SERVICE STANDARD

CORE SERVICES

MEDICAL CASE MANAGEMENT (MCM)

Initial Issue Date	February 22, 2023
Approved by the Planning Council (Date)	February 22, 2023
Review/Revision Date(s)	April 27, 2023
Future Review/Revision Date(s)	As Needed
GOAL	The goal of *Medical Case Management* is to assist Persons with HIV/AIDS (PWH) improve health outcomes in support of the HIV Care Continuum through: a) timely and effective access to medical care and HIV medications, 2) elimination of access barriers to medical care, c) adherence to prescribed treatment plans, and d) sustained viral suppression.
OBJECTIVE	The objective of Medical Case Management services is to improve health care outcomes.
CITATION	**Policy Clarification Notice (PCN) #16-02:** *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds*.
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 under this service category may be provided 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, telehealth, etc).
KEY ALLOWABLE ACTIVITIES:	● Initial assessment and re-assessment of service needs ● Development of a comprehensive, individualized care plan ● Timely, coordinated access to medically appropriate health and support services and continuity of care ● Continuous monitoring to assess the efficacy of the individualized care plan ● Ongoing assessment of clients' needs and support systems ● Treatment adherence* counseling to ensure readiness for and adherence to prescribed HIV treatments ● All referrals shall be made by the Medical Case Management (MCM) at their medical care home and or medical community partner. Referrals will be good for six (6) months. * *Treatment adherence activities provided by Medical Case Managers (MCM) are considered MCM services. Whereas treatment adherence activities provided during an OAHS visit are considered Outpatient/Ambulatory Health Services.*

Additional Allowable Activities	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)
KEY SERVICE COMPONENTS AND ACTIVITIES:	● Initial comprehensive assessment and regular (six months) re-assessment ● Regular communications with clients ● Development, implementation, monitoring and evaluation of the individualized comprehensive plan ● Adherence education and monitoring ● Timely and accurate documentation ● Confidentiality, HIPAA, stigma, trauma, cultural and linguistic competency
ASSESSMENT AND SERVICE PLAN **Primary Focus (Medical History, Psychosocial, Health Resources, Safer Sex and Service Needs)** **Secondary Focus (Housing, Functioning, Religious, Educational, Basic Needs)**	The Comprehensive Assessment should be completed within 30 business days of the initial contact and will include the following components: • Demographic information: legal name, date of birth, race, ethnicity • Gender assigned at birth and/or gender identity • Information about significant others, partners, minor children • Emergency contact name and contact information • Health insurance coverage including Health Insurance Premium and Cost Sharing Assistance (if applicable) • Contact information for client's primary care provider, dentist, and pharmacy • Current medications (including dosages), nutritional supplements and complementary therapies • Current CD-4 and Viral Load values • Summary of medical and behavioral health history including treatments and hospitalizations • Risk behavior and risk reduction interventions • Oral Health screening • Mental Health screening • Substance Abuse screening, including tobacco use • Nutritional screening • Public benefits and/or entitlements • Housing situation • History of significant debt and money management issues • Employment status • Legal history, including current probation/parole status, if applicable • Family and social support system • Religious and spiritual beliefs • Physical and/or social barriers to medical care and support services • Transportation needs • Agency(s) where client is currently receiving services or has previously received services (if not in care)

