successfully participate in and adhere to HIV medical care.

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 form 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

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-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 support services, and insurance plans through the health insurance Marketplaces/Exchanges).

STANDARDS DEVELOPMENT PROCESS

These standards were developed through extensive background research on standards of care, a review of existing standards from other Ryan White Part A Eligible Metropolitan Areas (EMA) and TGAs, meetings of the Evaluation and Assessment Committee of the Memphis TGA Ryan White Planning Council and meetings with the Ryan White Part A Grantee.

APPLICATION OF STANDARDS

These standards apply to all agencies that are funded to provide Ryan White Part A and/or MAI Medical Case Management services within the Memphis TGA.

Standard	Measure/Method
I. Policies and Procedures	
A. See Universal Standards of Care for detailed information	

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Standard	Measure/Method
B. Client records must be maintained in an orderly manner. The purpose of this phase is to ensure the availability of a systematic account of the client's case file. All case files must be maintained in the method approved by the agency and must outline the course of the coordinated set of services. An orderly form of record keeping should allow for rudimentary case review as well as participation in program evaluation.	• Policies and procedures on file • Site visit review and documentation
C. Providers must demonstrate strong linkages with HIV/AIDS medical providers.	• Intra-Agency Agreements/ Memorandum of Understanding on file
D. Providers must demonstrate coordination within the agency and with external partners for clients needing linkage and retention support.	• Intra-Agency Agreements/ Memorandum of Understanding on file • Policies and procedures on file • Documentation in client records
II. Program Staff	
A. See Universal Standards of Care for detailed information	

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Standard	Measure/Method
B. Bachelor level degree in a health or human services related discipline with equivalent to two years of full time professional case management in a public service agency **Or** Bachelor level degree in Social Work with equivalent to two years of full time professional case management in a public service agency (an appropriately supervised BSW internship may count for one year's experience) **Or** Master level degree in a health or human services related discipline with equivalent to one year of full time professional case management in a public service agency **OR** Licensure as a RN and two years of full time professional case management in a public service agency. **AND** Certification as an Application Counselor through www.healthcare.gov.	• Documentation on file

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C. Ryan White Part A/MAI Medical Case Managers must have the supervision and guidance of a Master Level Social Worker, an M.D., or a Master's level nurse. Supervision can be performed by an individual with a Master's degree in Counseling, provided the individual with a Master's degree in Counseling is supervised by an M.D. Supervision must occur at a minimum of 2 hours per month for a total of 24 hours per year in either a group or individual setting. Supervision will address issues of client care (e.g. boundaries and appropriate interactions with clients), case manager job performance, and skill development (e.g. record keeping). Clinical supervision addresses anything directly related to client care (e.g., supervision in order to address specific client issues), and issues related to job related stress. Administrative supervision addresses issues related to staffing, policy, client documentation, reimbursement, scheduling, trainings, quality enhancement activities, and the overall running of the program and/or agency. ***Note: In such cases where a Medical Case Manager was employed prior to the implementation of the Standard and does not meet the given qualifications, the agency seeking modification and/or waiver of qualifications must present a written plan to the Grantee, to insure that the Medical Case manager receives appropriate additional education, training, and supervision to insure the provision of care.***	• Documentation of group or individual staffing minutes OR • Documentation in personnel file
D. See Universal Standards of Care for detailed information	

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Standard	Measure/Method
E. Agencies providing Medical Case Management services must document efforts to assist Medical Case Managers and clinical supervisory staff in securing on-going mandatory education and training related to HIV care and treatment and/or services provision (minimum 3 hours HIV specific) to better perform their respective job duties.	• Documentation in personnel files • Minimum of 9 hours of continuing • education required annually to be tracked and maintained by the agency
III. Access to Services IV. Eligibility Determination/Intake/Screening	
A. Proof of lack of insurance or health insurance carrier	• Agency client data report consistent with funding requirements
B. All intake instruments must comply with necessary laws and statutes regarding privacy and confidentiality and must comply with local, state and federal confidentiality and privacy laws and regulations.	• Review of intake instruments
C. Intake instruments must include appropriately signed (client and/or legal guardian) contractual agreement for intake and/or service(s). This documentation should include statement acknowledging client awareness of services, limitations, Clients Right and Responsibilities and grievance procedures. If the client is unable to sign agreement, there should be written documentation of the reason(s) why and the mechanisms in place to later secure needed signature. D. Minimum / "core" data elements collected for certification and re-certification should include: Legal first name, Legal last name, Gender, Complete date of birth, Street Address, City, State, Zip code, County, Race, Ethnicity, and latest annual review information including: latest insurance assessment, latest	• Review of client record

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Federal poverty level, and the latest housing arrangement.	
VI. Assessment	
A. After each client is determined eligible for the program, needs must be assessed **within 30 calendar days** from intake and completed in a systematic manner in order to provide appropriate information for the written plan of care. The purpose of this stage is to develop an understanding of what services the client may need. This stage builds on the information gathered in the initial intake; however, more detailed information is sought.	• Review of client record
B. While the assessment of each client may require the selection from a variety of assessment tools, the assessment(s) should gather information from the many areas in which the client functions. These areas include but are not limited to: **PRIMARY FOCUS** ✓ Psychosocial (i.e., emotional functioning, alcohol and/or drug use, mental health diagnosis/history/treatment, substance abuse diagnosis/history/treatment, etc.) ✓ Medical History/Physical Health (i.e., HIV/AIDS, Opportunistic Infections, other medical conditions, medication(s) and adherence, medical providers / settings, hospitalizations, etc.) ✓ Health Resources (i.e., Insurance, Ryan White, TennCare [Medicaid], Medicare) ✓ Safer Sex Practices (i.e., awareness and/or practice of, resources to maintain) ✓ Service Needs (Client list of personal/family resource(s) and service(s) need(s))	• Documentation of assessment in client record

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SECONDARY FOCUS (*as each impacts and/or is impacted by the client/patient's health and medical needs, services and/or resources*) ✓ Housing (i.e., housing resources, utilities, special needs) ✓ ✓ Functional Capabilities (i.e., Activities of daily living) ✓ Financial Resources (i.e., income, entitlements, public assistance, budget) ✓ Service Needs ✓ Religious/Spiritual/Cultural Resources and functioning (i.e., particular affiliations, memberships, rituals, and/or role in personal well-being) ✓ Educational/Employment ✓ Social Functioning (i.e., family, peers, social activities) ✓ Practical resources (i.e., transportation, food, clothing)	
C. Previous assessments (i.e. medical and nursing) should be used in the determination of client needs.	• Documentation in client record
D. Results of assessments are kept in the client's record.	• Documentation in client record
VII. Treatment/ Care Plan	
A. A Written Plan of Care must be developed within 30 calendar days from assessment date and with the participation and agreement of the client or guardian. The purpose of the written plan is to turn the assessment into a workable plan of action. The client must be allowed to have an active role in determining the direction of the delivery of services. The written plan also serves as a vehicle for linking clients to one or more needed services. The plan must be realistic and obtainable. Clients should be fully involved in the development of the plan of care. Services must not be routinely rendered without a written plan of care.	• Documentation in client record

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B. Information included in the plan of care include: - List of client service needs - Establishment of short and long term goals - Objectives and action steps to meet short term goals - Formal and informal resources to accomplish goals - Gaps in services - Alternatives to meet client goals - Resources to be used to meet client goals - Criteria for determination of completion of goals	• Documentation in client record
C. The plan must be implemented, monitored, and facilitated by a Medical Case Manager.	• Documentation in client record
D. If applicable, provide the rationale(s) for client non-compliance in the written plan.	• Documentation by Case Manager in client record
E. Providers shall document client's progress with care plan(s). The Written Plan of Care should evidence on-going involvement and review by the Case Manager with the client. Minimally, this should be bi-annually with contact and review within 6 months of intake and/or re-assessment	• Documentation of Case Manager case notes in client record AND/OR • Progress documented on Written Plan of Care in client record OR • Revised plan of care within client file
VII. Monitoring/ Reassessment/ Termination of Treatment Plan	
A. Monitoring is an ongoing process. The purpose of this stage is to allow the	• Documentation of progress written by

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client and Medical Case Manager to observe the progress of the plan of care in order to make revisions. The needs and status of each client receiving Medical Case Management services will be reassessed every 6 months in a face to face encounter monitored on a regular basis. Phone follow up to monitor progress/completion of care plan goals is needed. The intervals between monitoring may vary among clients, but must reflect necessity and consistency with the written plan.	Case Manager in client record
B. During monitoring of the plan of care, methods used to obtain information may include: - Communication with client - Direct observation of the client - Contact with service provider The types of information to be gathered include: - Present status of client - Client satisfaction - Quality and appropriateness of services provided	• Documentation in client record
C. Each client may be terminated from services as a result of monitoring, reassessment, or any form of client ineligibility. Clear policies and procedures related to the closure of the patients record must be in place. The purpose of this phase is to systematically conduct closure of the patient's record. The criteria for termination must be the result of previously discussed conditions directly relating to the written plan of care. The purpose of termination may be initiated by the client or Medical Case Manager. All efforts should be made to ensure continuity of care whenever possible.	• Documentation in client record
D. Conditions which result in client's termination from services may include:	• Documentation in client record

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Standard	Measure/Method
o Non-compliance with the agencies standard operation procedures related to the safety of staff, clients, and visitors. o Change in status which results in program eligibility o Client desire to terminate services o Death	
IX. Client Rights and Responsibilities	
A. See Universal Standards of Care for detailed information	
B. A client may refuse agreement to the identification of any or all problems, goals and/or action steps. In such cases the client chart (written plan and/or progress notes) should reflect the refusal, reason(s) and if appropriate, client signature	• Documentation in client record
C. Clients must have the right to access an articulated appeal process when services are terminated.	• Documentation in client record
D. Client must be afforded information regarding transfer to an outside agency.	• Documentation in client record • Policies and procedures regarding • The availability of the client's transfer to an outside agency must be clearly stated.