DEVELOPMENT OF THE COMPREHENSIVE INDIVIDUALIZED PLAN	● Set measurable and mutually acceptable goals based on the *Comprehensive Assessment* ● Identify actions needed to attain each goal ● Identify timelines for achieving goals ● Describe how outcomes will be measured ● Develop a treatment adherence plan ● Ensure the individualized plan is reasonable, appropriate and doable by ensuring client's input and buy-in
IMPLEMENTATION OF THE INDIVIDUALIZED PLAN	● Schedule clients' appointments for medical visits ● Schedule clients' appointments for lab tests ● Refer clients for additional Core and Support services as needed ● Contact providers to set up appointments on clients' behalf and follow-up ● Arrange for transportation, if needed ● Confidentially remind clients of upcoming appointments ● Reschedule missed appointments and identify reasons for non-compliance ● Monitor clients' clinical indicators, specifically viral load and CD-4 values
MONITORING OF THE EFFICACY OF THE INDIVIDUALIZED PLAN	● Maintain contact with clients in the preferred manner at a minimum every three (3) months ● Discuss any treatment adherence issues (e.g. side effects) ● Address emergency situations as they arise ● Follow up to make sure diagnostic, medical and specialty appointments are kept ● Conduct chart reviews (including lab test results) prior to medical visits ● Meet with clients after medical visits to make sure that they understand doctor's instructions and prescribed medications, and to schedule a follow-up medical appointment ● Participate in interdisciplinary (physician, medical case manager, RN, and other providers) case conferences at a minimum every six (6) months ● Review and revise the individualized plan as needed but at a minimum every six (6) months
RE-ASSESSMENT OF THE INDIVIDUALIZED PLAN	● Review original medical care plan and progress notes with the client at a minimum of every six (6) months. ● Evaluate the appropriateness and effectiveness of the medical plan ● Update personal data if necessary ● Assess client's satisfaction with the services and plan to address any unresolved and new concerns ● Identify significant changes in client's clinical, psychological, or functional status ● Review the status of insurance, employment, benefits and entitlements ● Obtain signed initial and updated individualized treatment plans ● Update progress notes detailing each contact with, or on behalf of the client. These records should include date of contact, the nature of the service and the name of the employee providing the service. *If medical case management records are in a paper format, original handwritten signature of the service provider is required.* ● Obtain signed and dated *Consent to Release Information* form. This form must be specific and time limited. ● Document any new medical or psychiatric emergency room visits or hospitalization

	● Identify the *goals* that have been *reached* within the established timeframes ● Identify the *goals* that have been *not reached* and re-evaluate their appropriateness and timeframes ● Assess whether access barriers to medical care have been removed or improved ● Assess the pattern of HIV medical visit and treatment adherence ● Document any change in client status, such as client transfer, demise, etc and complete Case Closure/Discharge process (please see Universal Service Standards)
DOCUMENTATION	● Client's name and unique identifier number, photocopy of client's ID ● Name and contact info of client's Medical Case Manager ● Proof of positive HIV status ● Initial needs assessment ● Signed and dated individualized care plans (initial and updated) ● Evidence of client's consent for services ● Evidence of client's refusal to participate in proposed interventions ● Progress notes detailing each contact with or on behalf of the client. These records should include date of contact, the nature of the service and the name of the employee providing the service. ● Evidence of the client's understanding of their rights and responsibilities ● Signed and dated *Consent to Release Information* form. This form must be specific and time limited. ● Documentation of client program discharge if they are no longer receiving services
PERSONNEL	Medical case management services will be provided by Medical Case Managers.
PERSONNEL QUALIFICATIONS AND TRAINING	● BS/BA in health, human services, social work, or a Registered Nurse (RN) and two (2) years of relevant full-time experience in a public service setting. Master's degree in health, human services, or social work and one (1) year of relevant full-time experience in a public service setting ● Medical Case Managers must be certified as Application Counselors through www.healthcare.gov. preferred. ● Documentation of two (2) hours per month of MCM staff supervision by a Master's level social worker, RN, of a physician (MD)* ● Mandatory annual trainings to include at a minimum HIPAA Privacy law, confidentiality, client rights, stigma, trauma, health education and risk reduction, health literacy and organization's grievance process, etc ● Mandatory annual performance review and evaluation for all RWHAP funded staff ● HIV experience preferred *First ninety (90) days documented HIV MCM training. **In cases where a Medical Case Manager was employed prior to the implementation of this Standard and does not meet the required qualifications, the agency may seek modification and/or waiver of staff qualifications by presenting a written plan to the Recipient, to ensure that the Medical Case Manager receives appropriate and necessary additional education, training, and supervision.*

INTAKE AND ELIGIBILITY AND RE-CERTIFICATION	Please see Memphis TGA **Universal Service Standards**.
TRANSITION AND DISCHARGE	Please see Memphis TGA **Universal Service Standards**.
CASE CLOSURE PROTOCOL	Please see Memphis TGA **Universal Service Standards**.
CLIENT'S RIGHTS AND RESPONSIBILITIES	Please see Memphis TGA **Universal Service Standards**
GRIEVANCE PROCESS	Please see Memphis TGA **Universal Service Standards**
CULTURAL AND LINGUISTIC COMPETENCY	Please see Memphis TGA **Universal Service Standards**
PRIVACY AND CONFIDENTIALITY (including securing records)	Please see Memphis TGA **Universal Service Standards**